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7 UNITS/HOURS

SPOUSAL AND PARTNER ABUSE DETECTION AND INTERVENTION

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1. Overview

This course represents a select group of strategies based on the best available evidence to help clinicians sharpen their focus on detection and intervention activities with the greatest potential to provide evidence based services for intimate partner violence (IPV) and its consequences across the lifespan. These strategies include screening, assessment, detection, intervention and treatment in order to support survivors, increase safety, and lessen harms. The strategies represented in this course include those with a focus on detection and intervention.

This course is a compilation of a core set of empirically driven clinical strategies to provide screening, detection and intervention. This course has several components. The first component includes an emphasis on increasing awareness about IPV. The second component includes IPV detection tools and strategies. The third component highlights intervention and treatment strategies including but not limited to crisis intervention and counseling, trauma informed care, and empirically driven treatment models such as CBT and CPT.

IPV is a serious preventable public health problem that affects millions of Americans and occurs across the lifespan. It can start as soon as people start dating or having intimate relationships, often in adolescence. IPV that happens when individuals first begin dating, usually in their teen years, is often referred to as TDV. From here forward in this technical package, we will use the term IPV broadly to refer to this type of violence as it occurs across the lifespan.

IPV (also commonly referred to as *domestic violence*) includes "physical violence, sexual violence, stalking, and psychological aggression (including coercive tactics) by a current or former intimate partner (i.e., spouse, boyfriend/girlfriend, dating partner, or ongoing sexual partner)." Some forms of IPV (e.g., aspects of sexual violence, psychological aggression, including coercive tactics, and stalking) can be perpetrated electronically through mobile devices and social media sites, as well as, in person. IPV happens in all types of intimate relationships, including heterosexual relationships and relationships among sexual minority populations. *Family violence* is another commonly used term in prevention efforts. While the term *domestic violence* encompasses the same behaviors and dynamics as IPV, the term *family violence* is broader and refers to a range of violence that can occur in families, including IPV, child abuse, and elder abuse by caregivers and others. This course is focused on IPV detection and intervention across the lifespan.

This course largely focuses on heterosexual men who abuse their intimate partners and on women who are abused by men, because these individuals constitute a significant portion of the population seeking substance abuse treatment. Though IPV encompasses a range of behaviors, this course focuses more on physical, or a

combination of physical, sexual, and emotional, violence. Women's abuse of men, and IPV within same-sex relationships are important issues that are not addressed in depth in this document, largely because each requires separate comprehensive review. Other patterns of IPV outside the scope of this course are abused women who in turn abuse their children or react violently to their partners' continued attacks and adult or teenage children who abuse their parents. The primary purpose of this course is to provide an overview of IPV so that providers can understand the particular needs and behaviors of batterers and survivors and tailor treatment plans accordingly. This requires an understanding not only of clients' issues but also of when it is necessary to seek help from IPV experts. As the course makes clear, each field can benefit enormously from the expertise of the other, and cooperation and sharing of knowledge will pave the way for the more coordinated system of care. Future publications will examine aspects of the problem that concern such special populations as adolescent gang members, gay men and lesbians, and women who batter.

Research indicates that IPV is most prevalent in adolescence and young adulthood and then begins to decline with age

IPV is Highly Prevalent

IPV affects millions of people in the United States each year. Data from the National Intimate Partner and Sexual Violence Survey (NISVS) indicate that nearly 1 in 4 adult women (23%) and approximately 1 in 7 men (14%) in the U.S. report having experienced severe physical violence (e.g., being kicked, beaten, choked, or burned on purpose, having a weapon used against them, etc.) from an intimate partner in their lifetime. Additionally, 16% of women and 7% of men have experienced contact sexual violence (this includes rape, being made to penetrate someone else, sexual coercion, and/or unwanted sexual contact) from an intimate partner. Ten percent of women and 2% of men in the U.S. report having been stalked by an intimate partner, and nearly half of all women (47%) and men (47%) have experienced psychological aggression, such as humiliating or controlling behaviors.[3] The burden of IPV is not shared equally across all groups; many racial/ethnic and sexual minority groups are disproportionately affected by IPV. Data from NISVS indicate that the lifetime prevalence of experiencing contact sexual violence, physical violence, or stalking by an intimate partner is 57% among multi-racial women, 48% among American Indian/Alaska Native women, 45% among non-Hispanic Black women, 37% among non-Hispanic White women, 34% among Hispanic women, and 18% among Asian-Pacific Islander women. The lifetime prevalence is 42% among multi-racial men, 41% among American Indian/Alaska Native men, 40% among non-Hispanic Black men, 30% among non-Hispanic White men, 30% among Hispanic men, and 14% among Asian-Pacific Islander men.[3] Additionally, the NISVS special report on victimization

by sexual orientation demonstrates that some sexual minorities are also disproportionately affected by IPV victimization; 61% of bisexual women, 37% of bisexual men, 44% of lesbian women, 26% of gay men, 35% of heterosexual women, and 29% of heterosexual men experienced rape, physical violence, and/or stalking from an intimate partner in their lifetimes.[7] In regards to people living with disabilities, one study using a nationally representative sample found that 4.3% of people with physical health impairments and 6.5% of people with mental health impairments reported IPV victimization in the past year.[8] Studies also show that people with a disability have nearly double the lifetime risk of IPV victimization.

IPV Starts Early In the Lifespan

Data from NISVS demonstrate that IPV often begins in adolescence. An estimated 8.5 million women in the U.S. (7%) and over 4 million men (4%) reported experiencing physical violence, rape (or being made to penetrate someone else), or stalking from an intimate partner in their lifetime and indicated that they first experienced these or other forms of violence by that partner before the age of 18. A nationally representative survey of U.S. high school students also indicates high levels of TDV. Findings from the Youth Risk Behavior Survey indicate that among students who reported dating, 10% had experienced physical dating violence and a similar percentage (11%) had experienced sexual dating violence in the past 12 months. In an analysis of a recent survey where the authors examined students reporting physical and/or sexual dating violence, the findings indicate that among students who had dated in the past year, 21% of girls and 10% of boys reported either physical violence, sexual violence, or both forms of violence from a dating partner. Research also indicates that IPV is most prevalent in adolescence and young adulthood and then begins to decline with age,[2] demonstrating the critical importance of early prevention efforts.

IPV is Connected to Other Forms of Violence

Experience with many other forms of violence puts people at risk for perpetrating and experiencing IPV. Children who are exposed to IPV between their parents or caregivers are more likely to perpetrate or experience IPV, as are individuals who experience abuse and neglect as children. Additionally, adolescents who engage in bullying or peer violence are more likely to perpetrate IPV. Those who experience sexual violence and emotional abuse are more likely to be victims of physical IPV.1 Research also suggests IPV may increase risk for suicide. Both boys and girls who experience TDV are at greater risk for suicidal ideation. Women exposed to partner violence are nearly 5 times more likely to attempt suicide as women not exposed to partner violence. Intimate partner problems, which includes IPV, were also found to be a precipitating factor for suicide among men in a review of violent death records from 7 U.S. states. Research also shows that experience with IPV (either perpetration or victimization) puts people at higher risk for experiencing IPV in the future. The different forms of violence often share the same individual, relationship, community, and societal risk factors. The interconnections between the different forms of violence suggests multiple opportunities for prevention. Many of the strategies included in this

course include example programs and policies that have demonstrated impacts on other forms of violence as reflected in CDC's other technical packages for prevention of child abuse and neglect, sexual violence, youth violence and suicide

Impact of Intimate Partner Violence

Intimate partner violence (IPV) is a widespread and devastating phenomenon, with millions of women being assaulted by intimate partners and ex-partners across their lifespan. The term IPV refers to an ongoing pattern of coercive control maintained through physical, psychological, sexual, and/ or economic abuse that varies in severity and chronicity. It is not surprising, then, that IPV survivors' responses to this victimization would vary, as well. Many women recover relatively quickly from IPV, particularly if the abuse is shorter in duration and less severe and they have access to resources and support. Others, particularly those who experience more frequent or severe abuse, may develop symptoms that make daily functioning more difficult. Ongoing abuse and violence can induce feelings of shock, disbelief, confusion, terror, isolation, and despair, and can undermine a person's sense of self. These, in turn, can manifest as psychiatric symptoms (e.g., reliving the traumatic event, hyperarousal, avoiding reminders of the trauma, depression, anxiety, and sleep disruption). Some trauma survivors experience one or more of these symptoms for a brief period of time, while others develop chronic posttraumatic stress disorder (PTSD), a disorder that is a common response to overwhelming trauma and that can persist for years. Survivors are also at risk for developing depression, which has been found to significantly relate to the development of PTSD (Cascardi, O'Leary, & Schlee, Stein & Kennedy). For those who have also experienced abuse in childhood and/ or other types of trauma (i.e., cumulative trauma), the risk for developing PTSD is elevated (Campbell). Experiencing childhood trauma and/ or severe longstanding abuse as an adult can also disrupt one's ability to manage painful internal states (affect regulation), leaving many survivors with coping mechanisms that incur further harm (e.g., suicide attempts, substance use). Trusting others, particularly those in caregiving roles, may be especially difficult.

While keeping in mind that victimization can lead to mental health symptoms, it is also important to remember that for women who are currently experiencing IPV what may look like psychiatric symptomatology (e.g., an "exaggerated" startle response on hearing a door slam) may in fact be an appropriate response to ongoing danger. Although wariness, lack of trust, or seemingly paranoid reactions may be manifestations of previous abuse, this "heightened sensitivity" may also be a rational response that could protect a woman from further harm. Similarly, a survivor's seemingly passive response to abuse can be misinterpreted, as well. While passivity might be a response to previous experiences of trauma, for survivors of IPV, it may be an intentional strategy used to avoid or minimize abuse that is beyond their control (Goodkind, Sullivan, & Bybee, Stark). Choosing to remain in an abusive relationship is often based on a

strategic analysis of safety and risk (Davies, Lyon, & Monti-Catania). It is also influenced by culture, religion, and the hope (not always unfounded) that abusers can change (Warshaw, Brashler, & Gill). Some IPV survivors turn to professionals for help with PTSD, depression, or anxiety symptoms that are interfering with their functioning and wellbeing.

2. Intimate Partner Violence (IPV) Awareness

Intimate Partner Violence (IPV) Defined

IPV (also commonly referred to as domestic violence) includes "physical violence, sexual violence, stalking, and psychological aggression (including coercive tactics) by a current or former intimate partner (i.e., spouse, boyfriend/ girlfriend, dating partner, or ongoing sexual partner)." Some forms of IPV (e.g., aspects of sexual violence, psychological aggression, including coercive tactics, and stalking) can be perpetrated electronically through mobile devices and social media sites, as well as, in person. IPV happens in all types of intimate relationships, including heterosexual relationships and relationships among sexual minority populations. Family violence is another commonly used term in prevention efforts. While the term domestic violence encompasses the same behaviors and dynamics as IPV, the term family violence is broader and refers to a range of violence that can occur in families, including IPV, child abuse, and elder abuse by caregivers and others. This course is focused on IPV across the lifespan, including partner violence among older adult populations.

IPV is Associated with Several Risk and Protective Factors.

Research indicates a number of factors increase risk for perpetration and victimization of IPV. The risk and protective factors discussed here focus on risk for IPV perpetration, although many of the same risk factors are also relevant for victimization. Factors that put individuals at risk for perpetrating IPV include (but are not limited to) demographic factors such as age (adolescence and young adulthood), low income, low educational attainment, and unemployment; childhood history factors such as exposure to violence between parents, experiencing poor parenting, and experiencing child abuse and neglect, including sexual violence. Other individual factors that put people at risk for perpetrating IPV include factors such as stress, anxiety, and antisocial personality traits; attitudinal risk factors, such as attitudes condoning violence in relationships and belief in strict gender roles; and other behavioral risk factors such as prior perpetration and victimization of IPV or other forms of aggression, such as peer violence, a history of substance abuse, a history of delinquency, and hostile communication styles. Relationship level factors include hostility or conflict in the relationship, separation/ending of the relationship (e.g., break-ups, divorce/separation), aversive family communication and relationships, and having friends who perpetrate/ experience IPV. Although less studied than factors at other levels of the social ecology, community or societal level factors include poverty, low social capital, low collective efficacy in neighborhoods (e.g., low willingness of neighbors to intervene when they see violence), and harmful gender norms in

societies (i.e., beliefs and expectations about the roles and behavior of men and women). Additionally, a few protective factors have been identified that are associated with lower chances of perpetrating or experiencing TDV. These include high empathy, good grades, high verbal IQ, a positive relationship with one's mother, and attachment to school. Less is known about protective factors at the community and societal level, but research is emerging indicating that environmental factors such as lower alcohol outlet density and community norms that are intolerant of IPV may be protective against IPV. Although more research is needed, there is some evidence suggesting that increased economic opportunity and housing security may also be protective against IPV.

Intimate Partner Violence and Associated Terms

Intimate Partner Violence—Overall Definition

Intimate partner violence includes physical violence, sexual violence, stalking and psychological aggression (including coercive tactics) by a current or former intimate partner (i.e., spouse, boyfriend/girlfriend, dating partner, or ongoing sexual partner).

Intimate Partner

An intimate partner is a person with whom one has a close personal relationship that may be characterized by the partners' emotional connectedness, regular contact, ongoing physical contact and sexual behavior, identity as a couple, and familiarity and knowledge about each other's lives. The relationship need not involve all of these dimensions.

Intimate partner relationships include current or former:

- Spouses (married spouses, common-law spouses, civil union spouses, domestic partners)
- Boyfriends/girlfriends
- Dating partners
- Ongoing sexual partners

Intimate partners may or may not be cohabiting. Intimate partners can be opposite or same sex. If the victim and the perpetrator have a child in common and a previous relationship but no current relationship, then by definition
they fit into the category of former intimate partner. States differ as to what constitutes a common-law marriage.

Physical Violence

Physical violence is defined as the intentional use of physical force with the potential for causing death, disability, injury, or harm. Physical violence includes, but is not limited to: scratching, pushing, shoving, throwing, grabbing, biting, choking, shaking, hair-pulling, slapping, punching, hitting, burning, use of a weapon (gun, knife, or other object), and use of restraints or one's body, size, or strength against another

person. Physical violence also includes coercing other people to commit any of the above acts.

Sexual Violence

Sexual violence encompasses acts that range from verbal harassment to forced penetration, and an array of types of coercion, from social pressure and intimidation to physical force. Sexual violence is defined as a sexual act that is committed or attempted by another person without freely given consent of the victim or against someone who is unable to consent or refuse. It includes: forced or alcohol/ drug facilitated penetration of a victim; forced or alcohol/drug facilitated incidents in which the victim was made to penetrate a perpetrator or someone else; nonphysically pressured unwanted penetration; intentional sexual touching; or non-contact acts of a sexual nature. Sexual violence can also occur when a perpetrator forces or coerces a victim to engage in sexual acts with a third party.

BOX 1. DEFINITIONS OF SEXUAL VIOLENCE

The World Health Organization (WHO) defines sexual violence as: **'Any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances, or acts to traffic or otherwise directed against a person's sexuality using coercion, by any person regardless of their relationship to the victim, in any setting, including but not limited to home and work'**(*2*).

Coercion can encompass:

- varying degrees of force;
- psychological intimidation;
- blackmail; or
- threats (of physical harm or of not obtaining a job/grade etc.).

In addition, sexual violence may also take place when someone is not able to give consent – for instance, while intoxicated, drugged, asleep or mentally incapacitated.

While the WHO definition is quite broad, narrower definitions also exist. For example, for purposes of research, some definitions of sexual violence are limited to those acts that involve force or the threat of physical violence.

The *WHO multi-country study* (*3*) defined sexual violence as acts through which a woman:

- was physically forced to have sexual intercourse when she did not want to;
- had sexual intercourse when she did not want to, because she was afraid of what her partner might do; or
- was forced to do something sexual that she found degrading or humiliating.

There are many reasons women do not report sexual violence, including:

- ❖ Inadequate support systems;
- ❖ Shame;
- ❖ Fear or risk of retaliation;
- ❖ Fear or risk of being blamed;
- ❖ Fear or risk of not being believed;
- ❖ Fear or risk of being mistreated and/or socially ostracized.

What are the root causes of and risk factors for sexual violence?
Understanding the factors associated with a higher risk of sexual violence against women is complex, given the various forms that sexual violence can take and the numerous contexts within which it occurs. The ecological model, which proposes that violence is a result of factors operating at four levels: individual, relationship, community and societal, is helpful in understanding the interaction between factors and across levels.
The following lists of factors, which are common across studies and settings, are adapted primarily from publication *Preventing intimate partner and sexual violence against women: taking action and generating evidence* and the publication *World report on violence and health*.

Individual and Relationship Factors
Research into factors that increase men's risk of committing sexual violence is relatively recent and skewed towards those men who have been apprehended, particularly for rape. Among the factors that have been reported in multiple studies of this type are:
✓ Harmful or illicit use of alcohol or drugs;
✓ Antisocial personality;
✓ Exposure to intra-parental violence as a child;
✓ History of physical or sexual abuse as a child;
✓ Limited education;
✓ Acceptance of violence (e.g. belief that it is acceptable to beat one's wife or girlfriend);
✓ Multiple partners/infidelity; and
✓ Gender-inequitable views.

More recently, researchers in South Africa have completed a large cross-sectional survey of men in the population and found that having raped was associated with: higher levels of adversity in childhood; having been raped by a man; higher levels of maternal education; less equitable views on gender relations; having had more partners; and other gender-inequitable practices such as transactional sex.

Community and Societal Factors
From a public health perspective, community and societal factors may be the most important for identifying ways to prevent sexual violence before it happens, since society and culture may support and perpetuate beliefs that condone violence. Factors linked to higher rates of men's perpetration of sexual

violence include:

- ✓ Traditional gender and social norms related to male superiority (e.g. that sexual intercourse is a man's right in marriage, that women and girls are responsible for keeping men's sexual urges at bay or that rape is a sign of masculinity); and
- ✓ Weak community and legal sanctions against violence.

What are the health consequences of sexual violence?
Evidence suggests that male and female survivors of sexual violence may experience similar mental health, behavioral and social consequences. However, women bear the overwhelming burden of injury and disease from sexual violence and coercion , not only because they comprise the vast majority of victims but also because they are vulnerable to sexual and reproductive health consequences such as unwanted pregnancy, unsafe abortion and a higher risk of sexually transmitted infections, including from HIV, during vaginal intercourse. However, it is important to note that men are also vulnerable to HIV in cases of rape.

The Centers for Disease Control and Prevention (CDC) defines intimate partner violence (IPV) as actual or threatened physical, sexual, psychological, or stalking violence by current or former intimate partners (whether of the same or opposite sex). IPV is a major public health problem, reflected by both its prevalence and negative consequences.

- ➡ **Inability to Consent.** A freely given agreement to have sexual intercourse or sexual contact could not occur because of the victim's age, illness, mental or physical disability, being asleep or unconscious, or being too intoxicated (e.g., incapacitation, lack of consciousness, or lack of awareness) through their voluntary or involuntary use of alcohol or drugs.
- ➡ **Inability to Refuse.** Disagreement to engage in a sexual act was precluded because of the use or possession of guns or other non-bodily weapons, or due to physical violence, threats of physical violence, intimidation or pressure, or misuse of authority**.**

Sexual violence is divided into the following types:

- ▸ Completed or attempted forced penetration of a victim
- ▸ Completed or attempted alcohol/drug-facilitated penetration of a victim
- ▸ Completed or attempted forced acts in which a victim is made to penetrate a perpetrator or someone else
- ▸ Completed or attempted alcohol/drug-facilitated acts in which a victim is made to penetrate a perpetrator or someone else
- ▸ Non-physically forced penetration which occurs after a person is pressured verbally or through intimidation or misuse of authority to consent or acquiesce

- Unwanted sexual contact
- Non-contact unwanted sexual experiences

Penetration
Penetration involves physical insertion, however slight, of the penis into the vulva; contact between the mouth and the penis, vulva, or anus; or physical insertion of a hand, finger, or other object into the anal or genital opening of another person.

➡ **Penetration of Victim**
- *Penetration of the Victim by Force* - Includes completed or attempted unwanted vaginal (for women), oral, or anal insertion through use of physical force or threats to physically harm toward or against the victim. Examples include pinning the victim's arms, using one's body weight to prevent movement or escape, use of a weapon or threats of use, and assaulting the victim.
- *Penetration of Victim by Alcohol/drug-facilitation* - Includes completed or attempted unwanted vaginal (for women), oral, or anal insertion when the victim was unable to consent due to being too intoxicated (e.g., incapacitation, lack of consciousness, or lack of awareness) through their voluntary or involuntary use of alcohol or drugs.

➡ **Victim was Made to Penetrate**
- *Victim was Made to Penetrate a Perpetrator or Someone Else by Force* - Includes times when the victim was made, or there was an attempt to make the victim, sexually penetrate a perpetrator or someone else without the victim's consent because the victim was physically forced or threatened with physical harm. Examples include pinning the victim's arms, using one's body weight to prevent movement or escape, use of a weapon or threats of use, and assaulting the victim.
- *Victim was Made to Penetrate a Perpetrator or Someone Else by Alcohol/drug-facilitation* - Includes times when the victim was made, or there was an attempt to make the victim, sexually penetrate a perpetrator or someone else without the victim's consent because the victim is unable to provide consent due to being too intoxicated (e.g., incapacitation, lack of consciousness, or lack of awareness) through their voluntary or involuntary use of alcohol or drugs.

➡ **Nonphysically Pressured Unwanted Penetration**
- Victim was pressured verbally or through intimidation or misuse of authority to consent or acquiesce to being penetrated. Examples include being worn down by someone who repeatedly asked for sex or showed they were unhappy; feeling pressured by being lied to, or being told promises that were untrue; having someone threaten to end a relationship or spread rumors; and sexual pressure due to someone using their influence or authority (this is not an exhaustive list).

➡ **Unwanted Sexual Contact**

Intentional touching, either directly or through the clothing, of the genitalia, anus, groin, breast, inner thigh, or buttocks of any person without his or her consent, or of a person who is unable to consent or refuse. Unwanted sexual contact can be perpetrated against a victim or by making a victim touch the perpetrator. Unwanted sexual contact could be referred to as sexual harassment in some contexts (e.g., school or workplace).

➡ **Non-Contact Unwanted Sexual Experiences**

Sexual violence that does not include physical contact of a sexual nature between the perpetrator and the victim. This occurs against a person without his or her consent, or against a person who is unable to consent or refuse. Some acts of non-contact unwanted sexual experiences occur without the victim's knowledge. This type of sexual violence can occur in many different venues (e.g., school, workplace, in public, or through technology).

Non-contact unwanted sexual experiences includes acts such as:

- Unwanted exposure to sexual situations - pornography, voyeurism, exhibitionism (this is not an exhaustive list)
- Verbal or behavioral sexual harassment - making sexual comments, spreading sexual rumors, sending unwanted sexually explicit photographs, or creating a sexually hostile climate, in person or through the use of technology (this is not an exhaustive list)
- Threats of SV to accomplish some other end such as threatening to rape someone if he or she does not give the perpetrator money; threatening to spread sexual rumors if the victim does not have sex with them (this is not an exhaustive list)
- Unwanted filming, taking or disseminating photographs of a sexual nature of another person (this is not an exhaustive list)

➡ **Tactics**

Methods used by the perpetrator to coerce someone to engage in or be exposed to a sexual act. The following are tactics used to perpetrate SV (this is not an exhaustive list):

- Use or threat of physical force toward a victim in order to gain the victim's compliance with a sexual act (e.g., pinning the victim down, assaulting the victim)
- Administering alcohol or drugs to a victim in order to gain the victim's compliance with a sexual act (e.g., drink spiking)
- Taking advantage of a victim who is unable to provide consent due to intoxication or incapacitation from voluntary consumption of alcohol, recreational drugs, or medication
- Exploitation of vulnerability (e.g., immigration status, disability, undisclosed sexual orientation, age)
- Intimidation
- Misuse of authority (e.g., using one's position of power to coerce or force a person

to engage in sexual activity)
- Economic coercion, such as bartering of sex for basic goods, like housing, employment/wages, immigration papers, or childcare
- Degradation, such as insulting or humiliating a victim
- Fraud, such as lies or misrepresentation of the perpetrator's identity
- Continual verbal pressure, such as when the victim is being worn down by someone who repeatedly asks for sex or, for example, by someone who complains that the victim doesn't love them enough
- False promises by the perpetrator (e.g., promising marriage, promising to stay in the relationship, etc.)
- Nonphysical threats such as threats to end a relationship or spread rumors
- Grooming and other tactics to gain a child's trust
- Control of a person's sexual behavior/sexuality through threats, reprisals, threat to transmit STD's, threat to force pregnancy, etc.

➡ **Stalking**

A pattern of repeated, unwanted, attention and contact that causes fear or concern for one's own safety or the safety of someone else (e.g., family member, close friend).

Harassment, Stalking and Cyberstalking

Stalking is harassment of or threatening another person, especially in a manner that physically or emotionally disturbs them. Stalking of an intimate partner can take place during the relationship, with intense monitoring of the partner's activities, or it can take place after a partner or spouse has left the relationship. The stalker may be trying to get their partner back, or they may wish to harm their partner as punishment for their departure. Regardless of the motive, the victim fears for their safety. Stalking may occur at or near the victim's home, near or in their workplace, on the way to any destination, or on the internet (cyberstalking). Stalking can be on the phone, in person, or online. Stalkers sometimes do not reveal themselves, or they may just "show up" unexpectedly. Stalking is often unpredictable and dangerous.

In the past decade, stalking victimization has received greater recognition as a problem affecting both women and men in the United States. Much of what we have learned about stalking is based on studies of intimate partner violence and special populations, such as college students (Fisher, et al.). In recent years, technological advances have dramatically increased the options available for communication between people. Less is known about the extent to which newer technologies (e.g., text messages, emails, instant messages) have been used for stalking and harassment of others. Further, there are few recent national level estimates of stalking victimization (The National Intimate Partner and Sexual Violence Survey | Summary Report).

Cyberstalking is defined as utilizing the internet with the intention to harass and/or stalk another person. Cyberstalking is deliberate and persistent in nature. It may be an

additional form of harassment, or the only method the perpetrator employs. The cyber stalker's communication may be disturbing and inappropriate. Often, the more the victim protests or responds, the more rewarding the cyberstalker experiences the stalking. The best way to respond to a cyberstalker is not to respond. Cyberstalking may graduate to physical stalking, aggression, and violence.

Stalking acts by a perpetrator can include, but are not limited to:
- Repeated and unwanted phone calls, voice messages, text messages, pages, and hang-ups
- Repeated and unwanted emails, instant messages, or messages through websites (e.g., Facebook)
- Leaving cards, letters, flowers, or presents when the victim doesn't want them
- Watching or following from a distance
- Spying with a listening device, camera, or global positioning system (GPS)
- Approaching or showing up in places (e.g., home, work, school) when the victim does not want to see them
- Leaving strange or potentially threatening items for the victim to find
- Sneaking into the victim's home or car and doing things to scare the victim by letting them know they (perpetrator) had been there
- Damaging the victim's personal property, pets or belongings
- Harming or threatening to harm the victim's pet
- Threatening to hurt victim's family or friends
- Making threats to physically harm the victim
- "Showing up" wherever the victim is located
- Monitoring the victim's phone calls
- Monitoring the victim's mail or internet use
- Sifting through the victim's garbage
- Contacting the victim's friends, family, co-workers, or neighbors to obtain information about the victim

Criteria for stalking victimization: Victim must have experienced multiple stalking tactics or a single stalking tactic multiple times by the same perpetrator and:
- Felt fearful or
- Believed that they or someone close to them would be harmed or killed as a result of the perpetrator's behavior

➡ **Psychological Aggression**

Use of verbal and non-verbal communication with the intent to:
1. Harm another person mentally or emotionally, and/or
2. Exert control over another person.

Psychologically aggressive acts are not physical acts of violence, and in some cases may not be perceived as aggression because they are covert and manipulative in nature. Nevertheless, psychological aggression is an essential component of intimate

partner violence for a number of reasons. First, psychological aggression frequently co-occurs with other forms of intimate partner violence and research suggests that it often precedes physical and sexual violence in violent relationships. Second, acts of psychological aggression can significantly influence the impact of other forms of intimate partner violence (e.g., the fear resulting from being hit by an intimate partner will likely be greater had the intimate partner previously threatened to kill the victim). Third, research suggests that the impact of psychological aggression by an intimate partner is every bit as significant
as that of physical violence by an intimate partner. However, further work needs to be done related to the measurement of psychological aggression, particularly how to determine when psychologically aggressive behavior crosses the threshold into psychological abuse.

Positive and Negative Aspects of Bonding Among Batterers

Positive

- Support for change
- Amelioration of feelings of isolation; support for communicating experiences with others
- Help in dealing with crisis
- Friendships

Negative

- Support for control and dominant behavior over partners
- Support of counterproductive activities (e.g., having multiple sexual partners)
- Support of negative parenting activities (e.g., having children by different women)
- Support for a negative definition of manhood
- Support for believing he is correct and does not have to negotiate or compromise
- Access to information on how to violate laws such as orders of protection
- Use of alcohol and other drugs
- Opportunity to participate in "gripe sessions"—tirades against women under their control
- Reinforcement of perceived victim status

Psychological aggression can include, but is not limited to:

- Expressive aggression (e.g., name-calling, humiliating, degrading, acting angry in a way that seems dangerous).
- Coercive control (e.g., limiting access to transportation, money, friends, and family; excessive monitoring of a person's whereabouts and communications; monitoring or interfering with electronic communication (e.g., emails, instant messages, social media) without permission; making threats to harm self; or making threats to harm a loved one or possession).
- Threat of physical or sexual violence (e.g., "I'll kill you;" "I'll beat you up if you don't have sex with me;" brandishing a weapon)—use of words, gestures, or weapons to communicate the intent to cause death, disability, injury, or physical harm. Threats also include the use of words, gestures, or weapons to communicate the intent to compel a person to engage in sex acts or sexual contact when the person is either unwilling or unable to consent.
- Control of reproductive or sexual health (e.g., refusal to use birth control; coerced

pregnancy terminations).
- Exploitation of victim's vulnerability (e.g., immigration status, disability, undisclosed sexual orientation).
- Exploitation of perpetrator's vulnerability (e.g., perpetrator's use of real or perceived disability, immigration status to control a victim's choices or limit a victim's options). For example, telling a victim "if you call the police, I could be deported."
- Gaslighting (i.e., "mind games") – presenting false information to the victim with the intent of making them doubt their own memory and perception.

Terms Associated with the Circumstances and Consequences of Violence

Control of Reproductive or Sexual Health

Includes controlling or attempting to control a partner's reproductive health or decision making. This also includes SV behaviors by the perpetrator that increase the risk for sexually transmitted disease and other adverse sexual health consequences (e.g., unintended and frequent pregnancies). Examples include not allowing the use of birth control, coerced or forced pregnancy terminations, and forced sterilization because of abuse.

Physical Violence

Physical violence is defined as the intentional use of physical force with the potential for causing death, disability, injury, or harm. Physical violence includes, but is not limited to: scratching, pushing, shoving, throwing, grabbing, biting, choking, shaking, hair-pulling, slapping, punching, hitting, burning, use of a weapon (gun, knife, or other object), and use of restraints or one's body, size, or strength against another person. Physical violence also includes coercing other people to commit any of the above acts.

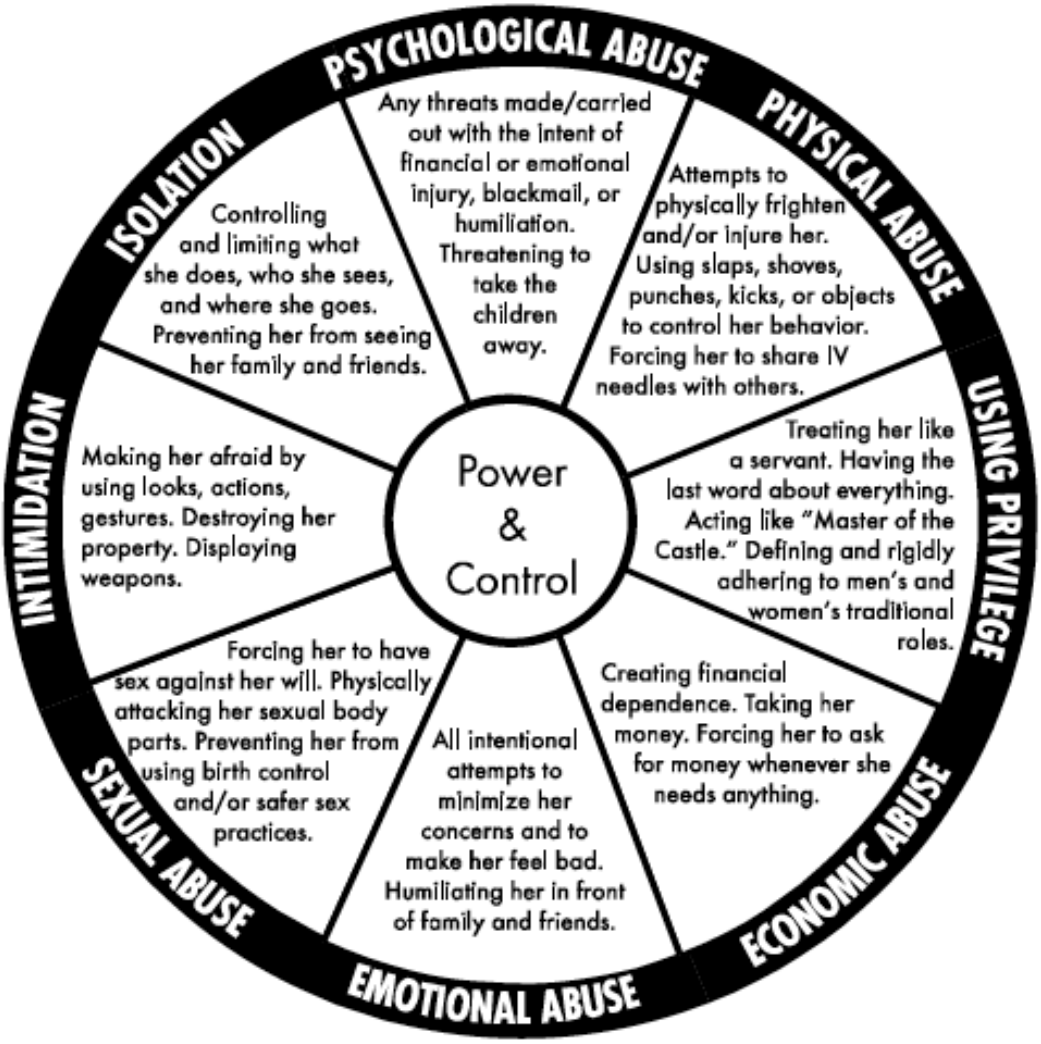
Psychological Functioning

The intellectual, developmental, emotional, behavioral, or social role functioning of the victim. Changes in psychological functioning can be either temporary (i.e., persisting for 180 days or less), intermittent, or chronic (i.e., likely to be of an extended and continuous duration persisting for a period greater than 180 days). Examples of changes in psychological functioning include increases in or development of anxiety, depression, insomnia, eating disorders, post-traumatic stress disorder, dissociation, inattention, memory impairment, self-medication, self-mutilation, sexual dysfunction, hypersexuality, and attempted or completed suicide.

Sexual Trafficking

The recruitment, harboring, transportation, provision, or obtaining of a person for the purpose of a commercial sex act. In order for a situation to be considered trafficking, it must have at least one of the elements within each of the three criteria of: process,

Figure 1-1
Manifestations of Domestic Violence



Source: Casa Myrna Vazquez, Inc. Adapted from the Domestic Abuse Intervention Project by Elba Crespo-Gonzalez. Developed for Casa Myrna Vazquez, Inc., and sponsored by the Boston Health Start Initiative, 1998.

means, and goal. If one condition from each criterion is met, the result is trafficking. For adults, victim consent is irrelevant if one of the means is employed. For children, consent is irrelevant with or without the means category.

- Process: Recruitment, transportation, transferring, harboring, or receiving
- Means: Threat, coercion, abduction, fraud, deceit, deception, or abuse of power
- Goal: Prostitution, pornography, violence/sexual exploitation, or involuntary sexual servitude

An example in the context of intimate partner violence includes a perpetrator forcing his wife or girlfriend into commercial sex work.

Researchers and prevention specialists are working to identify the factors that place intimate partners at risk for being victimized by or perpetrating violence, to find out which interventions are working, and to design more effective prevention programs. National data suggest that IPV is perpetrated against both women and men, although most research indicates that women are more likely than men to be victimized by almost every type of IPV, including rape, physical assault, and stalking by an intimate partner (Tjaden and Thoennes). The consequences of IPV are well documented and include substantial morbidity and mortality and physical and psychological health problems. Women are significantly more likely than men to be injured or killed by intimate partners. Approximately one in three females murdered in the United States is killed by a partner, whereas approximately one in twenty U.S. males murdered is killed by a partner (Puzone et al.). Psychological consequences include post-traumatic stress disorder, depression, substance abuse, and suicidal behaviors (Caetano and Cunradi; Campbell; Coker et al).

Systematic research investigating marital violence began in the 1970's and, by the early 1980's, expanded to include courtship or relationship violence. Several studies using nationally representative samples from the United States have been conducted among married couples, and college couples. In general, these studies reported alarming rates of interpersonal conflict among married and unmarried couples in terms of verbal and physical aggression. Recently, on reviewing the previous 17 years of empirical research revolving intimate relationships, it is estimated that 54% of women will experience at least one physical assault inflicted by an intimate partner during adulthood (American Journal of Drug and Alcohol Abuse). The magnitude of this statistic may be difficult for some to grasp.

IPV perpetrators come from all lifestyles. They can be doctors or lawyers as well as workers in factories or stores. They come from all racial groups. They can be drunk or sober. Most abusers have no mental illness. In addition, most people who were abused as children grow up to become warm and loving adults. When people use violence in the family, it is because they think it will help them to get something they want. Some abusers use violence because they do not know how to get what they want in any other way. The most common cause of family violence is the desire to control others.

The effects of IPV are far-reaching, affecting not only families but also communities, institutions, and societies a whole. It adversely affects the criminal justice system, social services, the legal system, the educational system, and the workplace. Too often, we hear that some husband has massacred his wife and children and then killed himself, with the details vividly broadcast in national headlines and news clips. One outcome of such media coverage is the marginalization of the perpetrators: These men are portrayed as unusual, psychotic, and deranged. They are depicted as different from us. We like to believe that the unusual origins of their psychosis explain how they could perform such violent acts. These events appear to be random floating blocks of ice, rather than the tip of the iceberg. Also, the fact of what happened—the

ultimate violence against a woman and her children—gets lost in the spectacle of the homicide/suicide. The daily violence against women—the slappings and beatings, controlling behaviors, streams of verbal abuse, and denigration—seem disconnected from these juicy media stories. And we do not make the connection (Journal of Family Practice).

Multiple factors may account for the connection between poverty and intimate partner violence. Just as child abuse, elder abuse, and other forms of family violence are more common among those who are poor, so, too is wife abuse. When resources are scarce due to poverty, the stressors that our families face may be compounded. The family with the exception of the military in times of war and the police is society's most violent social institution. Some structural factors that may account for the frequency of violence within families include the greater amount of the time spent interacting with family members compared with others, the intensity of involvement with the family members, and the privacy accorded families, which lessens social control. Furthermore, the family is constantly undergoing changes and transitions, which may increase tensions. Although all families may face stress, the lower level of resources among those who are poor may make them more vulnerable to its effects. Moreover, poor women may have few options that would enable them to escape an abusive relationship (American Journal of Community Psychology).

However, evidence indicates that some abuse is deliberately intended to prevent women from becoming economically self-sufficient. About 47% of abused women in a welfare- to-work program reported that their intimate partner tried to prevent them from obtaining education and training. Both abused and non-abused in this sample where discouraged from working by their partners, but women with abusive partners face active interference. Among women in three urban women's shelters, 46% of the male partners forbade women from getting job and 25% forbade them from going to school. Of those who worked and went to school anyway, 85% missed worked because of abuse and 56% missed school because of abuse; 52% where fired or quit because of abuse. Eight percent of randomly selected women in a low-income neighborhood in Chicago reported that their boyfriend or husband prevented them from going to school or work in the last 12 months. Psychological symptoms associated with abuse victimizations, such as depression, insomnia, nightmares, and flashbacks may interfere with employment or education (Centers for Disease Control).

IPV and emotional abuse is characterized by physically and/or psychologically dominating behaviors used by a perpetrator to control the victim. Partners may be married or unmarried; heterosexual, or homosexual; living together, separated or dating. IPV occurs in all cultures; people of all races, ethnicities, religions, sexes and classes can be perpetrators of IPV. IPV is also known as domestic violence, domestic abuse, or spousal abuse. IPV is perpetrated by both men and women. The perpetrator often will use fear and intimidation as a method of control. The perpetrator may also

threaten to use or may actually use physical violence. The perpetrator intentionally uses verbal, nonverbal, or physical methods to gain control over the other person.

There are many considerations in evaluating abuse including:
✓ ***Mode*****:** physical, psychological, sexual and/or social.
✓ ***Frequency****:* on/off, occasional and chronic.
✓ ***Severity:*** in terms of both psychological or physical harm and the need for treatment.
✓ ***Transitory or permanent injury:*** mild, moderate, severe and up to homicide.

An area of the field that is often overlooked is passive abuse leading to violence. Passive abuse is covert, subtle and veiled. This includes victimization, procrastination, forgetfulness, ambiguity, neglect, spiritual and intellectual abuse.

Increased recognition of IPV began during the women's movement. Awareness regarding IPV varies among different countries. Only about a third of cases are actually reported in the United States and the United Kingdom.

There is increasing awareness and advocacy for men victimized by women. In a report on violence related injuries by the US Department of justice hospital emergency room visits related to IPV revealed that physically abused men represent just under one-sixth of the total patients admitted to hospital reporting IPV as the cause of their injuries. The report reveals that significantly more men than women did not disclose the identity of their attacker. This is likely due to shame, stigma, and embarrassment associated with men victimized by women.
According to a *Centers for Disease Control Report*, data from the *Bureau of Justice, National Crime Victimization Survey* consistently show that women are at significantly greater risk of intimate partner violence than are men. Researchers with the Centers for Disease Control reported on rates of self-reported violence among intimate partners. In the study, almost one-quarter of participants reported some violence in their relationships. Half of these involved one-sided ("non- reciprocal") attacks and half involved both assaults and counter assaults ("reciprocal violence"). Women reported committing one-sided attacks more than twice as often as men (70% *versus* 29%). In all cases of intimate partner violence, women were more likely to be injured than men, but 25% of men in relationships with two-sided violence reported injury compared to 20% of women reporting injury in relationships with one- sided violence. Women were more likely to be injured in non-reciprocal violence

Physical Abuse

As mentioned earlier, physical abuse is characterized by aggressive behavior that may result in the victim sustaining injury. The abuse is rarely a single incident and typically forms identifiable patterns that may repeat more and more quickly, and which may become increasingly violent.

Financial/Economic Abuse

Financial abuse occurs when one individual attempts to take total or partial control of another's finances, inheritance or employment income. It may include denying access to one's own financial records and knowledge about personal investments, income or debt, or preventing a partner from engaging in activities that would lead to financial independence.

Financial or economic abuse includes:

- ❖ Withholding economic resources such as money or credit cards
- ❖ Stealing from or defrauding a partner of money or assets
- ❖ Exploiting the partner's resources for personal gain
- ❖ Withholding physical resources such as food, clothes, necessary medications, or shelter from a partner
- ❖ Preventing a partner from working or choosing an occupation

Ritual Abuse

Ritual abuse is defined as a combination of severe physical, sexual, psychological and spiritual abuses used systematically and in combination with symbols, ceremonies and/or group activities that have a religious, magical or supernatural connotation. Victims are terrorized into silence by repetitive torture and abuse over time and indoctrinated into the beliefs and practices of the cult or group. Ritual abuse may also be linked to Satanism or devil worship.

Spiritual Abuse

Spiritual abuse may include:

- ❖ Using the partner's religious or spiritual beliefs to manipulate them
- ❖ Preventing the partner from practicing their religious or spiritual beliefs
- ❖ Ridiculing the other person's religious or spiritual beliefs
- ❖ Forcing the children to be reared in a faith that the partner has not agreed to

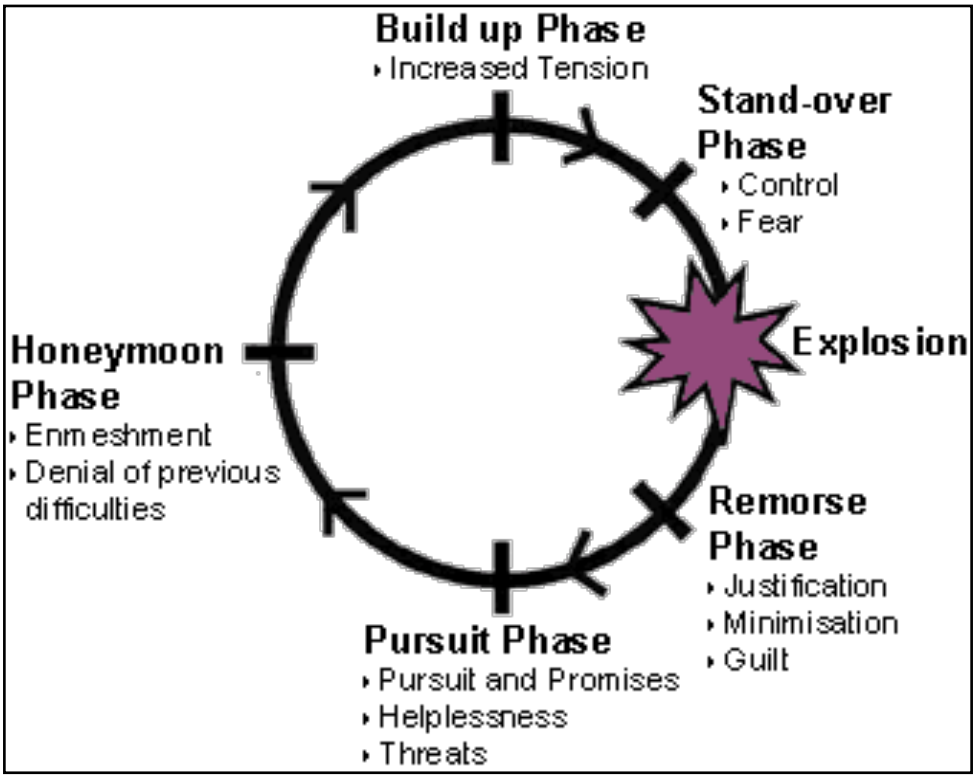
Spiritual and religious abuse is also abuse done in the name of, brought on by, or attributed to a belief system of the perpetrator, or abuse from a religious leader. This can include Priests, Ministers, cult members, family members, or anyone abusing in the name of a deity or perceived deity. Spiritual or religious abuse can find its way into every religion and belief system that exists. It may encompass many other forms of abuse, especially physical, sexual, emotional, psychological and financial

Battering Relationships

Battering relationships are often characterized by cyclical phases, sometimes referred to as *The Cycle of Violence*. A period of peace and calm is followed by escalating tension. A woman might feel as though she were walking on eggshells. Minor incidents may occur that the woman tries to minimize or deny, sometimes by taking the blame. When the tension becomes unmanageable, aggression occurs. The victim may be kicked, thrown against a wall, raped, threatened at gun or knife point, slapped, punched or subjected to any of the endless mental and physical abuses that

batterers use to intimidate and control their partners.

This then leads to *the honeymoon phase* where the relationship appears to be stable, the abusive incident is forgotten, and there is no active abuse. Of course, the abuse process remains unresolved and it is only a matter of time until tension develops, which leads to another explosion of violence, and the cycle continues.



Following the battering incident, the batterer is often remorseful and very loving. This is called the "honeymoon" phase. Because of the closeness the couple experiences during this phase and the promises the batterer makes, often the woman foregoes any plans to leave. She convinces herself that it will never happen again. Then the cycle repeats itself. However not everyone's experiences are the same. Sometimes a 'phase' does not occur, or two or more 'phases' can occur simultaneously.

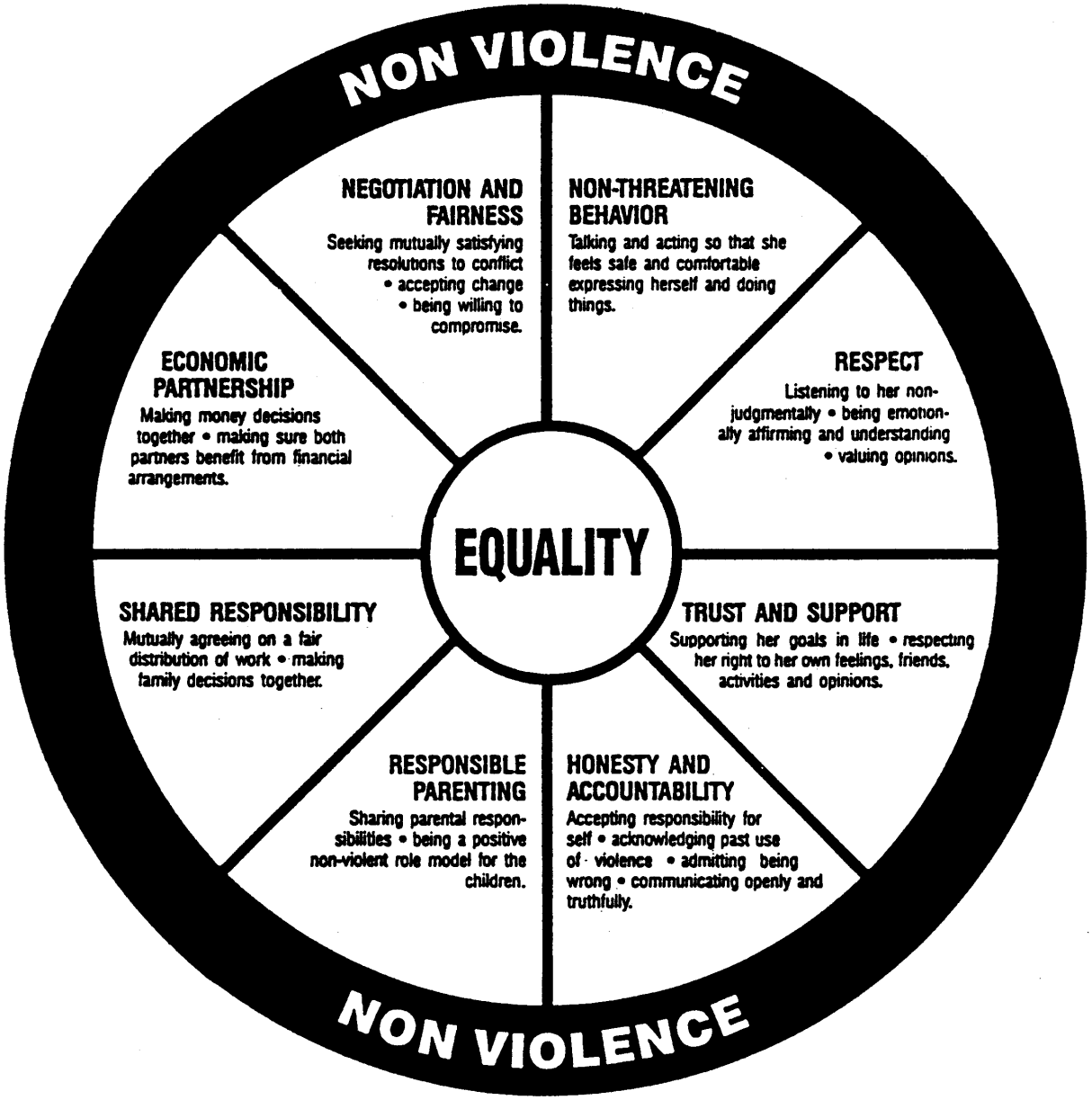
The *build up phase* is characterized by mounting tension. In a non-violent relationship, these tensions may often be resolved. In a violent relationship, the build up phase usually leads to a *stand-over phase*, in which the perpetrator uses their strength and belief system including their 'right' to dominate, in order to control and put down the victim. This then leads to the *explosion phase* when violence occurs.

The perpetrator may then enter the *remorse phase* where feelings of shame are experienced, or they may fear the consequences. The perpetrator may also attempt to justify or minimize their actions such as claiming that "she made me do it", or "it was only a little slap". This may consequently lead to the *pursuit phase* where the perpetrator may try to win back their victim with honeymoon behavior including gifts

and promises. The perpetrator may also behave helplessly such as claiming "I can't live without you", or "I'll kill myself". If these strategies are ineffective, the perpetrator may graduate to more and greater threats of violence.

The Power and Control Wheel illustrates the specific areas in which power and control are used in abusive relationships.

Conversely, the cycle of Fairness and Equality is characterized by negotiation and fairness, non-threatening behavior, respect, trust and support, honesty and accountability, responsible parenting, shared responsibility, and economic partnership.



3. Intimate Partner Violence (IPV) and Children

- ✓ 15.5 million U.S. children live in families in which partner violence occurred at least once in the past year, and seven million children live in families in which severe partner violence occurred.

- ✓ The majority of U.S. nonfatal intimate partner victimizations of women (two-thirds) occur at home. Children are residents of the households experiencing intimate partner violence in 43 percent of incidents involving female victims.

- ✓ The UN Secretary-General's Study on Violence against Children conservatively estimates that 275 million children worldwide are exposed to violence in the home.

- ✓ Children of mothers who experience prenatal physical domestic violence are at an increased risk of exhibiting aggressive, anxious, depressed or hyperactive behavior.

- ✓ Females who are exposed to their parents' domestic violence as adolescents are significantly more likely to become victims of dating violence than daughters of nonviolent parents.

- ✓ Children who experience childhood trauma, including witnessing incidents of domestic violence, are at a greater risk of having serious adult health problems including tobacco use, substance abuse, obesity, cancer, heart disease, depression and a higher risk for unintended pregnancy.

- ✓ Physical abuse during childhood increases the risk of future victimization among women and the risk of future perpetration of abuse by men more than two-fold.

- ✓ Psychotherapy designed for mothers and children together can increase the quality of parenting and increase positive outcomes for children.

- ✓ Many abusive men are concerned about the effect of violence on their children and the children of their partners. Some may be motivated to stop using violence if they understand the devastating effects on their children.

- ✓ A safe, stable and nurturing relationship with a caring adult can help a child overcome the stress associated with intimate partner violence.

Many factors influence children's responses to IPV. As you have probably observed in your work, not all children are equally affected. Some children do not show

obvious signs of stress or have developed their own coping strategies. Others may be more affected. A child's age, experience, prior trauma history, and temperament all have an influence. For example, an adolescent who grew up in an atmosphere of repeated acts of violence may have different post-traumatic stress reactions than a 12-year-old who witnessed a single violent fight. A six-year old girl who saw her mother bleeding on the floor and feared she would die would likely have more severe reactions than a child who perceived the incident she witnessed to be less dangerous.

A child's proximity to the violence also makes a difference. Consider the very different experiences of a 12-year-old child who was in another room with headphones on while her parents battled; an eight-year-old who had to call 911 despite a raging parent's threats against him; and a teenager who has frequently put himself at risk by getting into the middle of fights to protect his mother from her estranged boyfriend.

Here are some of the factors that can influence children's reactions to domestic violence:

- **The *severity* of the violence** (Was it life-threatening? Did the victim express terror in front of the child? Was a weapon used or brandished? Was there a serious injury?)
- **The child's *perception* of the violence** (A child may perceive violence as life-threatening even if adults do not.
- **The *age* of the child**
- **The quality of the child's *relationships* with both parents** (or involved parties)
- **The child's *trauma history*** (What other traumatic events has the child experienced? Was the child also a victim of physical abuse?)
- **Secondary *adversities* in the child's life**, such as moving, changing schools, or leaving behind support systems

Typical Short-term Responses

Children commonly respond to domestic violence as they do to other traumatic events. Short-term traumatic stress reactions include

- ***Hyperarousal.*** The child may become jumpy, nervous, or easily startled.
- ***Re-experiencing***. The child may continue to see or relive images, sensations, or memories of the domestic violence despite trying to put them out of mind.
- ***Avoidance***. The child may avoid situations, people, and reminders associated with the violence, or may try not to think or talk about it.
- ***Withdrawal***. The child may feel numb, frozen, or shut down, or may feel and act as if cut off from normal life and other people.
- ***Reactions to reminders***. The child may react to any reminder of the domestic violence. Sights, smells, tastes, sounds, words, things, places, emotions, even other people can become linked in the child's mind with the traumatic events. For example, a school-age child may become upset when watching a football game because the violent contact between players is a reminder of domestic violence.

Sometimes behavior that seems to come out of nowhere, such as a sudden tantrum, is actually a reaction to a trauma reminder.

- ***Trouble going to sleep*** or staying asleep, or having *nightmares*.
- ***Repetitive talk or play*** about the domestic violence. For example, a young girl may act out violence when playing with her dolls.

Other short-term symptoms may include anxiety (for example, separation anxiety); depression; aggression (perhaps reenactment of the witnessed aggression); physical complaints (stomachaches, headaches); behavioral problems (fighting, oppositional behavior, tantrums); feelings of guilt or self-blame; and poor academic performance.

Children's Responses in the Long Term

Research suggests that in the long term, children who have been exposed to domestic violence—especially those children who do not receive therapeutic intervention—may be at increased risk of

- Depression and anxiety
- Substance abuse
- Self-destructive or suicidal behaviors
- Self-destructive or suicidal behaviors
- Impulsive acts, including risky sex and unintended
- Pregnancy
- Chronic health problems
- Low self-esteem
- Criminal and violent behavior (including perpetration of domestic violence)
- Victimization by an intimate partner

Possible Reactions to Domestic Violence

Birth to Age 5

- Sleep or eating disruptions
- Withdrawal or lack of responsiveness
- Intense and pronounced separation anxiety
- Crying inconsolably
- Developmental regression, loss of acquired skills such as toilet training, or reversion to earlier behaviors, such as asking for a bottle again
- Intense anxiety, worries, or new fears
- Increased aggression or impulsive behavior
- Acting out witnessed events in play, such as having one doll hit another

Ages 6-11

- Nightmares, sleep disruptions
- Aggression and difficulty with peer relationships in school
- Difficulty with concentration and task completion in school

- Withdrawal and emotional numbing
- School avoidance or truancy
- Stomachaches, headaches, or other physical complaints

Ages 12-18

- Antisocial behavior
- School failure
- Impulsive or reckless behavior, such as
  - Truancy
  - Substance abuse
  - Running away
  - Involvement in violent or abusive dating relationships
- Depression
- Anxiety
- Withdrawal
- Self-destructive behavior such as cutting

It is important to remember that any of these symptoms can also be associated with other stress, traumas, or developmental disturbances. They should be considered in the context of the child's and family's functioning.

Factors That Help Children Recover

Most children are resilient if given the proper help following traumatic events. Research has shown that the support of family and community are key to increasing children's capacity for resilience and in helping them to recover and thrive. Crucial to a child's resiliency is the presence of a positive, caring, and protective adult in a child's life.

Although a long-term relationship with a caregiver is best, even a brief relationship with one caring adult—a mentor, teacher, day-care provider, an advocate in a domestic violence shelter—can make an important difference.

Here are some other protective factors for children:

✓ Access to positive social supports (religious organizations, clubs, sports, group activities, teachers, coaches, mentors, day care providers, and others)
✓ Average to above average intellectual development with good attention and social skills
✓ Competence at doing something that attracts the praise and admiration of adults and peers
✓ Feelings of self-esteem and self-efficacy
✓ Religious affiliations, or spiritual beliefs that give meaning to life

What Parents Should Tell Their Children About IPV

Some parents may be reluctant to tell you that their children have witnessed IPV. Others may try to minimize the children's actual exposure to the violence (saying, for

example, “They didn’t know it was happening,” or “They were always asleep or at school”). A victimized parent may also avoid talking to a child about domestic violence. The parent may assume that a child is too young to understand, or that it’s better to just move on. But *many children who’ve experienced IPV need to talk about it*. They may misunderstand what happened or why it happened. They may blame themselves, blame the victim, or blame the police or other authorities who intervened. They may have fantasies about how they can “fix” their family. They may take parental silence as a signal to keep silent themselves or to feel ashamed about what happened in their family.

As a clinician, you may be in the position of speaking to children yourself. If not, you can support the parents in breaking the silence. Start by assuming that children know more than we think they know. Talk to them about what happened, listen openly to what they have to say, and offer the following key messages:

- ✳ “The violence was not and is not okay.”
- ✳ “It is not your fault.”
- ✳ “I will listen to you.”
- ✳ “You can tell me how you feel; it is important.”
- ✳ “I’m sorry you had to see (or hear) that. You do not deserve to have this in your family.”
- ✳ “It is not your job or responsibility to prevent or change the situation.”
- ✳ “We can talk about what to do to keep you safe if it happens again” (such as staying in the bedroom, going to neighbors, calling a relative or 911).
- ✳ “I care about you. You are important.”
- ✳ “It is the job of adults to keep kids safe. There are adults who will work to keep you and your family safe.”

How Much Information Is Enough But Not Too Much?

Parents often struggle with how much specific information to share with children about what happened during a domestic violence incident. To gauge the right level of discussion, parents will find it helpful to

- ➡ Think about how to present the information in a form the child will understand. The amount of detail shared will often depend on the age and developmental stage of the child.
- ➡ Start by providing straightforward messages of support (see above), or by asking what the child saw, feels, or thinks about what happened.
- ➡ Ask the child if he or she has questions. Children will often stop asking questions when they have enough information to feel safe and secure. Refrain from giving them more information than they need or want.
- ➡ Remember that *it is always okay to ask children what they know and what they think*.
- ➡ Understand that giving children an opportunity to talk openly and ask questions about what they experienced can be more effective than reviewing the details from the adult’s perspective.

What Should a Parent Tell a Child about the Parent Who Was Abusive?

Parents who have experienced domestic violence often seek guidance on what to tell their children about the parent or partner who was abusive. Here are some key messages for children:

✓ The abusive behavior was not okay; violence is not okay.
✓ The abusive person is responsible: "It's not your fault. It's not my fault."
✓ It's okay to love and want to spend time with the person who was abusive.
✓ It's okay to be mad at or scared of the person who was abusive.
✓ It's also okay to feel mad at but still love the person who was abusive.

How Can Advocates Protect Children From Adult Information?

As a clinician, you may find yourself discussing details, and reviewing IPV incidents with clients in the presence of their children. Hearing the specific details of events can act as a trauma reminder for children. The descriptions themselves can be disturbing, as can the parent's distress in recounting them. A child too young to understand the content can still become upset. Even babies react to a caretaker's emotional distress with their own increased heart rates and signs of stress. The situation presents a challenge for advocates, but the following strategies can guide you in protecting children:

✓ If at all possible, avoid talking about the specifics of the intimate partner violence in front of children.
✓ Maintain a child-friendly waiting area for children old enough to wait on their own.
✓ Offer toys and games that may distract or comfort children if they have to be in the room with adults.
✓ Inform children that the advocate and parent are going to be talking about what happened, and that they might have some feelings about this. Check in on the child's feelings throughout the conversation, and offer comfort and reassurance.
✓ Encourage parents whenever possible to use natural supports for child care (such as friends, families, or familiar service providers), or ask if there is someone who can come and stay in the waiting room with the children for at least part of the time.
✓ Seek volunteers to provide child care during regularly scheduled hours in outreach offices and shelters.

How Should Parents Respond to and Cope With Their Children's Feelings About Them?

Children who have witnessed IPV often have confused and contradictory feelings. They may worry about the safety of the parent who has been abused. They may also worry that their parents won't be able to protect them. They may see the parent who was abusive as generous and loving some of the time, and terrifying and dangerous at other times. They may even blame the abused parent for causing the abuse that led to separation from the other parent. Often, children feel torn over loyalties and caught in

the middle. Here are some messages to offer children to help them explore and cope with these feelings:

- ✓ It is okay to feel more than one emotion at the same time (such as anger and love).
- ✓ It is normal to feel angry at either or both parents when violence happens.
- ✓ You can love someone and hate that person's behavior.
- ✓ It's okay to love both parents at the same time.
- ✓ Violence is an adult problem and it is not your fault or responsibility. You can't fix it.

A parent who has experienced IPV may expend a lot of energy simply surviving and helping the children survive. Other aspects of parenting may suffer as a consequence. The parent may become either overly permissive or too rigid and harsh in applying discipline. Or the parent may be inconsistent and fluctuate between permissiveness and harshness. Roles in the family may have become reversed. Children may have taken on parenting responsibilities in an effort to care for and protect family members.

In addition to providing emotional support and safety for families following IPV, advocates may need to model better parenting and offer strategies for behavior management. Indeed, these strategies may be needed immediately for some families in offices and shelters. Basic strategies include:

- ✓ ***Active ignoring or "picking your battles**."* Children's negative behaviors may be efforts to get attention from adults. An effective strategy is to identify the behaviors that can be ignored. Of course, a parent cannot ignore unsafe behaviors, but withdrawing attention from other negative or unwanted behaviors should eventually decrease them.
- ✓ ***Specific praise***. Using very specific praise to reward positive behavior not only increases the likelihood that the behavior will be repeated, but helps children feel valued and proud of themselves. Active ignoring is often most effective when paired with specific praise.
- ✓ ***Rules and routines***. Structured, consistent, and predictable rules and routines canbe extremely helpful. Children living with domestic violence often see the world as unpredictable and unsafe. Maintaining consistent rules and routines teaches children that life can be predictable. It also helps improve behavior problems and contributes to the child's sense of safety.
- ✓ ***Relaxation***. Teaching children simple relaxation skills, such as deep breathing, and providing the space for them to practice relaxing, can be very effective in helping them manage fear and anxiety. Relaxation can decrease acting-out behavior that may be due to anxiety and exposure to trauma reminders. For younger children, providing a safe and quiet place to play and explore can be helpful.
- ✓ ***Adequate suppor**t.* Parents who get help and support in coping with their own feelings are better equipped to help their children. They should be encouraged to seek help from mental health professionals or other support systems.

How Advocates Can Determine When a Child Needs More Help

Exposure to domestic violence can place children at risk for a variety of emotional, social, and behavioral problems. Some children, including those who exhibit the following warning signs, may require additional professional help to achieve recovery. If parents describe these signs, you should consider talking with them about seeking additional help:

- ➡ The child's traumatic stress reactions—such as re-experiencing, withdrawal, arousal, sleep disturbances, and reactions to trauma reminders—are severe enough to interfere with daily life.
- ➡ The child doesn't seem like herself. The child's behavior or mood has changed.
- ➡ The child is having significant trouble eating or sleeping, or complains of a lot of physical symptoms that have no apparent medical cause.
- ➡ The child's behaviors are becoming more risky and less predictable.
- ➡ The child seems sad, depressed, clingy, hopeless, or withdrawn from activities that were once loved.
- ➡ The child talks about dying or engages in self-injurious behaviors such as substance abuse, unhealthy sexual activity, cutting, or head banging.
- ➡ The child is increasingly worried, anxious, or fearful, or exhibits increased anger or aggression.

Secondary Trauma and How it Can Impact Clinicians

Caring for survivors of IPV and their children can exact a toll. In the process of hearing the vivid details of domestic violence, and responding with empathy, advocates themselves can experience traumatic stress reactions. A victim's story may even serve as a trauma reminder if you have experienced IPV or other traumatic events in your own life. Repeated exposure to trauma reminders can compromise your health and well-being. For example, you may feel overwhelmed by what you have heard or seen, and perhaps find yourself losing patience with a demanding mother or child. Reactions like these are often referred to as signs of *secondary traumatic stress* (or compassion fatigue, or vicarious trauma). *Secondary trauma is not a sign of weakness or lack of skill.* It is a normal response to working in the field of domestic violence advocacy. Possible signs of secondary traumatic stress include:

- ✓ Increased irritability or impatience with clients
- ✓ Intense feelings and intrusive thoughts (including nightmares) about a client's trauma
- ✓ Changes in how you experience yourself, others, and the world
- ✓ Persistent anger or sadness
- ✓ Increased fatigue or illness
- ✓ Disconnection from your colleagues or loved ones

If you notice these or other signs of secondary trauma, take steps to care for yourself and get support relevant to your work. Consider these possible strategies:

- ✓ Talk to a professional if your symptoms are affecting your day-to-day functioning at work or at home.
- ✓ Seek professional help to address your own history of domestic violence or other trauma.
- ✓ Reach out to team leaders, managers, and colleagues for support.
- ✓ Renew your commitment to creating a work-life balance.
- ✓ Identify and use coping strategies to manage stress.
- ✓ Utilize personal support systems.
- ✓ Attend to your physical, spiritual, and emotional health needs.
- ✓ Take some time off.

For further information about the impact of IPV on children and families, these Web sites offer valuable resources for advocates and parents:

National Child Traumatic Stress Network http://www.nctsn.org

National Center for Children Exposed to Violence http://www.nccev.org

Safe Start Center http://www.safestartcenter.org

National Coalition Against Domestic Violence http://www.ncadv.org

Office on Violence Against Women http://www.enditnow.gov

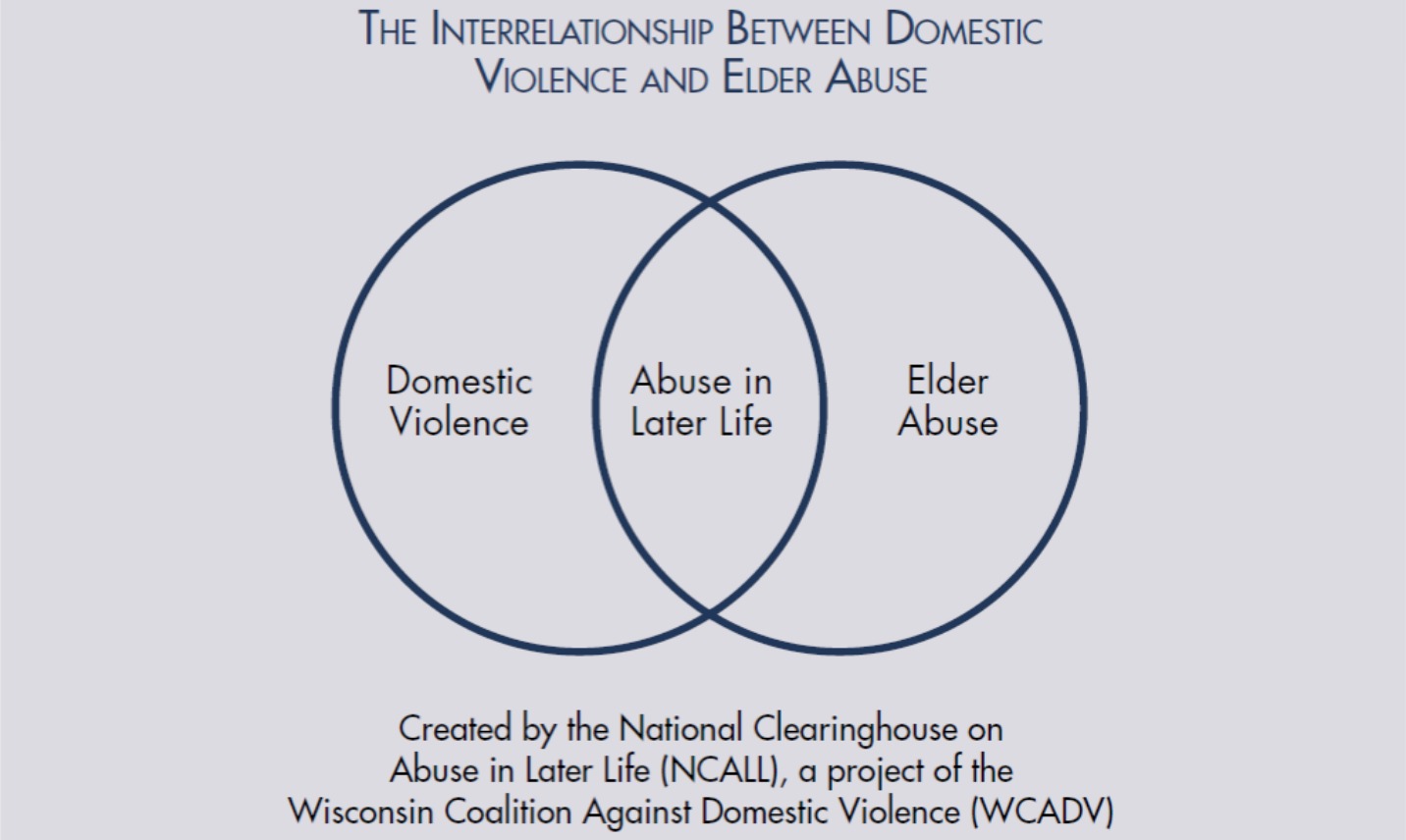
Clinical Documentation

Evaluative clinical information should be carefully entered in the client's record, since there may be future legal implications, including child custody determination. Mental health care professionals should remember that while there is no legal obligation to report cases of adult abuse, the law requires that all cases of child abuse must be reported to official child protective services. At the same time, mental health professionals should be sensitive to the possibility that victimized women may lose custody of their victimized children to the abuser. Positive aspects of parenting should be recorded as well *(Warshaw, C."Limitations of the Medical Model in the Care of Battered Women". in Bart, P., E. Moran. Violence Against Women: The Bloody Footprints, Sage.)*.

4. Intimate Partner Violence Later in Life

The World Health Organization defines elder abuse as "a single, or repeated act, or lack of appropriate action, occurring within any relationship where there is an expectation of trust, which causes harm or distress to an older person."
IPV is a pattern of coercive tactics that abusers use to gain and maintain power and control over their victims. Abusers believe they are entitled to use any method

necessary to control their victims. IPV in later life is a subset of elder abuse.



Spousal and partner relationships can include long-term relationships of 50 years or more, with the abuse present throughout that time. Spousal or partner relationships may also be new, often following the death of a previous partner or a separation or divorce. A final category of spousal or partner abuse is late-onset abuse, in which a long term relationship that had not been abusive previously becomes so in later life. In some cases, a medical or mental health condition may have led to aggressive or violent behavior. In other cases, power and control dynamics may have been present throughout the relationship but were not named or identified by the victim, so the situation is not late-onset but rather a long-term domestic violence case. In these training materials, abuse between strangers (e.g., scams and identity theft) is not considered domestic abuse in later life. Location. The abuse generally occurs where the victim lives, in either a residential or facility setting.

Forms

The abuse can be physical, sexual, emotional, or verbal; it also can encompass neglect or financial exploitation, including threats of harm. Most of these cases exhibit a combination of one or more of these tactics. NCALL's Abuse in Later Life Power and Control Wheel can be found in tab 12: Additional Resources.

What Causes Domestic Abuse in Later Life?

In many cases of domestic abuse in later life, one person uses power and control to get what he or she wants out of the relationship with the older person. Even if physical abuse is not used, the threat of harm is generally present. The person with the power typically uses many tactics to maintain control, including emotional and psychological abuse, threats of physical violence or abandonment, isolating the individual from family and friends, limiting the victim's use of the telephone, breaking assistive devices, and denying health care. Individuals who use power and control tactics in a relationship can be very persuasive, and often try to convince family, friends, and professionals that they are only trying to help. Abusive individuals rarely take any responsibility for their inappropriate behavior.

Issues That Often Co-Occur but Do Not Cause Abuse

A number of issues co-occur with abuse and are often mistaken as causes of abuse, neglect, or exploitation. These issues include anger, stress/ caregiver stress, medical conditions or mental health issues, substance abuse, or prior poor relationships. In most cases, however, these are issues that should be dealt with separately because they do not cause abusive behavior. Resolving these issues may deal with one problem but generally will not enhance victim safety or hold the abuser accountable. Anger is a normal and healthy emotion but it does not cause abuse. Even though abusers can be angry at times, abuse happens when an individual chooses manipulative, threatening, or physically violent behavior to gain power and control over another individual. Abusive tactics may occur without any evident anger in the abuser. In some instances, displays of anger are just one of many tactics used by an abusive person to gain control over another.

Originally, researchers thought that abuse of older adults was caused by caregiver stress. Although stress is a commonly used rationale for abuse, stress does not cause abuse. Everyone experiences stress. Most stressed people do not hurt others. Most abusers under stress do not hit their bosses or law enforcement officers. They choose their victims (such as family members) from those who have less power. Providing care for an ill or frail older person can be stressful. Some abusers suggest that their negative behavior is due to caregiver stress because they are physically and emotionally overwhelmed by the demands of providing care. However, research does not support caregiver stress as a primary cause of elder abuse. Instead, it is considered an excuse used by abusers so they can continue their behavior without consequences such as intervention by social services or law enforcement. For more information confirming that caregiver stress is not the primary cause of elder abuse, go to www.ncall.us. Challenging or violent behaviors may occur as a symptom of some medical or mental conditions or as a side effect of combinations of medications. In these circumstances, medical or mental health professionals need to be consulted for a diagnosis and recommended treatment. In other situations, some abusers may use a medical condition as an excuse for their behavior to avoid arrest or otherwise being held accountable. Professionals are encouraged to request a medical diagnosis to ensure that effective interventions are considered in these cases.

Victim safety should always be paramount. Drugs and alcohol are commonly used as excuses for abusive behavior (e.g., "I was so drunk, I didn't know what I was doing"). Yet, many people use drugs and alcohol and are never abusive. Drugs and alcohol do not cause abuse or violence; however, they may intensify the violence. Although abusers will sometimes use drugs or alcohol as an excuse for their behavior, abusers who misuse drugs and alcohol have two separate problems: abusive behavior and substance abuse.

Drug and alcohol treatment programs are designed to help an individual stay sober, not to eliminate abusive behavior. Abuse also does not occur because a victim of child abuse grows up and then abuses his or her parents. Abusive parents can unknowingly teach children that abuse is an effective way to control another individual. However, abusive behavior is a choice. Individuals who grew up with abuse can choose to behave abusively or they can choose to stop the pattern of violence that may be all too familiar for them.

Many adults who were victims of child abuse or who witnessed domestic abuse growing up have healthy, happy adult relationships and do not hurt their children, spouse/partner, or parents. Some individuals who were abused as children experience emotional problems and trauma related symptoms as adults. They may require specific treatment to deal with the effects of their victimization; however, this is not an excuse for someone to continue abusive behavior.

The Older Victim's Dilemma: To Remain In or End a Relationship With an Abuser — Challenges and Barriers to Living Free From Abuse

Victims of abuse often love or care about the people who harm them, including spouses, adult children, additional family members, or others. Keeping the family together may be very important to the victim for many reasons, including religious and cultural beliefs. Victims may want to maintain a relationship with the abuser—they simply want the abusive behavior to end. Victims often have a difficult time deciding whether or not to continue to have contact with an abuser. This ambivalence may be connected to very real fears and safety concerns. It is not unusual for victims to change their minds; at times they will leave a relationship, only to return later. Many factors affect the victims' decision-making process, and those who decide to end the relationship often face significant barriers. Some issues, challenges, and barriers include, but are not limited to—

- Fear of
  - ➢ Being seriously hurt or killed if they leave their abuser.
  - ➢ Retaliation for seeking assistance.
  - ➢ Being alone.
  - ➢ Losing their independence, autonomy, and even the ability to live in their own home.
- Economic issues:

- ✓ Lack of access to financial resources.
- ✓ Lack of available, affordable housing if they leave.

- Emotional concerns and connections:
  - ✓ Compassion and love for the abuser; not wanting to get a family member into trouble.
  - ✓ Not wanting to involve an outsider in their family's private business.
  - ✓ Embarrassment and shame, both that they are victims and that a family member (including a spouse or adult child) is the perpetrator.
  - ✓ Not wanting to leave behind a home, cherished possessions, or a pet.
  - ✓ A sense of responsibility to continue parenting an abusive adult child. A belief that they failed as a parent if their child is abusive.
- Medical conditions and disabilities:
  - ✓ The victims' medical needs may make living on their own difficult or impossible.
  - ✓ The abusive individual may need the victim's care.
- If the abuser is an adult child or grandchild, it can be difficult to cut ties completely because of—
  - ✓ A sense of responsibility as a parent or grandparent.
  - ✓ Love for the adult child or grandchild.
  - ✓ Memories of good times.
  - ✓ Shame or embarrassment.
  - ✓ Hope that things will get better.
  - ✓ Lack of a process for divorcing or completely severing the relationship with the adult child, as with a spouse.

Effective Interventions

Older victims of domestic abuse may require assistance to break their isolation and live more safely. Some older victims may need more time to heal physically and emotionally and may need different types of support than younger victims. They may need a safe place to be heard, emergency and transitional housing, transportation, support groups and counseling, legal assistance, and medical assistance or services. In addition, older victims may need more time to sort out their affairs and rebuild their lives, which could involve rekindling old friendships or acquiring new friends; obtaining assistance with financial planning, benefits, and insurance; and securing permanent housing. Cases of abuse in later life are often complex and require services from various organizations. The chart below lists some agencies that may be helpful for older victims and a few of the services they offer.

Collaboration Is Essential

Collaboration among community agencies is crucial to addressing domestic abuse in later life. Informal relationships among staff from various agencies may exist where professionals work together on specific cases or broader community initiatives. Many communities have created more formal teams, such as coordinated community response teams, fatality review teams, or elder abuse interdisciplinary teams. These

teams may focus on reviewing individual cases, coordinating the efforts of the various agencies involved, identifying gaps in services, and defining ways the public and private sectors can work together to meet victims' needs. Communication is often an issue among professionals from various disciplines. Each system has its own definitions and understanding of the problem and its own guiding principles, policies, and laws about how best to respond. These various approaches can sometimes lead to conflict and a
breakdown in communication and collaboration. Information sharing can be another area of contention. When victim safety is a concern, maintaining the victim's confidentiality can be imperative. Yet this means not sharing the victim's personal identifying information with other professionals who may be involved with the case, unless the victim gives his or her permission. Many states require that elder abuse cases be reported to APS/elder abuse agencies and/or law enforcement. However, mandatory reporting by domestic violence and sexual assault advocates is often controversial because it diminishes victims' autonomy and compromises victim advocate confidentiality.

Advocates who are mandated reporters can find more information about considerations regarding mandatory reporting at www.ncall.us/docs/Mandatory_Reporting_EA.pdf. Meeting regularly with collaborators can minimize conflicts and encourage communication. In addition, creating memorandums of understanding between agencies can do much to create smooth working relationships. A well-executed memorandum of understanding can facilitate all of the following: sharing knowledge and resources; eliminating duplication of services; creating an effective system for referring, assessing, and responding to clients; and fostering a shared commitment to victim safety and to holding abusers accountable. Most elder abuse cases are too complex for professionals from any one system to handle alone. Training and cross-training can help professionals understand the dynamics of abusive relationships and the interventions available for older victims of domestic abuse. Working together as an interdisciplinary team is also effective. Note to Trainers: Both "multidisciplinary team" and "interdisciplinary team" describe a group of professionals from different disciplines who work collaboratively to accomplish common goals. The term "elder abuse interdisciplinary team" is used in this guide to incorporate both concepts.

Abusive Tactics

- Physical Abuse
- Slaps, hits, punches
- Throws things
- Burns
- Chokes
- Breaks bones
- Creates hazards
- Bumps and/or trips

➢ Forces unwanted physical activity
➢ Pinches, pulls hair, and twists limbs
➢ Restrains

Sexual Abuse

➢ Makes demeaning remarks about intimate body parts
➢ Is rough with intimate body parts during care giving
➢ Takes advantage of physical or mental illness to engage in sex
➢ Forces sex acts that make victim feel uncomfortable or are against victim's wishes
➢ Forces victim to watch pornography on television or computer Psychological Abuse
➢ Withholds affection

Psychological/Emotional Abuse

➢ Engages in crazy-making behavior
➢ Publicly humiliates or behaves in a condescending manner Emotional Abuse
➢ Humiliates, demeans, ridicules
➢ Yells, insults, calls names
➢ Degrades, blames
➢ Uses silence or profanity Threatening
➢ Threatens to leave and never see older individual again
➢ Threatens to divorce or to refuse divorce
➢ Threatens to commit suicide
➢ Threatens to institutionalize the victim
➢ Abuses or kills pet or prized livestock
➢ Destroys or takes property
➢ Displays or threatens with weapons Targeting Vulnerabilities
➢ Takes or moves victim's walker, wheelchair, glasses, dentures
➢ Takes advantage of confusion
➢ Makes victim miss medical appointments Neglecting
➢ Denies or creates long waits for food, heat, care, or medication
➢ Does not report medical problems
➢ Understands but fails to follow medical, therapy, or safety recommendations
➢ Refuses to dress the victim or dresses inappropriately

Denying Access to Spiritual Traditions and Events

➢ Denies access to ceremonial traditions or church
➢ Ignores religious traditions
➢ Prevents victim from practicing beliefs and participating in traditional ceremonies and events

Using Family Members

➢ Magnifies disagreements
➢ Misleads family members about extent and nature of illnesses/conditions

➢ Excludes family members or denies the victim access to family members
➢ Forces family members to keep secrets
➢ Threatens and denies access to grandchildren
➢ Leaves grandchildren with grandparent against grandparent's needs and wishes

Ridiculing Personal and Cultural Values

➢ Ridicules victim's personal and cultural values
➢ Makes fun of a victim's racial background, sexual preference, or ethnic background
➢ Entices or forces the victim to lie, commit a crime, or engage in other acts that go against the victim's value system

Isolation

➢ Controls what the victim does, whom the victim sees, and where the victim goes
➢ Limits time with friends and family
➢ Denies access to phone or mail
➢ Fails to visit or make contact

Using Privilege

➢ Treats the victim like a servant
➢ Makes all major decisions
➢ Ignores needs, wants, desires
➢ Undervalues victim's life experience
➢ Takes advantage of community status, i.e., racial, sexual orientation, gender, economic level

Financial Exploitation

➢ Steals money, property titles, or possessions
➢ Takes over accounts and bills and spends without permission
➢ Abuses a power of attorney
➢ Tells victim that money is needed to repay a drug dealer to stay safe

5. Family Trauma Assessment

Children depend on their families for support and reassurance. This is especially true following a traumatic event when a child's belief in the safety and predictability of the world has been undermined. But trauma does not affect the child alone.The effects of any traumatic event reverberate throughout the family system. A child's greatest need for love and support may come at a time when the trauma itself has compromised a family's ability to provide it. This can happen for a variety of reasons:

➢ Other family members may have experienced the same traumatic event.
➢ Family members may have a history of trauma. The current event may bring back memories or feelings from the past.
➢ The traumatic event puts additional stress on a family whose current living situation is already stressful. They may lack the resources – emotional and material

– to help the child recover.

➢ The family already interacts and communicates in negative, or even destructive, ways.

A trauma-specific, family-centered assessment can provide valuable feedback to you and the family so that treatment can target the specific and interrelated needs of children and their families. Begin by partnering with caregivers in the assessment process. Their collaboration can help you develop a treatment plan that is workable and acceptable to the entire family. Without the engagement and active participation of caregivers, it is much more difficult for a child's individual therapy to succeed. The family assessment process will build collaboration with caregivers.

If a family session is a standard part of assessments within a clinic or practice, it becomes part of the culture. Clinicians and families will come to expect it as part of the treatment planning

The assessment will reveal:

➢ Which family members are affected and how

➢ The family's strengths and ways to utilize their natural sources of support

➢ Options for treatment

How do you get families to embrace the need for assessment?

How you first introduce the assessment to the family is vital. Convey your confidence in the benefits of the process and clearly describe why the information you'll gain is so important. Here are some key points to make when framing the family trauma assessment for caregivers:

➢ Caregivers and family members are the most important people in the child's life. They have the most intimate understanding of their child, and the child spends more time with them than anyone else. They are uniquely able to partner with the therapist in serving the best interest of the child and family.

➢ Research has shown time and time again that the support of family, peers, and community are essential elements in children's recovery.

➢ It is normal for caregivers to be upset about a child's having been exposed to a traumatic event. It is normal to find the child's post-traumatic stress reactions distressing and challenging. A caregiver who understands how the trauma is affecting each member of the family and the family's overall well-being can seek out the kinds of supports that will be most helpful.

➢ Learning about the child's immediate and extended family can help the clinician identify sources of support and aid in treatment/intervention recommendations.

➢ A clinician's primary goal is to help the child and family feel better, and to make sure that they emerge from the traumatic event stronger and more capable of coping with life. Your goal is for the child to no longer need therapy. To reach that goal, the family is an essential partner.

THE STEVENS FAMILY ASSESSMENT

The Stevens family was given the task of telling a story together. When they began to disagree over the course the story should take, the 6-year-old picked up some toys and began banging them together loudly. The mother grabbed the toys away and raised her voice as she instructed her son, "Be quiet and stop banging those toys!" The interactions observed between the mother and her boyfriend had a similar quality, with voices raised at the slightest hint of disagreement. The interactions between the mother and her other children were more constructive and less reactive.

What are best practices in family assessment?

A comprehensive assessment should include an individual meeting with the child, an individual meeting with primary caregivers, and a family session. This family session should include everyone in the household: parents, stepparents, siblings, and other relatives living in the home. This provides you the chance to talk with the entire family as a group and observe interactions and communication styles. You'll learn which members are on board with the idea of mental health treatment, which family members may provide the most support to the child, and any symptoms or behaviors that cause you concern as a clinician.

Some family members may be reluctant to talk about their own histories right at the beginning of a clinical relationship. It might take a little time to get to know each other before moving to the bigger family picture. If in place, a peer to peer or family advocacy program can be used to educate and reassure family members, and make them more comfortable with the family assessment process.
Understanding and addressing any immediate safety concerns facing the family is an important first step in the assessment process.

Assess the functioning of each dyadic relationship within the family since each may be affected by trauma in different ways, and each may have an impact on the child's recovery. Consider how parents interact with one another; how each parent interacts with each child; and how siblings interact with one another. By collecting information from multiple reporters (such as by asking both a parent and child about a parent's behavior or family support) you may get a more complete picture of how well the family is functioning.

During the family session, you may choose to create a structured family history. As part of this history, you will work with the family to construct a genogram and family

trauma timeline. This will allow you to observe how openly the family can describe their extended family situation and how able members are to talk about traumatic events in their past as well as those that brought them to therapy.

What are the appropriate domains of family trauma assessment?

It is standard practice when a child presents for treatment to assess the child's history, symptoms, and functioning. The family trauma assessment adds additional domains. The complexity of issues and how these issues interact can make a comprehensive assessment complicated. It is important to target those aspects of the family that need to be assessed and to identify the specific issues most relevant to the child's recovery.

Assessment of Adult Caregiver Trauma History, Symptoms, and Functioning:

Sometimes a child's adaptation to trauma is affected by the trauma history, symptoms, and functioning of his/her caregiver. Ask caregivers if they have past experience with the same type of trauma that has recently occurred. For example, if the child was sexually abused, do caregivers have a past history with sexual abuse? Their history provides the context for their reaction to the recent event.

Also ask them about traumatic events that may not appear related. Even when past traumatic events differ from the current event, the current trauma may serve as a reminder of the past. Remember that how people experience, remember, and make meaning of traumatic events can be highly subjective. Understanding each family member's subjective experience of prior traumas can help you to see the current traumatic event in a more complete light.

In addition to trauma history, other important areas for inquiry might include symptoms of physical and/or mental illness, including PTSD; indicators of substance abuse; intimate partnership issues; and caregivers' ability to carry out activities of daily living, especially those involved with caregiving.

Assessment of Parenting: Aspects of parenting, including warmth, discipline style, and satisfaction are important for understanding a child's daily life and the parent-child relationship. These factors can be assessed through interview questions and observations, as well as through any of the myriad of parenting questionnaires available.

Assessment of Family Violence: Family violence includes physical abuse, sexual abuse, and psychologically aggressive interactions among family members. Screening and assessment for family violence should be routine practice. When asking about family violence, use behavioral descriptions, such as "Has your child ever been spanked or punished in a way that left a mark?" and "Do you or your spouse hit, shove, or throw things at each other?"

Assessment of Family Separations: Many children dealing with traumatic stress

disorders are also dealing with losses of, or separations from, some family members. Domestic violence and intra-familial child abuse often result in a family member being removed or separated. Ask the family if children have ever lived outside the home and what other adults have lived in the home in the past.

How do you choose instruments and prioritize what to measure?

Choosing instruments and prioritizing assessment needs can be daunting, especially with a highly traumatized, chaotic, and needy family. The first priority is understanding significant symptoms that may lead to self-harm or need immediate intervention. Since the family is bringing the child to treatment, assessing the severity of the child's symptoms should have top priority; however, the child's symptoms occur within the context of the family environment.

Assessing immediate safety concerns for the family is always a top priority.

Other assessment priorities:

➢Child trauma history, symptoms/crisis issues
➢Caregiver/family trauma history, symptoms /crisis issues
➢Current or past domestic violence
➢Changes in family constellation
➢Relationships/communication within the family
➢Resiliency and extended family support

Once you determine the domains to assess, other factors may influence your choice of instruments. These include:

✓ Cost (is the measure in the public domain?)
✓ Clinical utility (does it provide the information you need)
✓ Ease of administration and scoring and
✓ Assessment burden on both family and clinician

Finally, developmental level will influence a child's ability to participate in the assessment. Most self-report measures of family functioning are not designed for children under 12.

How do you present the results to the family?

It is important for families to understand that it is normal for trauma to stress the entire family system. Whatever problems preceded the trauma may be amplified by the added stress. The purpose of providing the family with feedback is to enable them to act as informed partners in making decisions about the best treatment for their child and family. Your feedback also helps them to conceptualize their baseline and track

their own progress towards treatment goals.

Giving assessment results to families can be tricky. For example, there is the initial dilemma of who gets told what. Everyone in the family has a right to information about what the assessments have shown but every family member also has a right to privacy. Decisions about who receives what information have to be made on a case by case basis. Here are some important questions to consider:

- ➡ How should I handle information that might be perceived as negative, critical, or judgmental?
- ➡ Do I disclose information to caregivers individually and then repeat the disclosure with the family?
- ➡ Do I engage caregivers in deciding what children should be told or how they should be told?
- ➡ Have I identified the decision maker(s) in this family? How do I best structure the information to facilitate decision making?

MS. M AND HER FAMILY'S ASSESSMENT

Ms. M came for an assessment of her two children, who were 5 and 10 years old, after a long history of exposure to intimate partner violence and physical abuse by their father who is now in jail. During the assessment the family was asked to describe a typical day in their household. The 10-year reports that it is her job to get herself and her little sister ready for school and on the bus. Ms. M states that she is too tired in the mornings and is often still asleep when her daughters leave for school. Ms. M prepares dinner for the children when they return home but has difficulty implementing a homework or bedtime routine. She states, "The kids have been through so much, I just let them stay up as late as they want watching TV. Their father never let them watch and yelled at them all the time. I don't want to yell at them, and I think the TV helps them get to sleep." Ms. M and her children's responses provide valuable information about family roles and structure and potential areas for intervention.

Another tricky part of giving feedback is sharing the results in a developmentally sensitive manner. This is important so that family members of all ages understand the results. Everyone in the family is given an opportunity to ask questions about the results. Family members may not all agree on the results and important information can be gained from discussing any disagreements.

What are some caveats and considerations?

Responsibility when assessing all family members: A family assessment undertaken as part of the treatment of one family member may reveal that other family members are also in need of services. In this case, you need to be prepared to offer services either through your own agency or through partnerships with other agencies. It is imperative to become familiar and up to date on resources in your area. Establish connections with other agencies so that the referral process is as smooth and

easy as possible.

Ethnocultural Factors: Ethnocultural background can influence a family's participation in assessment. Some cultures have very strong prohibitions against discussing family problems with "outsiders." A "normal" pattern of interaction in your own culture may appear foreign or incomprehensible to your clients and vice versa. As in all clinical work, it is important to consider how a family's ethnocultural background influences their participation in the assessment, response, and presentation. Understanding how a family's behavior fits within their cultural norms helps build a more accurate picture of the family.

Family Structures: Families come in many shapes and sizes – two parent heterosexual, two parent homosexual, single parent, multigenerational, etc. When determining who to include in the assessment, ask the caregiver and child to name the important figures in the family. Keep in mind that parents may not necessarily be the primary caregivers. In addition, extended family members may play a key role, even if they do not live in the same household. Finally, in separated families or children placed outside the home, any family member that the child interacts with regularly can be an important asset to the evaluation.

When NOT to do a family-based assessment: There are some circumstances in which a family-based assessment is contraindicated. These circumstances might include:

- ➡ Ongoing safety issues and risk for violence within the family: Before undertaking a family-based assessment, always determine whether there is a history of, or current pattern of family violence. Under such circumstances, family members may not feel safe sharing information, and actual or perceived disclosure of information by some family members may increase the risk of violence. When there is any risk of family violence, even if all members appear to feel safe participating in a family-based assessment, first ensure that a safety plan is in place.
- ➡ Legal limitations on collecting family level information: In court-involved families, it is important to determine whether there are legal strictures that prevent an individual from providing information on other family members. In addition, consider the likelihood that records will be subpoenaed and for what purpose. That is not to say that family-based assessments should never be done with court-involved families, but rather a caution to consider the ramifications for all family members.

Summary

No child is an island – parental and family dynamics have significant influence on a child's recovery from trauma. An assessment of the family provides valuable insights into both potential sources of support for the child as well as potential obstacles to therapeutic success. Armed with this knowledge, you and the family can plan a course of treatment with the best possible chance of success.

6. Intimate Partner Violence Screening, Detection, and Evaluation

Intimate Partner Violence: Risk and Protective Factors

Risk factors are associated with a greater likelihood of intimate partner violence (IPV) victimization or perpetration. They are contributing factors and may or may not be direct causes. Not everyone who is identified as "at risk" becomes involved in violence.

Some risk factors for IPV victimization and perpetration are the same. In addition, some risk factors for victimization and perpetration are associated with one another; for example, childhood physical or sexual victimization is a risk factor for future IPV perpetration and victimization. A combination of individual, relational, community, and societal factors contribute to the risk of becoming a victim or perpetrator of IPV. Understanding these multilevel factors can help identify various opportunities for prevention.

Individual Risk Factors

✓ Low self-esteem
✓ Low income
✓ Low academic achievement
✓ Young age
✓ Aggressive or delinquent behavior as a youth
✓ Heavy alcohol and drug use
✓ Depression
✓ Anger and hostility
✓ Antisocial personality traits
✓ Borderline personality traits
✓ Prior history of being physically abusive
✓ Having few friends and being isolated from other people
✓ Unemployment
✓ Emotional dependence and insecurity
✓ Belief in strict gender roles (e.g., male dominance and aggression in relationships)
✓ Desire for power and control in relationships
✓ Perpetrating psychological aggression
✓ Being a victim of physical or psychological abuse (consistently one of the strongest predictors of perpetration)

✓ History of experiencing poor parenting as a child
✓ History of experiencing physical discipline as a child

Relationship Factors
✓ Marital conflict-fights, tension, and other struggles
✓ Marital instability-divorces or separations
✓ Dominance and control of the relationship by one partner over the other
✓ Economic stress
✓ Unhealthy family relationships and interactions

Community Factors
✓ Poverty and associated factors (e.g., overcrowding)
✓ Low social capital-lack of institutions, relationships, and norms that shape a community's social interactions
✓ Weak community sanctions against IPV (e.g., unwillingness of neighbors to intervene in situations where they witness violence)

Societal Factors
✓ Traditional gender norms (e.g., women should stay at home, not enter workforce, and be submissive; men support the family and make the decisions)

Physical Abuse Indicators
The following lists indicators of possible physical abuse victimization:
✓ Bruises (often in multiple stages of healing), scrapes, minor cuts, fractures or sprains, Injuries to the head (particularly the back where hair will cover the injury), chest, neck, breasts and abdomen.
✓ Strangulation marks and effects.
✓ Sustained injuries during pregnancy.
✓ Repeated injuries or multiple injuries in multiple stages of healing.
✓ History of similar injuries.

IPV Warning Signs
✓Vague and repeated complaints
✓A Possessive and controlling partner
✓An overtly attentive partner
✓Repeated urinary infection
✓Sexual complaints
✓Irritable colon syndrome
✓Depression
✓Anxiety
✓Repeated abortions
✓Suicide attempts
✓Substance abuse
✓Attendance at prenatal care only after the first trimester

The Stress of Living with Ongoing Abuse May Cause:

➡ Imagined or real pain due to widely distributed trauma without physical evidence.
➡ Gynecologic problems, frequent vaginal or urinary tract infections, pelvic pain.
➡ Frequent use of prescribed tranquilizers or pain medications.
➡ Symptomology resulting from endured stress, PTSD, other anxiety disorders, or depression including: Fatigue, decreased concentration, chronic headaches, abdominal and gastrointestinal complaints, chest pain, palpitations, dizziness, numbness or tingling of extremities and difficulty breathing.

Behavioral Signs of Domestic Violence:

➡ Perpetrator and/or victim denies and/or minimizes violence.
➡ Victim is excessively apologetic.
➡ Victim's self blame and an exaggerated sense of personal responsibility for the relationship,
➡ Reluctance of victim to speak while in front of the perpetrator.
➡ Perpetrator exhibits intense irrational jealousy.
➡ Perpetrator constantly accompanies victim, insists on staying close, and/or answers questions on behalf of him/her.

Psychological Symptoms of IPV

➡ Isolation and inability to cope.
➡ Panic attacks and other anxiety symptoms.
➡ Depression
➡ Fearfulness
➡ Suicide attempts or gestures.
➡ Alcohol/drug abuse.
➡ Post-traumatic stress reactions or disorder.
➡ Insomnia
➡ Anger
➡ Shame

The Perpetrator's Attempts at Domination May Result in:

✓ Not being allowed to obtain or take prescribed medication.
✓ Limited access to routine or emergency medical care.
✓ Lack of transportation, access to finances, or ability to communicate by telephone.
✓ Noncompliance with treatment.

Battered Women Syndrome (BWS)

Battered Women Syndrome (BWS) is characterized by psychological, emotional and behavioral deficits arising from chronic and persistent violence. Characteristics of BWS include learned helplessness, passivity, and paralysis. PTSD may result from domestic violence. Symptoms may include fear, flashbacks, re-experiencing the trauma, nightmares, easily startled, and difficulty concentrating. Psychiatric illness, particularly PTSD, depression, and anxiety is greater among people who have

experienced domestic violence compared to those who have not *(Saunders DG, "Wife Abuse, Husband Abuse, or Mutual Combat? A Feminist Perspective on the Empirical Findings". Bograd ML, Yllö K. Feminist perspectives on wife abuse. Thousand Oaks: Sage Publications)*.

Conducting the Interview

Screening for IPV should take into account the client's cultural background and environment. Interviewers should be knowledgeable about the social mores of clients' groups and trained to avoid culturally bound stereotypes and jargon. Anecdotal evidence suggests that female interviewers may be more effective at working with survivors.

A provider who suspects that a client is being abused by her partner must use caution and tact in approaching this subject. Timing is important, too; in most cases, more information about a survivor's experience of violence will begin to emerge as she gains confidence and as treatment staff continue to foster an atmosphere of trust and respect. It is important not to ask potentially painful questions too soon; otherwise, a client may feel overwhelmed and reluctant to return.

Screening for IPV more likely to be effective when the interviewer offers concrete examples and describes hypothetical situations than when the client is asked vague, conceptual questions. If using a yes/no questionnaire, interviewers should be prepared to follow up on "no" answers.

Another helpful screening technique is to focus questions on the behavior of the client's partner in order to ameliorate any discomfort she may feel in talking directly about herself. An important caveat to this recommendation, however, is that the interviewer should beware of "bad-mouthing" or otherwise attacking the batterer, as doing so may cause the abused client to defend the batterer and assume the role of his ally.

Setting is also important in asking clients sensitive questions about their home lives. Privacy and an atmosphere of trust and respect are necessary if the interviewer expects to obtain candid answers to screening questions, especially since survivors may for many reasons be unable to tell the whole truth about being abused. It is of utmost important for treatment staff to be aware that a client who may be a survivor of domestic violence should never be asked about battering when she is in the presence of someone who might be her batterer. In fact, providers should always interview clients about IPV in private, even if the woman requests the presence of another person who is unlikely to be her batterer. It is not uncommon for batterers to manipulate friends and family members into relaying information they heard in the interview that would put the client at risk. Her potential abuser may be a boyfriend or spouse, a stepfather or father, a mother's boyfriend, or a male sibling. Querying her in the presence of the abuser can seriously endanger her and may place her at risk of

reprisal. In addition, obtaining accurate information from a survivor is highly unlikely in this situation.

The interviewer needs to keep in mind that the client who has been sexually assaulted by her partner may normalize her experience, particularly if it has been a repeated one. If sex has always, or nearly always, been accompanied by violence or substance abuse, she may believe this is typical of all sexual relations.

If it becomes evident during a screening interview that a client has been or is being abused by her partner, the following four key questions can help delineate the frequency and severity of the abuse:

- "When was the first time you were [punished, hurt, or whatever word reflects the survivor's interpretation of abuse]?"
- "When was the last time you were abused?"
- "What is the most severe form of abuse you have experienced?"
- "What is the most typical way in which you are abused?"

Sometimes pointing to a body map is easier for a survivor client than naming where she has sustained injuries from battering (see Appendix C). It is also important to include questions about the extent of her injuries and the batterer's involvement in the criminal justice system.

Framing the Questions

The interviewer should be aware that many survivors of IPV see the batterer's substance abuse as the central problem or cause of the abuse, believing that "if he would just stop drinking (or taking drugs)," the violence would end. In framing screening questions, it is extremely important to convey to the survivor that there is no justification for the battering and that substance abuse is no excuse. Questions such as, "Does he blame his violence on his alcohol or other drug use?" or, "Does he use alcohol (or other drugs) as an excuse for his violence?" serve the dual purpose of determining whether the client's partner may be a substance abuser while reinforcing to her that substance abuse is not the real reason for his violence. Nor should questions feed into the batterer's excuse-making mechanism. The interviewer can shift the focus and the blame for the abuse away from the survivor by asking her questions about the batterer such as "Has he always handled problems by getting violent?"

Cultural Considerations

In keeping a client-centered perspective, treatment providers must be aware of cultural factors that bear on the survivor's view of her experience and her willingness to talk about it. For many survivors, being battered is often a source of great shame that must be kept secret at almost any cost. Others may be unaccustomed to talking about family matters openly and directly with non-family members. To put the client at ease as much as possible, it may be helpful and appropriate for the interviewer

initially to seek her permission to ask the screening questions, using language such as: "In order to help you, I need to know about what has been happening in your home. May I ask you some questions about you and your [partner, boyfriend, husband]? Or would you rather be asked these questions at another time?"

Respecting the survivor's sense of privacy in this way can boost her sense of control over her present situation. This can be especially important in light of the fact that most survivors present for services in a crisis. For example, a battered woman who seeks help with a substance abuse problem may have been abandoned by her abusive partner or may be in drug withdrawal. Her general feelings of powerlessness may be eased somewhat by this approach. Although most women who are victims of abuse appear to respond better to a female interviewer, a client should be asked, and granted, her preference (Bland, 1995; Minnesota Coalition for Battered Women, 1992). If translators or hand signers are needed, a neutral party (not a family member) should be enlisted to perform this function.

Barriers to an Accurate Screen

As mentioned previously, it is common for a survivor of IPV to evade the issue or lie when asked about her abusive experiences. Survivors' reasons for lying about being abused are numerous and varied. Many blame themselves for the violence and make excuses for the batterer's erratic or destructive behavior. For example, a client who has been battered by her partner may attempt to justify his behavior with comments such as, "I deserved it," "I nagged him," or, "It was my fault." It is common for a survivor to believe that if only she would stop upsetting the batterer, or "pushing his buttons," the abuse would stop. As one field reviewer noted, this self-blame may be more a mechanism to explain the violence that dominates survivors' lives than to justify it.

Some survivors go further than downplaying and self-blame and deny that there is abuse. Such denial may be a functional mechanism for her that helps her avoid dealing with problems that seem overwhelming and insurmountable. Denial is also, in some cases, an adaptive survival technique developed as a direct response to unsuccessful attempts to obtain help. Additionally, the survivor of domestic violence may not be entirely truthful because she may be accustomed to using manipulation as a survival mechanism. Because survivor clients do not know how interviewers will use information about battering, they do not always divulge it. Finally, as discussed previously, many survivors have concrete reasons for hiding domestic violence. A survivor could lose custody of her children if it is discovered that they live in a violent household. And the batterer may well have told her that he will beat or kill her or her children if she reports the abuse.

Guidelines for Assessing Violence

It is up to therapists to assess the potential for anger and violence and construct therapy so it can be conducted without endangering any family members. Because of

the life- and-death nature of this responsibility, the consensus panel included recommended guidelines for the screening and treatment of people caught up in the cycle of IPV.

If, during the screening interview, it becomes clear that a batterer is endangering a client, the treatment provider should respond to this situation before any other issue, and if necessary, suspend the rest of the screening interview until the safety of the client can be ensured. The provider should refer the client to an IPV program and possibly to a shelter and legal services. To determine if someone has endured domestic violence, look for physical injuries, especially patterns of untreated injuries to the face, neck, throat, and breasts. Other indicators may include:

- ➢ Inconsistent explanations for injuries and evasive answers when questioned about them
- ➢ Complications in pregnancy, including miscarriage, premature birth, and infant illness or birth defects
- ➢ Stress-related illnesses and conditions such as headache, backache, chronic pain, gastrointestinal distress, sleep disorders, eating disorders, and fatigue
- ➢ Anxiety-related conditions, such as heart palpitations, hyperventilation, and panic attacks
- ➢ A sad, flat affect or talk of suicide
- ➢ History of relapse or noncompliance with substance abuse treatment plans

Always interview clients about domestic violence in private. Ask about violence using concrete examples and hypothetical situations rather than vague, conceptual questions. Screening questions should convey to survivors that no battering is justified and that substance abuse is not an acceptable excuse for violent behavior.

- ➢ As soon as it is clear that a client has been or is being battered, domestic violence experts should be contacted.
- ➢ The provider should contact a forensics expert to document the physical evidence of battering.
- ➢ Referrals should be made whenever appropriate for specialized psychotherapy and counseling. IPV training is important so that clinicians can respond effectively to an IPV crisis.

A survivor of IPV who relocates to another community should be referred to the appropriate shelter programs within that community. Because batterers in treatment frequently harass their partners (threatening them by phone, mail, and messages sent through approved visitors), telephone and visitation privileges of batterers and survivors in residential substance abuse treatment programs should be carefully monitored. The discussion of family relationships, which is included screening interviews, can be used to identify IPV and gauge its severity.

Screening for Survivors Caution

It is important not to ask potentially
painful questions too soon; otherwise, a client may feel overwhelmed and reluctant to return.

Warning Signs for the Treatment Provider

- ❖ Physical injuries around the face, neck and throat • Inconsistent/evasive answers when questioned about injuries
- ❖ A history of relapse or noncompliance with substance abuse treatment
- ❖ Stress related illness and conditions
- ❖ Complications in pregnancy

The way in which a client describes her partner's treatment of her can also be a clue to possible domestic violence. Does he:

- ❖ Isolate her?
- ❖ Force her to sell drugs?
- ❖ Harm or threaten to harm other family members or pets
- ❖ Threaten to hurt her, himself or others?

Child abuse is also a clue. Research indicates that a father who
abuses his children often abuses his wife as well. Survivors are often reluctant to disclose the amount of violence in their lives.

Uncovering Past Sexual Abuse

When dealing with concurrent substance abuse, the treatment provider should ask about the substance-abusing client's family of origin in a way that gives the client "permission" to talk about it openly. For example, providers might preface their questions with, "In most homes where there is substance abuse, families have other problems, too. I'm going to ask some questions to see whether any of these things have happened to you or your family." Again, the interviewer should keep reassuring the client of confidentiality and safety while asking the following questions:

- ➡"Were you ever told by an adult to keep a secret and threatened if you did not?"
- ➡"Were you ever forced to watch sex between other people?"
- ➡"Were you ever touched in a way you didn't like?"
- ➡"How old were you when you first had sex (including anal, vaginal, and oral penetration)?" Then, "How old was the person you had sex with?"

Uncovering Current Abuse

Discussion of childhood abuse may open the door to discussion of current violence. In moving the interview from past to current violence, the possibility that they are survivors should be explored first, before questions about perpetrating violence themselves. This initial screening can be done by asking questions such as

- ➡"Do you feel safe at home?"
- ➡"Has anyone in your family ever physically hurt you?"

➡"Has anyone in your family made you do sexual things you didn't want to do?"
➡"Have you ever hurt anyone in your family physically or sexually?"

At this point, the interviewer can ask more specific questions regarding the nature and circumstances of specific incidents. Three questions have been cited as key to identifying victims of IPV:
➡"Have you been hit, kicked, punched, or otherwise hurt by someone within the past year? If so, by whom?"
➡"Do you feel safe in your current relationship?"
➡"Is there a partner from a previous relationship who is making you feel unsafe now?" (Feldhaus et al.).

The interviewer might go on to say, "We will be talking about these situations at different times throughout your treatment, and I want to know about any upsetting experiences that you may have had. Even if you don't feel like talking about this with me today, it is important that we eventually address all aspects of your life." The client should also be asked about her thoughts, feelings, and actions in particular situations. Questions (such as the following) about marital rape and nonconsensual sex should be included:
✤"Do you feel comfortable with the ways you have sex?"
✤"Has your partner ever forced you to do anything sexually that made you feel uncomfortable or embarrassed?"
✤"Do you feel you can say no if you don't want to have sex?"
✤"Are you ever hurt during sex?"
✤"How do you feel about talking about safe sex and HIV with your partner?"

Crisis Intervention

When a woman informs staff she is a victim of IPV, providers should:
✓ Ensure her safety: Whether a client is entering inpatient or outpatient treatment, the immediate physical safety of her environment must be of chief concern. If inpatient, security measures should be intensified; if outpatient, a safety plan should be developed.
✓ Assure her she is believed: Reinforcement of the clinician's belief of a survivor's victimization is a critical component of ongoinge motional support. Affirming the survivor's experience helps empower her to participate in immediate problem solving and longer term treatment planning.
✓ Identify her options: Treatment providers should ask the survivor to identify her options, share information that would expand her Substance Abuse Treatment and IPV options, and support her in devising a safety plan.
✓ Evaluate health concerns, including any need for detoxification.
✓ Attend to anything that may interrupt the initiation of treatment.

Child Abuse or Neglect

Screening for Child Abuse or Neglect

When family violence comes to the attention of the treatment provider, it is essential to determine whether children have been present or have been involved in any way. It is not advisable for the substance abuse clinician to perform an assessment of children for abuse or incest; this function should be performed by clinicians with special expertise.

Inquiries into possible child abuse should not occur until the limits of confidentiality, as defined in Title 42, Part II, of the Code of Federal Regulations (or 42 C.F.R, II) have been explained and the client has acknowledged receipt of this information in writing. Clients also must be informed that mandated reporters (such as substance abuse treatment providers) are required to notify a child protective services agency if they suspect child abuse or neglect.

✓ During initial screening, the interviewer should attempt to determinewhether a client's children have been physically or emotionally harmed and whether their behavior has changed. Have they become mute? Do they scream, cry, or act out

✓ Indications of child abuse that can crop up in a client interview include:

- Has a protective services agency been involved with anyone who lives in the home?
- Do the children's behaviors, such as bedwetting or sexual acting out, indicate abuse?
- Is extraordinary closeness noted between a child and another adult in the household?
- Does the client report blackouts? (Batterers often claim to black out during a violent episode.)

If a treatment provider suspects that a client's child has been violently abused, the provider must immediately refer the child to a health care provider. If the parent will not take the child to a doctor (who is required by law to report suspected abuse), the provider must contact home health services or child protective services.

✤ If the treatment provider reports suspected or definite child abuse or neglect, the provider must assess the impact on any client also being battered and develop a safety plan if one is deemed necessary.

✤ Providers should be aware that if a child has been or is being abused by the mother's partner, it is likely that the mother is also being abused.

Reporting Suspected Neglect or Abuse and Children's Protective Services Agencies

➡Clients must be informed that mandated reporters, a category that includes substance abuse treatment providers, are required to notify Children's Protective Services (CPS) if they suspect child abuse or neglect.

➡Clients can be informed of the right to report their partner's abuse of children.
➡It is ultimately the mandated reporter's responsibility to ensure CPS is contacted in the event of suspected child abuse or neglect.
➡It is important to prepare for the impact of reporting child abuse on the children and the family as whole.
➡It is imperative for professionals working with family members to provide information to them about what to
expect from CPS and, if at all possible, to talk with CPS caseworkers and accompany the family to any court hearings.

The Role of Treatment Providers in Supporting the Mother

Help her identify and coordinate various services available to her.
➡Support her efforts to participate in and take advantage of these services.
➡Listen as she voices her frustration about the difficulties of meeting the demands of the various agencies.

IPV Screening Techniques and Questions for Batterers

A discussion of family relationships is an element of all screening interviews. Based on their experience, the Consensus Panel recommends using this component of the interview to address the issue of IPV with male clients. To initially gauge the possibility that the client is being abusive toward his family members, the interviewer can ask whether he thinks violence against a partner is justified in some situations. This is the concept of "circumstantial violence." It is best to explore this possibility using a third person example so as not to personalize the question or make the client feel defensive; for example: "Some people think that, under certain circumstances, it's OK to hit your wife (girlfriend, etc.). Under what circumstances do you think violence might be justified?" The answer reveals clues about whether and when a client might use violence against his partner.

Specific questions about events in the client's family, particularly his own current worries, may provide a sense of the environment in which violence may be occurring. Part of an interviewer's aim here is to give the client a good reason to discuss the violence in a manner similar to that described for interviewing survivors ...to help the client see that there are benefits to acknowledging the abuse. The interviewer may tell the client that violence toward a partner is not uncommon among the other people enrolled in a treatment program, opening the door for the client to respond truthfully.The interviewer can now shift the questions to the client himself. The interviewer can ask questions to assess the client's sense of self-efficacy and self-control:

Questions

‣"Some people think that, under certain circumstances, it's OK to hit your wife (girlfriend, etc.). Under what circumstances do you think violence might be justified?”

‣"If you were faced with overwhelming stress (use a hypothetical situation), do you think you could keep your cool?"
‣"What do you think you'd do?"

By taking an open ended social and family history, the interviewer can gradually move to specific, direct questions.
‣"Have you ever been physically hurt by someone in your family?" (If the client's partner has hurt him or her, the reverse may be true.)
‣"Have you ever hurt someone in your family?"

A good initial question to investigate the possibility that a client is abusing family members is, "Do you think violence against a partner is justified in some situations?" A third-person example may be used, followed by specific, concrete questions that define the extent of the violence:

- ❖ What happens when you lose your temper?
- ❖ When you hit (person), was it a slap or a punch?
- ❖ Do you take car keys away? Damage property?
- ❖ Threaten to injure or kill (person)?

Once it has been confirmed that a client has been abusive—whether physically, sexually, or psychologically—the provider should contact a domestic violence expert, either for referral or consultation. Treatment providers should ensure that the danger the batterer poses is carefully assessed.

Batterers entering treatment can be required to sign a contract agreeing to refrain from using violence. "No violence" contracts are most effective when linkages with batterers' intervention programs are also in place, but they can also help structure treatment by specifying an achievable behavioral goal. If substance abuse has been identified, treatment providers should determine the relationship between the substance abuse and the violent behavior:

- ➡ When you take/drink (substance), exactly when does the violence occur?
- ➡ How much of your violent behavior occurs while you are drinking or on other drugs?
- ➡ What substances lead to violence?
- ➡ What feelings do you have before and during the use of alcohol or other drugs?
- ➡ Do you use substances to get over the violent incident?

After identifying the chain of events that precedes or triggers violent episodes, the provider and client should formulate strategies for modifying those behaviors and recognizing emotions that contribute to violent behavior. Providers of services to clients who batter should watch for signs that the clients are misinterpreting the 12-Step philosophy to excuse continued violence. For example, the first step is admitting powerlessness over alcohol. Thus the client may be one short rationalization away from excusing a violent act while intoxicated, which is later justified because the

substance “made me do it.” Another danger is that batterers will call their partners “codependent” to shift blame for battering to the person harmed. Referrals to self-help aftercare groups such as Batterers Anonymous should be made only after the client has completed a batterers’ intervention program and has remained nonviolent for a specified period of time.

The provider should be direct and candid, avoiding vague or euphemistic language, such as, “Is your relationship with your partner troubled?” Instead, ask about “violence,” and keep the focus on behavior. Become familiar with batterers’ rationalization and excuses for their behavior:

- Minimizing: “I only pushed her.” “She bruises easily.” “She exaggerates.
- Claiming good intentions: “When she gets hysterical, I have to slap her to calm her down.”
- Blaming intoxication: “I was drunk.” “I’m not myself when I drink.”
- Pleading loss of control: “Something snapped.” “I can only take so much.” “I was so angry, I didn’t know what I was doing.”
- Faulting the partner: “She drove me to it.” “She really knows how to get to me.”
- Shifting blame to someone or something else: “I was raised that way.” “My probation officer is putting a lot of pressure on me.” “I’ve been out of work.” Substance abuse treatment providers should frame screening questions so that they do not allow a batterer to blame the person battered or a drug.

When treating a client who batters, providers should try to ensure the safety of those who have been or may be battered (partners and children, usually) during any crisis that precedes or occurs during the course of his treatment.

Avoiding Collusion

Avoiding the implication that substance abuse is the "cause" of violence is as important in screening batterers as it is in screening survivors. Batterers often blame the victim, the victim's substance abuse, or their own substance abuse for the battering. In asking screening questions such as those just described, substance abuse treatment providers must be careful not to enable a batterer to place the blame for the battering on the victim or the drug. Interviewers must neither directly nor indirectly support the batterer's assertion that some other force has caused the violence or substance abuse.

An example of collusion would be the interviewer's assent that the client drinks because of some external source of stress, such as his job or his wife's "nagging." It is common for the survivor herself to think, feel, and act in accordance with this view, so often a tacit agreement exists between a batterer and a survivor to blame the latter for the violence.

The client's failure to take responsibility for his behavior is further reinforced when a treatment provider or other team member speculates that circumstances, rather than the individual, are the cause.

Interviewing the Partner

Since clients who disclose their violence toward their partners often minimize its frequency and severity, experienced domestic violence staff may interview the batterer's partner in order to obtain salient information about his dangerousness to himself, his partner, and others. In fact, many batterers' programs require batterers to give permission for staff to interview the female partner as a prerequisite for acceptance into the program. This type of collateral interviewing, however, is quite different from that practiced in the substance abuse treatment setting and *requires specialized skills and expertise*. Prior to conducting the interview, violence support staff and the involved partner carefully weigh the risks associated with participating in such an interview (e.g., the possibility that it may precipitate another battering incident). If the partner agrees to the interview, she will be interviewed alone. Her perspective will be compared with the batterer's and used carefully and sensitively by the violence specialist in working with the batterer.

Many substance abuse treatment providers routinely facilitate therapy sessions with substance abusers and their families. However, this approach *should not* be used with substance-abusing batterers and their partners. While substance abuse programs can cooperate with batterers' programs by reinforcing "no violence" messages and behaviors, providers should refer the client to a domestic violence specialist for further assessment and intervention. Some batterers' programs will not accept active substance abusers. In that case, participation in a batterers' program can become a specified part of the aftercare plan *(Source: Engelmann*).

Screening for Presence of Child Abuse

When family violence comes to the attention of the treatment provider, it is essential to determine whether children have been present or have been involved in any way. During the initial screening of the client, the Consensus Panel recommends that the interviewer should attempt to determine whether the children have been physically harmed and whether their behavior has changed (e.g., they have become mute or they scream or cry).

The confidentiality regulations spelled out in Title 42, Part 2, of the *Code of Federal Regulations* require that a client be given notice regarding the limitations of confidentiality ...orally and in writing ...upon admittance to a substance abuse treatment program. Inquiries into possible child abuse should not occur until this notice has been given and the client has acknowledged receipt of it in writing. Great care must be taken when approaching either a batterer or a survivor of domestic violence about whether any children in the household have been abused.

There may be a number of barriers to obtaining a complete and accurate picture of the children's situation from these clients. First, adults who abuse children are generally aware of the laws that require substance abuse treatment providers, among others, to

report suspected child abuse to agencies such as children's protective services (CPS), and they tend not to volunteer such information for fear of recrimination. Second, a survivor may be aware that her perceived "failure" to protect her children from violence may have implications for her retaining custody of them. Such fears are likely to be reinforced by her feelings of shame and guilt over "letting it happen." Or she may be abusing the children herself.

It is not advisable for the substance abuse treatment provider to perform an assessment of children for abuse or incest; this function should be performed by personnel with special expertise. The substance abuse treatment provider should, however, note any indications of whether abuse of children is occurring in a client's household and pass on what they find to the appropriate agency.

Indications of Child Abuse

In the Consensus Panel's experience, clues to possible child abuse may be obtained by questioning the client regarding

- Whether CPS has been involved with anyone who lives in the home
- Children's behaviors such as bedwetting and sexual acting out
- "Special" closeness between a child and other adults in the household
- The occurrence of "blackouts": Batterers often claim blackouts for the period of time during which violence occurs.

This area of questioning need not be repeated for each child in the household, but rather can be done in a general way in order to get a sense of the overall family environment.

If a treatment provider suspects that the child of a client has been a victim of violence, he or she must refer the child to a health care provider immediately. If it appears that the parent will not take the child to a doctor (who is required by law to report the suspected abuse), the provider must contact home health services or CPS. This should be done even if a child appears to be unharmed, because some injuries may not be immediately apparent.

Immediate attention to the child's emotional state is also important. Emergency room physicians or nurses who conduct physical examinations may not be in a position to thoroughly assess the impact of abuse on the child's emotional status. Initially, it may be that the most that can be done is to reassure the child that he is safe and will be taken care of. Ideally, however, he should be referred to a therapist who specializes in counseling traumatized children.

Reporting Suspected Neglect or Abuse

Clients must be informed that mandated reporters, a category that includes substance abuse treatment providers, are required to notify CPS if they suspect child abuse or neglect. In addition, a client can be informed of the right to report his or her partner's

abuse of children. Whatever decision is made concerning who will actually notify CPS, ultimately it is the mandated reporter's responsibility to ensure that this is done. The treatment provider must assess the impact on a survivor client of reporting suspected or confirmed child abuse or neglect. If she cannot be protected from her abuser on a 24- hour basis, she may become the object of his violence if he blames her for the report, so a safety plan should be developed. It is equally important to prepare for the impact of reporting child abuse on the children and on the family as a whole. The possible results of such a report must be considered and explained to the client in advance. For instance, if CPS is unable to confirm that abuse or neglect has occurred, the children could be endangered if the abuser learns of the report. In other instances, CPS may remove the children from the home until further investigation can be undertaken. If the investigation confirms abuse or neglect, a series of court appearances will be required, and children may be placed in foster care either in the short or long term. In any case, it is imperative for professionals working with family members to provide information about what to expect and, if at all possible, talk with the CPS caseworker and accompany the family to court hearings. Child abuse and neglect is a complicated issue and will be discussed in detail in a pending Treatment Improvement Protocol.

Referral

When answers to screening questions suggest that clients may be either batterers or survivors of domestic violence, the Consensus Panel recommends an immediate referral to a domestic violence support program. When referrals are not possible, ongoing consultation with a domestic violence expert is strongly encouraged. In some instances, clients have been mandated into substance abuse treatment by the courts. Participation in a battering program may be another court-mandated requirement. Substance abuse treatment providers should not hesitate to use the leverage provided by the criminal justice system to ensure that clients who batter participate in batterers' treatment as well.

Referring Survivors

- ➢ If the client reveals that she is in immediate danger, the clinician needs to attend to this before addressing other issues.
- ➢ Advise the client to take simple legal precautions and to safeguard important documents, e.g., social security card, driver license, etc.
- ➢ Discuss possible reprisal by the batterer if the police become involved and plan a response.
- ➢ If a survivor client expresses concern about her children, refer her for shelter and legal advocacy.
- ➢ Resources can be identified by contacting a local domestic violence program, a State program or the National 24 Hour Domestic Violence Hotline, 1-800-799SAFE.

Referring Batterers

- When suspected batterers are identified, substance treatment providers should refer them to batterer's intervention programs as a key part of treatment planning.
- With the client's signed consent to release information, substance clinicians can share pertinent information with domestic violence staff to ensure both problems are being addressed.
- Family therapy or family intervention for batterers and their partners should be provided by an IPV specialist or program.

Linkages

- To effectively treat substance abuse, care must be coordinated with IPV programs and other agencies pertinent to a client's recovery, e.g., the criminal justice system, the workplace, etc.
- Substance abuse treatment providers, IPV experts, and legal or other relevant professionals should plan client treatment collaboratively.
- Treatment providers should get to know what resources and institutions exist in their communities.

Collaborative Care Services

When creating linkages, remember that collaborative services should be

- Client centered.
- Holistic.
- Flexible.
- Collaborative.
- Coordinated.
- Accountable.

The Violence Against Women Act

The Violence Against Women Act (VAWA) strengthens many of the laws regarding violence motivated by gender, outlines Federal as well as State enforcement provisions and penalties, and makes crimes against women and children a civil rights violation. Under VAWA:

- Past sexual behavior or alleged sexual predisposition of the victim is no longer admissible evidence in civil or criminal proceedings involving sexual misconduct.
- New Federal criminal penalties apply to anyone who crosses a State line in order to commit domestic violence or to violate a civil protection order. • States are required to enforce civil protection orders issued by other states.

Legal Issues

Victims must have the opportunity to testify regarding the potential danger of the pretrial release of a defendant.

Disclosure and Consent

- Typically, State laws regulate the disclosure of patient information related to IPV
- These laws differ from Federal laws that govern consent to disclose substance abuse related information. When it comes to reporting crimes that are discussed in treatment to a third party (e.g., the police or a lawyer), the clinician must ask three questions: (1) Does State law require the program to make a report? (2) Does State law permit the program to make a report? (3) How can a report be made without violating the Federal law and regulations governing confidentiality or patients' records?

Legal Resources

- State Department of Health
- Single State Authority for Substance Abuse and/or Domestic Violence
- State Attorney General
- Local bar associations
- Agency board members who are attorneys
- Local advocacy groups for people experiencing domestic violence
- Local law schools

Treatment Concerns for Survivors and Batterers

Even though a provider has referred a client involved in domestic violence to a survivors' or batterers' program or incorporated participation in such programs as part of the aftercare plan, domestic violence remains an issue. The treatment provider should see that the following actions are taken, either by the substance abuse or violence program or by a case manager assigned responsibility for the client's holistic care.

The "No-Contact Contract"

Some survivors' programs require participants to sign a contract agreeing to have no contact with their batterers for the duration of the program. In addition to helping to ensure her safety, such contracts can provide opportunities for staff to evaluate a survivor's current attitudes toward and thinking about the batterer. Such "reality checks" can be helpful if, as is often the case, a survivor begins to believe the batterer's assurances that he has changed and is no longer violent. The staff can point out the reality of the situation if the batterer is still abusing alcohol or other drugs and has not changed his life in any significant way.

The "No-Violence Contract"

Batterers entering treatment can be required to sign a contract agreeing to refrain from using violence. While such "no-violence contracts" are most effective when linkages with batterers' intervention programs are also in place, they can help structure treatment by specifying an achievable behavioral goal. It is more difficult for clients to play one agency against another when all those involved in a particular case prescribe common goals. When the court has a role in mandating treatment services

and specifying sanctions for failure to comply, clients have an added incentive to adhere to such stipulations as "no-violence" contracts. Consensus Panel members believe that the prospects for positive outcome (e.g., reductions in substance abuse and domestic violence) will be improved when substance abuse and batterers' treatment programs and the courts collaborate to ensure that needed services are provided, consistent behavioral messages are communicated, and consequences for violating contracts and other programmatic stipulations are upheld.

Recovery Pitfalls for Batterers and Survivors

A number of violence support experts, including members of the Consensus Panel, have observed a tendency among some substance-abusing batterers to twist the messages of 12-Step programs in order to evade responsibility for their violent behavior: Men in recovery often gain more tools of abuse from their distorted interpretation of 12-Step and treatment programs. One of the most frequently used tools by batterers in groups has been the label of codependent. Men use it to put down their partners, saying this means battered women are as sick or sicker than them, to define victims as at least partly responsible for their violence, and to manipulate women into feeling guilty and ashamed of their expectations that men stop abusing.

Providers should be alert to signs that clients are misinterpreting the 12-Step philosophy to justify or excuse continued violence, especially since 12-Step programs can play a valuable role in supporting batterers' treatment as well as recovery from substance abuse when its principles are followed rather than distorted (*Wright and Pophan)*. Men who have embraced the 12-Step model will often challenge the excuse-making of batterers, encouraging them to take responsibility for all their actions, including the domestic violence.

Group therapy is an essential feature of most substance abuse treatment programs. However, members of the Consensus Panel who have worked extensively with substance-abusing survivors observe that survivors "may have an especially difficult time talking about past experiences if men are included in the group. Often, the safest and most comfortable time for her to discuss violence is during one-on-one sessions with her counselor. These sessions are also an opportune time to ask about her needs regarding the abuse" -Minnesota Coalition for Battered Women

Ongoing Attention to Issues of IPV

As discussed previously in this chapter, many survivors and batterers presenting for treatment do not disclose domestic violence on intake, and treatment providers must rely on signs of violence that become apparent as the client spends time in treatment. Ongoing attention to issues of domestic violence is particularly important in these clients not only because it may take time for them to begin talking about it, but also because as they become abstinent, additional issues arise that are integrally related to the violence. As with substance abuse, the full dimensions of a domestic violence problem are seldom immediately clear and may emerge unexpectedly at a later stage

in treatment. If this happens, questions posed during screening can be asked again, and a referral to a violence support or batterers' intervention program can be initiated.

Instruments

Please see the following screening and related resources tools:

- Abuse Assessment Screen (in English)
- Abuse Assessment Screen (in Spanish)
- Sample Personalized Safety Plan for IPV Survivors
- Danger Assessment
- Psychological Maltreatment of Women Inventory (PMWI)
- Revised Conflict Tactics Scale (CTS2)
- Assessment of Immediate Safety Screening Questions
- Computer Based IPV Questionnaire

Although these instruments have been used extensively in research settings, they have not been validated as clinical tools; nor do they have instructions for scoring. The PMWI and the CTS2, in particular, were designed as research tools, not clinical tools, and do not have cutting scores (the score beyond which a person has a problem). All of the following instruments can, however, serve to open dialogue with a client, elicit information, promote discussion, and help evaluate a program.

Abuse Assessment Screen (English Version)

1. WITHIN THE LAST YEAR, *have you been hit, slapped, kicked, or otherwise physically hurt by someone?* **YES NO**

If YES, by whom?_____
Total number of times _____

2. SINCE YOU'VE BEEN PREGNANT, have you been hit, slapped, kicked, or otherwise physically hurt by someone? **YES NO**

If YES, by whom?_____
Total number of times_____

MARK THE AREA OF INJURY ON THE BODY MAP, SCORE EACH INCIDENT ACCORDING TO THE FOLLOWING SCALE:

	Score
1 = Threats of abuse including use of a weapon	_____
2 = Slapping, pushing; no injuries and/or lasting pain	_____
3 = Punching, kicking, bruises, cuts and/or continuing pain	_____
4 = Beating up, severe contusions, burns, broken bones	_____
5 = Head injury, internal injury, permanent injury	_____
6 = Use of weapon; wound from weapon	_____

If any of the descriptions for the higher number apply, use the higher number

3. **WITHIN THE LAST YEAR**, has anyone forced you to have sexual activities?
YES NO
If yes, by whom?_____

Developed by the Nursing Research Consortium on Violence and Abuse.
Reproduced with permission from J. McFarlane B. Parker. *Abuse During Pregnancy: A Protocol for Prevention and Intervention*. White Plains, NY: The March of Dimes Birth Defects Foundation, pp. 22-23.

Encuesta Sobre El Maltrato (Spanish Version)

1. **DURANTE EL LTIMO AO**, fu golpeada, bofeteada, pateada, o lastimada fisicamente de alguna otra manera por alguien? **SI NO**
   Si la respuesta es "SI" por quien(es)?_____ Cuantas veces?_____

2. **DESDE QUE SALIO EMBARAZADA**, ha sido golpeada, bofeteada, pateada, o lastimada fisicamente de alguna otra manera por alguien?____ **SI NO**
   Si la respuesta es "SI" por quien(es)? _____
   Cuantas veces?_____

   EN EL DIAGRAMA ANAT MICO, MARQUE LAS PARTES DE SU CUERPO QUE HAN SIDO LASTIMADAS. VALORE CADA INCIDENTE USANDO LAS SIGUIENTE ESCALA:

	GRADO
1 = Amenazas de maltrato que incluyen el uso de un arma	_____
2 = Bofeteadas, permanentel ompujones sin lesiones fisicas o dolor permanente	_____
3 = Moquestos, patadas, moretones, heridas y/o dolor continuo	_____
4 = Molida a palos, contusiones severas, quemaduras, fracturas de huesos	_____
5 = Heridas en la cabeza, lesiones internas, lesiones permanentes	_____
6 = Uso de armas, herida por arma	_____

Si cualquiera de las situaciones valora un numero alto en la escala, selo.

3. **DURANTE EL LTIMO A O**, fu forzada a tener relaciones sexuales?
Si la respuesta es "SI" por quien(es)
Cuantas veces? _____

Developed by the Nursing Research Consortium on Violence and Abuse.
Reproduced with permission from J. McFarlane B. Parker. Abuse During Pregnancy: A Protocol for Prevention and Intervention. White Plains, NY: The March of Dimes Birth Defects Foundation, pp. 22-23.

Sample Personalized Safety Plan for IPV Survivors

Name:_____Date:_____ Review dates:_____

Personalized Safety Plan

The following steps represent my plan for increasing my safety and preparing in advance for the possibility for further violence. Although I do not have control over my partner's violence, I do have a choice about how to respond to him/her and how to best get myself and my children to safety.

Step 1: Safety during a violent incident. Women cannot always avoid violent incidents. In order to increase safety, battered women may use a variety of strategies.
I can use some or all of the following strategies:

A. If I decide to leave, I will_____. (Practice how to get out safely. What doors, windows, elevators, stairwells, or fire escapes would you use?)
B. I can keep my purse and car keys ready and put them (place)____in order to leave quickly.
C. I can tell_____about the violence and request they call the police if they hear suspicious noises coming from my house. I can also tell _____ about the violence and request they call the police if they hear suspicious noises coming from my house.
D. I can teach my children how to use the telephone to contact the police and the fire department.
E. I will use_____as my code word with my children or my friends so they can call for help.
F. If I have to leave my home, I will go_____. (Decide this even if you don't think there will be a next time.) If I cannot go to the location above, then I can go to_____or_____.
G. I can also teach some of these strategies to some/all of my children.
H. When I expect we are going to have an argument, I will try to move to a space that is lowest risk, such as_____. (Try to avoid arguments in the bathroom, garage, kitchens, near weapons or in rooms without access to an outside door.)
I. I will use my judgment and intuition. If the situation is very serious, I can give my partner what he/ she wants to calm him/her down. I have to protect myself until I/we are out of danger.

Step 2: Safety when preparing to leave. Battered women frequently leave the residence they share with the battering partner. Leaving must be done with a careful plan in order to increase safety. Batterers often strike back when they believe that a battered woman is leaving a relationship.
I can use some or all of the following safety strategies:

A. I will leave money and an extra set of keys with_____so I can leave quickly.
B. I will keep copies of important documents or keys at_____
C. I will open a savings account by_____(date), to increase my independence.
D. Other things I can do to increase my independence include:
   - ✓ The domestic violence program's hotline number is_____ I can seek shelter by calling this hotline.
   - ✓ I can keep change for phone calls on me at all times. I understand that if I use my telephone credit card, the following month the telephone bill will tell my batterer those numbers that I called after I left. To keep my telephone communications confidential, I must either use coins or I might get a friend to permit me to use their telephone credit card for a limited time when I first leave.
   - ✓ I will check with_____and_____to see who would be able to let me stay with them or lend me some money.

E. I can leave extra clothes with_____-.
F. I will sit down and review my safety plan every_____in order to plan the safest way to leave the residence._____(domestic violence advocate or friend) has agreed to help me review this plan.
G. I will rehearse my escape plan and, as appropriate, practice it with my children.

Step 3: Safety in my own residence. There are many things that a woman can do to increase her safety in her own residence. It may impossible to do everything at once, but safety measures can be added step by step.

Safety measures I can use include:

A. I can change the locks on my doors and windows as soon as possible.
B. I can replace wooden doors with steel/metal doors.
C. I can install security systems including additional locks, window bars, poles to wedge against doors, an electronic system, etc.
D. I can purchase rope ladders to be used for escape from second floor windows.
E. I can install smoke detectors and purchase fire extinguishers for each floor in my house/apartment.
F. I can install an outside lighting system that lights up when a person is coming close to my house.
G. I will teach my children how to use the telephone to make a collect call to me and to (friend/ minister/other) in the event that my partner takes the children. I will tell people who take care of my children which people have permission to pick up my children and that my partner is not permitted to do so. The people I will inform about pick-up permission include

_____ (school),
_____ (day care staff),
_____ (babysitter),
_____ (Sunday school teacher),
_____ (teacher),
_____ and (others).

I can inform_____(neighbor), _____(pastor), and_____(friend) that my partner no longer resides with me and they should call the police if he is observed near my residence.

Step 4: Safety with a protection order. Many batterers obey protection orders, but one can never be sure which violent partner will obey and which will violate protection orders. I recognize that I may need to ask the police and the courts to enforce my protection order.

The following are some steps that I can take to help the enforcement of my protection order:

A. I will keep my protection order_____(location). (Always keep it on or near your person. If you change purses, that's the first thing that should go in.)
B. I will give my protection order to police departments in the community where I work, in those communities where I usually visit family or friends, and in the community where I live.
C. There should be a county registry of protection orders that all police departments can call to confirm a protection order. I can check to make sure that my order is in the registry. The telephone number for the county registry of protection orders is_____.
D. For further safety, if I often visit other counties in my state, I might file my protection order with the court in those counties. I will register my protection order in the following counties: _____,_____, and_____.
E. I can call the local domestic violence program if I am not sure about B, C, or D above or if I have some problem with my protection order.
F. I will inform my employer, my minister, my closest friend and_____ that I have a protection order in effect.
G. If my partner destroys my protection order, I can get another copy from the courthouse by going to [the office] located at ___
H. If my partner violates the protection order, I can call the police and report a violation, contact my attorney, call my advocate, and/or advise the court of the violation.
I. If the police do not help, I can contact my advocate or attorney and will file a complaint with the chief of the police department.
J. I can also file a private criminal complaint with the district justice in the jurisdiction where the violation occurred or with the district attorney. I can charge my battering partner with a violation of the protection order and all the crimes that he commits in violating the order. I can call the domestic violence advocate to help me with this.

Step 5: Safety on the job and in public. Each battered woman must decide if and when she will tell others that her partner has battered her and that she may be at continued risk. Friends, family and coworkers can help to protect women. Each woman should consider carefully which people to invite to help secure her safety.

I might do any or all of the following:

A. I can inform my boss, the security supervisor and_____at work of my situation.
B. I can ask_____to help screen my telephone calls at work.
C. When leaving work, I can_____.
D. When driving home if problems occur, I can_____.
E. If I use public transit, I can_____.
F. I can use different grocery stores and shopping malls to conduct my business and shop at hours that are different than those when residing with my battering partner.

G. I can use a different bank and take care of my banking at hours different from those I used when residing with my battering partner.
H. I can also_____.

Step 6: Safety and drug or alcohol use. Most people in this culture use alcohol. Many use mood- altering drugs. Much of this use is legal and some is not. The legal outcomes of using illegal drugs can be very hard on a battered woman, may hurt her relationship with her children and put her at a disadvantage in other legal actions with her battering partner. Therefore, women should carefully consider the potential cost of the use of illegal drugs. But beyond this, the use of any alcohol or other drugs can reduce a woman's awareness and ability to act quickly to protect herself from her battering partner. Furthermore, the use of alcohol or other drugs by the batterer may give him/her an excuse to use violence. Therefore, in the context of drug or alcohol use, a woman needs to make specific safety plans. If drug or alcohol use has occurred in my relationship with the battering partner, I can enhance my safety by some or all of the following:

A. If I am going to use, I can do so in a safe place and with people who understand the risk of violence and are committed to my safety.
B. I can also_____.
C. If my partner is using, I can_____.
D. I might also_____.
E. To safeguard my children, I might_____and_____.

Step 7: Safety and my emotional health. The experience of being battered and verbally degraded by partners is usually exhausting and emotionally draining. The process of building a new life for myself takes much courage and incredible energy. To conserve my emotional energy and resources and to avoid hard emotional times, I can do some of the following:

A. When I have to communicate with my partner in person or by telephone, I can_____
B. I can try to use "I can . . ." statements with myself and to be assertive with others.
C. I can tell myself, "_____" whenever I feel others are trying to control or abuse me.
D. I can read_____to help me feel stronger.
E. I can call_____and_____as other resources to be of support to me.
F. Other things I can do to help me feel stronger are_____
G. I can attend workshops and support groups at the domestic violence program or_____ or to gain support and strengthen my relationships with other people.

Step 8: Items to take when leaving. When women leave partners, it is important to take certain items with them. Beyond this, women sometimes give an extra copy of papers and an extra set of clothing to a friend just in case they have to leave quickly. Items with asterisks on the following list are the most important to take. If there is time, the other items might be taken, or stored outside the home.mThese items might best be placed in one location, so that if we have to leave in a hurry, I can grab them quickly. When I leave, I should take:

* Identification for myself
* Children's birth certificates
* My birth certificate
* Social Security cards
* School and vaccination records
* Money
* Checkbook, ATM (Automatic Teller Machine) card
* Credit cards
* Keys-house/car/office
* Driver's license and registration
* Medications
* Welfare identification
* Work permits
* Green card
* Passport(s)
* Divorce papers
* Medical records-for all family members
* Lease/rental agreement, house deed, mortgage payment book
* Bank books
* Insurance papers
* Small saleable objects
* Address book
* Pictures
* Jewelry
* Children's favorite toys and/or blankets
* Items of special sentimental value

Computer-Based IPV Questionnaire

Intimate Partner Violence Questions

Possible emotional abuse

- Do you have a partner or spouse who gets very jealous or tries to control your life? YES NO
- Does your partner or spouse try to keep you away from your family or friends? YES NO
- Does someone close to you sometimes say insulting things or threaten you? YES NO
- (Yes to at least one of the above emotional abuse questions?) YES NO

Perception of safety

- Is there someone you are afraid to disagree with because they might hurt you or other family members? YES NO

Physical abuse in a current relationship

- Are you in a relationship with someone who has pushed, hit, kicked, or otherwise physically hurt you? YES NO
- (Possible current intimate partner abuse?) YES NO
- (Yes to any of the above domestic violence questions?) YES NO

Other violence-related questions

- Have you ever physically hurt someone close to you? YES NO
- Are you worried that you might physically hurt someone close to you? YES NO
- In the past 12 months, have you ever felt so low that you thought about harming yourself or committing suicide? YES NO
- Have you ever been made to have sex when you didn't want to? YES NO
- Is there a handgun in your home or car? YES NO
- Have you ever witnessed or taken part in any argument or fight where someone had a gun or knife? YES NO

Administration method: Self-report via computer located in the emergency department (ED). Note that phrases in parentheses are intended for the individual reviewing the print out and not the patient.
Scoring procedures: Patients answer each question "yes" or "no." If a patient responds affirmatively to questions about either emotional or physical abuse by a current partner, this is considered positive for IPV (Rhodes et al.).
Follow-up procedures: After completing the computer-based questionnaire, patients are offered a printout to take with them, which lists their individualized health recommendations. The results of the patient survey are shared with the treating physician in the ED and the summary includes a physician prompt to assess for domestic violence if the patient has answered one or more of the IPV questions affirmatively. Community service, hotline numbers, and hospital-based social service resources are also provided to the patient (Rhodes et al).

Reprinted from Annals of Emergency Medicine, 40, Rhodes K V, Lauderdale D S, He T, Howes D S, Levinson W, "Between me and the computer": Increased detection of intimate partner violence using a computer questionnaire, 476-84 Index Reference: Rhodes KV, Lauderdale DS, He T, Howes DS, Levinson W (2002). "Between me and the computer": Increased detection of intimate partner violence using a computer questionnaire. Annals of Emergency Medicine, 40, 476-84. Additional Reference: Heron SL, Kellermann AL (2002). Screening for intimate partner violence in the emergency department: Where do we go from here? Annals of Emergency Medicine, 40, 493-95.

Assessment of Immediate Safety Screening Questions

1. Are you in immediate danger?
2. Is your partner at this facility now?
3. Do you want to (or have to) go home with your partner?
4. Do you have somewhere safe to go?
5. Have there been threats of direct abuse of the children (if s/he has children)?
6. Are you afraid your life may be in danger?
7. Has the violence gotten worse or is it getting scarier? Is it happening more often?
8. Has your partner used weapons, alcohol, or drugs?
9. Has your partner ever held you or your children against your will?
10 Does your partner ever watch you closely, follow you or stalk you?
11. Has your partner ever threatened to kill you, him/herself or your children?

Reprinted with permission from Family Violence Prevention Fund. Produced by The Family Violence Prevention Fund 383 Rhode Island Street, Suite 304 San Francisco, CA 94103-5133 (415) 252-8900 TTY (800) 595-4889 Developer: Family Violence Administration method: Clinician administered. Scoring procedures: This information is not available. Follow-up Procedures: Clinicians should assess the impact of the abuse on the patient's health and the pattern and history of the abuse. Clinicians also need to provide validation, information about IPV, domestic violence, referrals to local resources, and information about safety planning. See the National Consensus Guidelines for more detailed information. Index Reference: Family Violence Prevention Fund. National consensus guidelines on identifying and responding to domestic violence victimization in health care settings. San Francisco, CA

Applicable Phone and Internet Resources

Hotlines

National Domestic Violence Hotline (800) 799SAFE (800) 7993224

Rape, Abuse, and Incest National Network (RAINN) (800) 6564673 http://www.rainn.org

Child Help USA/National Child Abuse Hotline (800) 4ACHILD http://www.childhelp.org

General Resources National Coalition Against Domestic Violence (303) 8391852 http://www.ncadv.org

National Victim Center (NVC)/Infolink (800) FYICALL https://www.victimsofcrime.org/

American College of Obstetricians and Gynecologists (ACOG) (202) 6385577 http://www.acog.org

Other Services

Center for the Prevention of Sexual and Domestic Violence (206) 6341903 http://www.ncdsv.org/

Domestic Violence Project/Face to Face (800) 8424546

Domestic Violence Training Project (800) 8653699

Family Violence and Sexual Assault Institute (903) 5345100

American Bar Association Commission on Domestic Violence http://www.abanet.org/domviol/home.html

National Domestic Violence Hotline
(800) 799-SAFE
(800) 787-3224 (TDD)
Suite 101-297
3616 Far West Boulevard Austin, TX 78731-3074
The National Domestic Violence Hotline links individuals and services using a nationwide database of domestic violence and other emergency shelters, legal advocacy and assistance programs, and social services programs. The hotline provides crisis intervention, information about sources of assistance, and referrals to battered women's shelters.

Rape, Abuse, and Incest National Network (RAINN)
(800) 656-4673
RAINN links 628 rape crisis centers nationwide. *Sexual assault survivors* who call will be automatically connected to a trained counselor at the closest center in their

area.

Childhelp USA/National Child Abuse Hotline
(800) 4A-CHILD
15757 North 78th Street Scottsdale, AZ 85260
(602) 922-8212
With a focus on *children* and the prevention of *child abuse*, this hotline provides crisis counseling, referrals, and reporting guidance to callers in crisis, including children, troubled parents, and adult survivors of abuse. All calls are answered by a staff of professional counselors. In addition, statistical and other informative materials can be ordered through this number.

General Resources

American College of Obstetricians and Gynecologists (ACOG)
ACOG Resource Center 409 12th Street, S.W.
Washington, DC 20024-2188
(202) 638-5577
ACOG has patient education pamphlets and bulletins for medical professionals on both domestic violence and substance abuse.

American Medical Association (AMA) Department of Mental Health 515 State Street
Chicago, IL 60610 Contact: Jean Owens (312) 464-5000
(312) 464-5066 (to order resources) (312) 464-4184 (fax)
The AMA educates physicians through publications, conferences, and by serving as a resource center for physicians and other concerned professionals. Among its publications are six diagnostic and treatment guidelines on child physical abuse and neglect, child sexual abuse, domestic violence, elder abuse and neglect, mental health effects of domestic violence, treatment and prevention of sexual assault, and media violence.

March of Dimes Birth Defects Foundation
1275 Mamaroneck Avenue White Plains, NY 10605 Attn: Resource Center (914) 428-7100
http://www.modimes.org/
The March of Dimes provides general information on prenatal care and on the first few years of life through its resource center and its fulfillment center.
March of Dimes Resource Center (888) 663-4637
(914) 997-4763 (fax)
resourcecenter@modimes.org Contact: Beverly Robertson, Director
Callers to this number can speak to someone about pregnancy, pre-pregnancy, drug use during pregnancy, birth defects, genetics, and other issues related to prenatal care.
March of Dimes Fulfillment Center (800) 367-6630

Callers to this number can only place an order for materials. Two domestic violence materials are available at cost: *Abuse During Pregnancy Nursing Module*, which provides continuing education units to nurses, and a video titled *Crime Against the Future*.

National Center for Missing or Exploited Children (NCMEC)
Suite 550
2101 Wilson Boulevard
Arlington, VA 22201-3052
Hotline: (800) THE LOST, (800) 843-5678, (800) 826-7653 (TDD)
Business office: (703) 235-3900, (703) 235-4067 (fax) http://www.missingkids.org/
NCMEC leads national efforts to locate and recover missing children and raises public awareness about ways to prevent child abduction, molestation, and sexual exploitation. The hotline is available to report information on missing or exploited children or to request information or assistance. NCMEC publishes materials, including handbooks, pamphlets containing parental and professional guidelines on runaways and missing or exploited children, and publication packages aimed toward families, child care and social service practitioners, and law enforcement, legal, and criminal justice professionals.

National Clearinghouse on Child Abuse and Neglect
P.O. Box 1182
Washington, DC 20013-1182
(800) FYI-3366
(703) 385-7565
(703) 385-3206 (fax)
nccanch@calib.com
This clearinghouse offers child abuse and neglect information in the form of manuals, research reports, studies, directories, grant compendia, literature reviews, annotated bibliographies, fact sheets, database searches, CD ROM databases, and on-line services. It is sponsored by the National Center on Child Abuse and Neglect.

National Coalition Against Domestic Violence
P.O. Box 18749 Denver, CO 80218 (303) 839-1852 (303) 831-9251 (fax)
The National Coalition Against Domestic Violence serves as an information and referral center for the general public, the media, battered women and their children, and agencies and organizations. Among its purposes are to enhance coalition-building at the local, State, and national levels; support the provision of community-based, nonviolent alternatives such as safe homes and shelters for battered women and their children; provide information and referral services, public education, and technical assistance; and develop public policy and innovative legislation. The coalition maintains a public policy office in Washington, DC, and maintains a National Directory of Domestic Violence Programs.

7. Intimate Partner Violence Intervention

7.1 Treatment Planning

Treatment Planning for Survivors

Safety From the Batterer In the Early Stages of Treatment
The treatment provider should help the client develop a safety plan by referring her to an IPV service provider. It is also important to address the batterer's reaction to his partner being in treatment and minimize the client's risk of harm in order for her to more easily continue her treatment.

Psychosocial Issues
A key aspect of treatment is dispelling the notion she is responsible for her partner's behavior. For some battered women, every aspect of their life has been controlled by the batterer. Helping her develop her own decision-making skills will be integral to her recovery. The client's perception of her own safety is an issue that can affect her treatment and should be dealt with in treatment. Linkages with other programs and agencies become extremely important in meeting the client's responsibilities. Four areas that may need special consideration during this time are:

- ✓ Social functioning: Social isolation is common among domestic violence survivors. Providers should encourage the client to make her own decisions about new activities and pastimes.
- ✓ Parenting: A survivor may need to learn new skills that take into account the reality of her status as a domestic violence survivor. Handling frustration and anger is a crucial life skill that must be addressed directly in treatment.
- ✓ Financial and legal concerns: Treatment providers should explore with the client her plans for future education and employment and should have information on a variety of options.
- ✓ Relapse prevention: If substance abuse is present, revictimization by an abusive partner poses the greatest risk of relapse for battered women. Careful attention to recurring episodes of violence is essential to working with survivor clients to prevent or minimize the negative effects of relapse.

Treatment Planning for Batterers

- ✓ Gauge client's acceptance of responsibility.
- ✓ Link client's actions with tangible consequences, e.g., through a no violence contract.
- ✓ Encourage the batterer client to develop enough self-awareness to recognize the beliefs and attitudes that are precursors to violence and to control the emotions that contribute to violence.
- ✓ Formulate a treatment plan with strategies that ensure safety for the partner and family members.
- ✓ Help the batterer focus on changing the behaviors and events that have precipitated violence or relapse.
- ✓ Watch for and stop clients from condoning violence or reinforcing each others' excuse-making.
- ✓ Raise the batterer's awareness of the impact his violence has on his children's future behavior (young boys often learn violent behavior from male role models).
- ✓ Help batterers adopt nonviolent modes of behavior through anger management and coping skills.
- ✓ Reinforce the importance of modeling non-violent behavior in their interactions with their partners as well as their children.

7.2 Trauma Informed Interventions for IPV

Trauma-Informed Prevention and Treatment Objectives

Trauma-informed care (TIC) not only focuses on identifying individuals who have histories of trauma and traumatic stress symptoms; it also places considerable effort in creating an environment that helps them recognize the impact of trauma and determine the next course of action in a safe place. For some individuals, psychoeducation and development or reinforcement of coping strategies will be the most suitable and effective strategy, whereas others may request or warrant a referral for more trauma-specific interventions. Although research is limited in the area of building resilience to prevent exacerbation of trauma symptoms and traumatic stress disorders, TIC also focuses on prevention strategies to avoid retraumatization in treatment, to promote resilience, and to prevent the development of trauma-related disorders. The following sections highlight key trauma-informed prevention and treatment objectives.

Establish Safety

Beyond identifying trauma and trauma-related symptoms, the initial objective of TIC is establishing safety. Borrowing from Herman’s conceptualization of trauma recovery, safety is the first goal of treatment. Establishing safety is especially crucial at the outset of trauma-informed treatment and often becomes a recurrent need when

events or therapeutic changes raise safety issues, such as a change in treatment staffing due to vacations.

In the context of TIC, safety has a variety of meanings. Perhaps most importantly, the client has to have some degree of ***safety from trauma symptoms***. Recurring intrusive nightmares; painful memories that burst forth seemingly without provocation; feelings of sadness, anger, shame, or being overwhelmed; or not having control over sudden disconnections from others make moment-to-moment living feel unsafe. Clients might express feeling unsafe through statements such as, "I can't control my feelings," or, "I just space out and disconnect from the world for no reason," or,"I'm

Strategies To Promote Safety

Strategy #1: Teach clients how and when to use grounding exercises when they feel unsafe or overwhelmed.
Strategy #2: Establish some specific routines in individual, group, or family therapy (e.g., have an opening ritual or routine when starting and ending a group session). A structured setting can provide a sense of safety and familiarity for clients with histories of trauma.
Strategy #3: Facilitate a discussion on safe and unsafe behaviors. Have clients identify, on paper, behaviors that promote safety and behaviors that feel unsafe for them today.
Strategy #4: Refer to *Seeking Safety: A Treatment Manual for PTSD and Substance Abuse* (Najavits). This menu-based manual covers an array of treatment topics, including the core concept of safety. Each topic consists of several segments, including preparing for the session, session format, session content, handouts, and guidelines.
Strategy #5: Encourage the development of a safety plan. Depending on the type of trauma, personal safety can be an issue; work with the client to develop a plan that will help him or her feel in control and prepared for the unexpected. If the trauma was a natural or human-caused disaster, encourage thinking about how family and friends will respond and connect in the event of another crisis. If sexual abuse or rape was the event, encourage thinking about future steps that could help make the client safer. There is a delicate balance between preparation and the realization that one cannot prepare for all possible traumatic events. Nonetheless, an action plan can help the client regain a sense of environmental balance.

afraid to go to sleep because of the nightmares." The intense feelings that accompany trauma can also make clients feel unsafe.They may wake up in the morning feeling fine but become immobilized by depression as the day progresses. Clients with histories of trauma may experience panicky feelings of gain more control over trauma symptoms (and be able to label them as such) by learning more about the client and helping him or her develop new coping skills to handle symptoms when they arise and stay more grounded when flooded with feelings or memories.

A second aspect is ***safety in the environment***. Trauma reactions can be triggered by sudden loud sounds (e.g., television at high volume, raised voices), tension between people, certain smells, or casual touches that are perceived as invasions of physical boundaries. The vulnerability of exposing one's history in the treatment setting can manifest in the client as feeling physically vulnerable and unsafe in the treatment environment. Sudden or inadequately explained treatment transitions, such as moving from one level of treatment to another or changing counselors, can also evoke feelings of danger, abandonment, or instability. Early in treatment, trauma survivors generally value routine and predictability. The counselor should recognize these needs and respond appropriately by offering information in advance, providing non shaming responses to a client's reactions to stimuli in his or her environment, and helping the client build a daily structure that feels safe.

A third aspect of safety is ***preventing a recurrence of trauma***. People with histories of trauma and substance abuse are more likely to engage in high-risk behaviors and to experience subsequent traumas. Early treatment should focus on helping clients stop using unsafe coping mechanisms, such as substance abuse, self-harm, and other self-destructive behaviors, and replacing them with safe and healthy coping strategies. Helping clients learn to protect themselves in reasonable ways is a positive goal of treatment.

Prevent Retraumatization

A key objective in TIC is to prevent retraumatization generated by intervention and treatment practices and policies. Unfortunately, treatment settings and clinicians can unintentionally create retraumatizing experiences (for a review of traumas that can occur when treating serious mental illness, see Fruehet al.). For instance, compassionate inquiry into a client's history can seem similar to the interest shown by a perpetrator many years before. Direct confrontation by clinicians about behaviors related to substance abuse can be seen, by someone who has been repeatedly physically assaulted, as provocation building up to assault. Clinician and program efforts to help clients constrain destructive behaviors can be interpreted as efforts to control and dominate the individual. Intrusive shaming or insensitive behavior demonstrated by another client in the program can threaten a trauma survivor whose boundaries have been disregarded in the past—thus making the experience of treatment feel dangerous rather than safe. Some staff and agency issues that can result in retraumatization include:

- Disrespectfully challenging reports of abuse or other traumatic events.

- Discounting a client's report of a traumatic event.
- Using isolation.
- Using physical restraints.
- Allowing the abusive behavior of one client toward another to continue without intervention.
- Labeling intense rage and other feelings as pathological.
- Minimizing, discrediting, or ignoring client responses.
- Disrupting clinician–client relationships by changing clinicians' schedules and assignments.
- Obtaining urine specimens in a non private and/or disrespectful manner.
- Having clients undress in the presence of others.
- Being insensitive to a client's physical or emotional boundaries.
- Inconsistently enforcing rules and allowing chaos in the treatment environment.
- Applying rigid agency policies or rules without an opportunity for clients to question them.
- Accepting agency dysfunction, including alack of consistent, competent leadership.

Strategies To Prevent Retraumatization

Strategy #1: Be sensitive to the needs of clients who have experienced trauma regarding behaviors in the treatment setting that might trigger memories of the trauma.

Strategy #2: Do not ignore clients' symptoms and demands when clients with trauma histories act out in response to triggered trauma memories; doing so may replicate t he original traumatic experience.

Strategy #3: Be mindful that efforts to control and contain a client's behaviors in treatment can produce an abnormal reaction, particularly for trauma survivors for whom being trapped was part of the trauma experience.

Strategy #4: Listen for specific triggers that seem to be driving the client's reaction. An important step in recovery is helping the client identify these cues and thereby reach a better understanding of reactions and behaviors.

Provide Psychoeducation

Trauma-informed education informs clients about traumatic stress and trauma-related symptoms and disorders as well as the related consequences of trauma exposure. It focuses on giving information to clients to help normalize presenting symptoms, to highlight potential short-term and long-term consequences of trauma and various paths to recovery, and to underscore the message that recovery is possible. Education

Strategies To Implement Psychoeducation

Strategy #1: Remember that this may be the client's first experience with treatment. It's easy to use program or clinical jargon when you're around it every day, but most individuals who seek help are unfamiliar with clinical language, how the program works, and treatment objectives. Psychoeducation begins with understanding the client's expectations and reasons for seeking help, followed by educating the client and other family members about the program. Remember that this is all new for them.

Strategy #2: After obtaining acknowledgment of a trauma history, provide an overview of common symptoms and consequences of traumatic stress, regardless of whether the client affirms having trauma-related symptoms. It is equally important to educate the client on resilience factors associated with recovery from trauma (Wessely et al.). A trauma-informed perspective provides a message that trauma reactions are normal responses to an abnormal situation.

Strategy #3: Develop a resource box that provides an array of printed or multimedia educational materials that address t he program, specific symptoms and tools to combat trauma-related symptoms, treatment options and therapy approaches, advantages of peer support, and steps in developing specific coping strategies.

Strategy #4: Develop a rotating educational group that matches services and client schedules to complement treatment. Remember that education can play a pivotal role in enhancing motivation, in normalizing experiences, and in creating a sense of safety as individuals move further into treatment. For some survivors, education can be a powerful intervention or prevention strategy.

frequently takes place prior to or immediately following an initial screening as a way to prepare clients for hearing results or to place the screening and subsequent assessment findings in proper context. Education in and of itself, however, does not necessarily constitute a stand-alone treatment; rather, it can be conceptualized as a first step and/or component of more comprehensive treatment. Nonetheless, education may be a prevention and intervention strategy for individuals who have histories of trauma without current consequences or symptoms and/or those who have reported a resolution of past trauma(s). For example, some clients may have significantly delayed onset of traumatic stress symptoms. In this scenario, earlier education can enhance recognition of symptoms and ease the path of seeking treatment.

Some clients do not recognize the link between their current difficulties and their trauma histories; education can help them understand the possible origin of their difficulties. Psychoeducation presents trauma-related symptoms that follow a trauma as normal reactions. By identifying the source of clients' current difficulties and framing them as normal thoughts, emotions, and behaviors in response to trauma, many trauma survivors report a reduction in the intensity of the difficulties or symptoms. Often, a client will express relief that his or her reactions are normal. You may find the U.S. Department of Veterans Affairs (VA) National Center onPTSD's educational handouts on traumatic stress reactions useful.

Psychoeducation goes beyond the identification of traumatic stress symptoms and/or learning about the psychological, cognitive, and physical impacts of trauma. Numerous curricula are available that use psychoeducation as a first-line or complementary approach to trauma-specific therapies to enhance coping strategies in key areas, including safety, emotional regulation, help-seeking, avoidant behavior, and so forth. An example is S.E.L.F.,a trauma-informed psychoeducational group curriculum with educational components related to trauma recovery in the following areas: creating **S**afety, regulating **E**motions, addressing **L**oss, and redefining the **F**uture (Bloom, Foderaro, & Ryan,)

Offer Trauma-Informed Peer Support

Living with a history of trauma can be isolating and consuming. The experience of trauma can reinforce beliefs about being different, alone, and marred by the experience. At times, behavioral health treatment for trauma-related effects can inadvertently reinforce these beliefs. Simply engaging in treatment or receiving specialized services (although warranted) can further strengthen clients' beliefs that there is something wrong with them. Formalized peer support can enhance the treatment experience. Treatment plus peer support can break the cycle of beliefs that reinforce traumatic stress (e.g., believing that one is permanently damaged; that nobody could understand; that no one should or could tolerate one's story). Peer support provides opportunities to form mutual relationships; to learn how one's history shapes perspectives of self ,others, and the future; to move beyond trauma; and to mirror and learn alternate coping strategies. Peer support defines recovery as

Strategies To Enhance Peer Support

Strategy #1: Provide education on what peer support is and is not. Roles and expectations of peer support can be confusing, so providing clarification in the beginning can be quite useful. It is important to provide initial education about peer support and the value of using this resource.

Strategy #2: Use an established peer support curriculum to guide the peer support process. For example, *Intentional Peer Support: An Alternative Approach* (Mead) is a workbook that highlights four main tasks for peer support: building connections, understanding one's worldview, developing mutuality, and helping each other move toward set desires and goals. This curriculum provides extensive materials for peer support staff members as well as for the individuals seeking peer support.

an interactive process, not as a definitive moment wherein someone fixes the "problem."

Normalize Symptoms

Symptoms of trauma can become serious barriers to recovery from substance us e and mental disorders, including trauma-related ones. Clinicians should be aware of how trauma symptoms can present and how to respond to them when they do appear. A significant step in addressing symptoms is normalizing them. People with traumatic stress symptoms need to know that their symptoms are not unique and that their reactions are common to their experience(s). Often, normalizing symptoms gives considerable relief to clients who may have thought that their symptoms signified some pervasive, untreatable mental disorder.

The Subjective Units of Distress Scale (SUDS) uses a 0 -10 rating scale, with 0 representing content that causes no or minimal distress and 10 representing content that is exceptionally distressing and overwhelming.

Identify and Manage Trauma-Related Triggers

Many clients who have traumatic stress are caught off guard with intrusive thoughts, feelings, sensations, or environmental cues of the trauma. This experience can be quite disconcerting, but often, the individual does not draw an immediate connection between the

Strategies To Normalize Symptoms

Strategy #1: Provide psychoeducation on the common symptoms of traumatic stress.
Strategy #2: Research the client's most prevalent symptoms specific to trauma, and then provide education to the client. For example, an individual who was conscious and trapped during or as a result of a traumatic event will more likely be hypervigilant about exits, plan escape routes even in safe environments, and have strong reactions to interpersonal and environmental situations that are perceived as having no options for avoidance or resolution (e.g., feeling stuck in a work environment where the boss is emotionally abusive).
Strategy #3: First, have the client list his or her symptoms. After each symptom, ask the client to list the negative and positive consequences of the symptom. Remember that symptoms serve a purpose, even if they may not appear to work well or work as well as they had in the past. Focus on how the symptoms have served the client in a positive way (see Case Illustration: Hector). This exercise can be difficult, because clients as well as counselors often don't focus on the value of symptoms.

internal or external trigger and his or her reactions. At other times, the trigger is so potent that the individual is unable to discern the present trigger from the past trauma and begins to respond as if the trauma is reoccurring.

Key steps in identifying triggers are to reflect back on the situation, surroundings, or sensations prior to the strong reaction. By doing so, you and your client may be able to determine the connections among these cues, the past trauma(s), and the client's reaction. Once the cue is identified, discuss the ways in which it is connected to past trauma. For some cues, there will be an obvious and immediate connection (e.g., having someone say "I love you"in a significant relationship as an adult and connecting this to an abuser who said the same thing prior to a sexual assault). Other cues will not be as obvious. With practice, the client can begin to track back through what occurred immediately before an emotional, physical, or behavioral reaction and then examine how that experience reminds him or her of the past.

Draw Connections

Mental health and substance abuse treatment providers have historically underestimated the effects of trauma on their clients for many reasons. Some held a belief that substance abuse should be addressed before attending to any co-occurring conditions. Others did not have the knowledge and training to evaluate trauma issues or were uncomfortable or reluctant to discuss these sensitive issues with clients (Ouimette & Brown). Similarly, in other behavioral health settings, clinicians sometimes address trauma-related symptoms but do not have experience or training in the treatment of substance abuse.
So too, people who have histories of trauma will often be unaware of the connection between the traumas they've experienced and their traumatic stress reactions.They may notice depression, anger, or anxiety, or they may describe themselves as "going

crazy" without being able to pinpoint a specific experience that produced the trauma symptoms. Even if clients recognize the events that precipitated their trauma symptoms, they may not understand how others with similar experiences can have different reactions. Thus, a treatment goal for trauma survivors is helping them gain awareness of the connections between their histories of trauma and subsequent consequences. Seeing the connections can improve clients' ability to work on recovery in an integrated fashion.

Teach Balance

You and your clients need to walk a thin line when addressing trauma. Too much work focused on highly distressing content can turn a desensitization process into a session whereby the client dissociates, shuts down, or becomes emotionally overwhelmed. On the other hand, too little focus by the client or counselor can easily reinforce avoidance and confirm the client's internal belief that it is too dangerous to deal with the aftermath of the trauma. Several trauma-specific theories offer guidelines on acceptable levels of distress associated with the traumatic content that the therapy addresses. For example, some traditional desensitization processes start at a very low level of subjective distress, gradually working up through a hierarchy of trauma memories and experiences until those experiences produce minimal reactions when paired with some coping strategy, such as relaxation training. Other desensitization processes start at a higher level of intensity to provide more rapid extinction of traumatic associations and to decrease the risk of avoidance—a behavior that reinforces traumatic stress.

Strategy To Teach Balance

Strategy #1: Teach and use the SUDS in counseling. This scale can be useful from the outset as a barometer for the client and counselor to measure the level of distress during and outside of sessions. It provides a common language for the client and counselor, and it can also be used to guide the intensity of sessions. SUDS can tangibly show a client's progress in managing experiences. Without a scale, it is more difficult to grasp that a distressing symptom or circumstance is becoming less and less severe without some repeated measure.

Working with trauma is a delicate balancing act between the development and/or use of coping strategies and the need to process the traumatic experiences. Individuals will choose different paths to recovery; it's a myth that every traumatic experience needs to be expressed and every story told. For some individuals, the use of coping skills, support, and spirituality are enough to recover. Regardless of theoretical beliefs, counselors must teach coping strategies as soon as possible. Retraumatization is a risk whenever clients are exposed to their traumatic histories without sufficient tools, supports, and safety to manage emotional, behavioral, and physical reactions.

Build Resilience

Survivors are resilient! Often, clinicians and clients

who are trauma survivors focus on the negative consequences of trauma while failing to recognize the perseverance and attributes that have helped them survive. It is natural to focus on what's not working rather than what has worked. To promote growth after trauma and establish a strengths-based approach, focus on building on clients' resilience. Current resilience theories claim that building or reinforcing resilience prevents further development of trauma-related symptoms and disorders.

Build Trust

Some traumatic experiences result from trusting others (e.g., interpersonal trauma). In other cases, trust was violated during or after the traumatic experience, as in cases when help was late to arrive on the scene of a natural disaster. This lack of trust can leave individuals alienated, socially isolated, and terrified of developing relationships. Some feel that the trauma makes them different from others who haven't had similar experiences. Sometimes, a client's trust issues arise from a lack of trust in self—for instance, a lack of trust in one's perceptions, judgment, or memories. People who have also experienced severe mental or substance use disorders may have difficulty trusting others because, during the course of their illness, they felt alienated or discriminated against for behaviors and emotions generated by or associated with the disorders.

Some client groups (e.g., gay, lesbian, and bisexual clients; people from diverse cultures; those with serious mental illness) evidence significant mistrust because their trust has been repeatedly violated in the past. Traumatic experiences then compound this mistrust. Mistrust can come from various sources, is usually unstated, and, if left unaddressed, can impede treatment. For example, some clients leave treatment early or do not engage in potentially beneficial treatments. Others avoid issues of trust and commitment by leaving treatment when those issues begin to arise.

Establishing a safe, trusting relationship is paramount to healing—yet this takes time in the counseling process. Clinicians and other behavioral health professionals need to be consistent throughout the course of treatment; this includes maintaining consistency in the parameters set for availability, attendance, and level of empathy.

Trust is built on behavior shown inside and outside of treatment; you should immediately address any behavior that may even slightly injure the relationship (e.g.,being 5 minutes late for an appointment, not responding to a phone message in a timely manner, being distracted in a session).

Support Empowerment

Strong feelings of powerlessness can arise in trauma survivors seeking to regain some control of their lives. Whether a person has survived a single trauma or chronic trauma, the survivor can feel crushed by the weight of powerlessness. Mental illness and substance abuse, too, can be disempowering; clients may feel that they've lost control over their daily lives, over a behavior such as drug use, or over powerful

emotions such as fear, sadness, oranger. Empowerment means helping clients feel greater power and control over their lives, as long as such control is within safe and healthy bounds. A key facet of empowerment is to help clients build on their strengths. Empowerment is more than helping clients discover what they "should" do; it is also helping them take the steps they feel ready to take.

Acknowledge Grief and Bereavement

The experience of loss is common after traumas, whether the loss is psychological (e.g., no longer feeling safe) or physical (e.g., death of a loved one, destruction of community, physical impairment). Loss can cause public displays of grief, but it is more often a private experience. Grieving processes can be emotionally overwhelming and can lead to increased substance use and other impulsive behaviors as a way to manage grief and other feelings associated with the loss. Even for people who experienced trauma years prior to treatment, grief is still a common psychological issue. Delayed or absent reactions of acute grief can cause exhaustion, lack of strength, gastrointestinal symptoms, and avoidance of emotions.

Strategies To Acknowledge and Address Grief

Strategy #1: Help the client grieve by being present, by normalizing the grief, and by assessing social supports and resources.
Strategy #2: When the client begins to discuss or express grief, focus on having him or her voice the losses he or she experienced due to trauma. Remember to clarify that losses include internal experiences, not just physical losses.
Strategy #3: For a client who has difficulty connecting feelings to experiences, assign a feelings journal in which he or she can log and name each feeling he or she experiences, rate the feeling's intensity numerically, and describe the situation during which the feeling occurred. The client may choose to share the journal in an individual or group session.
Strategy #4: Note that some clients benefit from developing a ritual or ceremony to honor their losses, whereas others prefer offering time or resources to an association that represents the loss.

Risk factors of chronic bereavement (grief lasting more than 6 months) can include:

- Perceived lack of social support.
- Concurrent crises or stressors (including reactivation of PTSD symptoms).
- High levels of ambivalence about the loss.
- An extremely dependent relationship prior to the loss.

- Loved one's death resulting from disaster: unexpected, untimely, sudden, and shocking (New South Wales Institute of Psychiatry & Centre for Mental Health).

Monitor and Facilitate Stability

Stability refers to an ongoing psychological and physical state whereby one is not overwhelmed by disruptive internal or external stimuli (Briere & Scott). It's common for individuals to have an increase in symptoms, distress, or impairment when dealing with the impact of their trauma or talking about specific aspects of their trauma. There is a thin line that the client and counselor need to negotiate and then walk when addressing trauma. Too much work focused on highly distressing content can turn a desensitization process into a session that causes the client to dissociate, shut down, or become emotionally overwhelmed. On the other hand, too little focus by the client or counselor can easily reinforce avoidance and confirm the client's internal belief that it is too dangerous to deal with the aftermath of the trauma.

Managing Destabilization

When a client becomes destabilized during a session, you can respond in the following manner: "Let's slow down and focus on helping you be and feel safe. What can we do to allow you to take care of yourself at this moment? Then, when you feel ready, we can decide what to focus on next."

Clients should have some psychological stability to engage in trauma-related work. An important distinction can be made between a normative increase in symptoms (e.g., the typical up-and-down course of traumatic stress reactions or substance abuse) and destabilization (dangerous, significant decrease in functioning). Signs of destabilization include (Green Cross Academy of Traumatology, Najavits):

- Increased substance use or other unsafe behavior (e.g., self-harm).
- Increased psychiatric symptoms (e.g., depression, agitation, anxiety, withdrawal, anger).
- Increased symptoms of trauma (e.g., severe dissociation).
- Helplessness or hopelessness expressed verbally or behaviorally.
- Difficulty following through on commitments (e.g., commitment to attend treatment sessions).
- Isolation.
- Notable decline in daily activities (e.g.,self-care, hygiene, care of children or pets,going to work).

7.3 Intervention and Treatment Issues

The treatment environment itself can significantly affect how clients experience traumatic stress and how the client responds to treatment. Some specific issues related to working with trauma survivors in a clinical setting are discussed in the following sections.

Client Engagement

A lack of engagement in treatment is the client's inability to make progress toward treatment goals, deal with important topics in treatment, or complete treatment. Clients who have histories of trauma will express ambivalence about treatment similarly to others, except that clients who have traumatic stress can feel more "stuck" and perceive themselves as having fewer options. In addition, clients maybe avoiding engagement in treatment because it is one step closer to addressing their trauma.You should attend to the client's motivation to change, implement strategies that address ambivalence toward treatment, and use approaches that help clients overcome avoidant behavior.

Pacing and Timing

Although your training or role may prohibit you from providing trauma-specific services, you must still be prepared for the fact that clients are not as focused on when or where it is most appropriate to address trauma—they want relief, and most lay and professional people have been taught that the only path to recovery is disclosure. Some clients are reluctant to talk about anything associated with their histories of trauma. Other clients immediately want to delve into the memories of their trauma without developing a safe environment. The need to gain any relief for the traumatic stress pushes some individuals to disclose too quickly, without having the necessary support and coping skills to manage the intensity of their memories. Clients who enter treatment and immediately disclose past trauma often don't return because the initial encounter was so intense or because they experienced considerable emotional distress for several days afterward and/or in anticipation of the next session.

Proper pacing of sessions, disclosure, and intensity is paramount. Clients who immediately disclose without proper safety nets are actually retraumatizing themselves by reliving the experience without adequate support—often placing themselves in the same circumstances that occurred during the actual traumas they experienced. Although you should not adamantly direct clients not to talk about what happened, it is important to discuss with the clients, even if you have to interrupt them empathically and respectfully, the potential consequences of disclosing too soon and too fast. Ask whether they have done this before ,and then inquire about the outcome. Reinforce with clients that trauma heals when there are support, trust, and skills in place to manage the memories of the traumatic experiences. Ideally, disclosure begins after these elements are secured, but realistically, it is a balancing act for both the counselor and client as to when and how much should be addressed in any given session. Remember not to inadvertently give a message that it is too

dangerous to talk about trauma; instead, reinforce the importance of addressing trauma without further retraumatization.

Length of Treatment

Many factors influence decisions regarding the length of treatment for a given client. Severity of addiction, type of substance abused, type of trauma, age at which the trauma occurred, level of social support, and the existence of mental disorders all influence length of treatment. External factors, such as transportation and childcare, caps on insurance coverage, and limitations in professional resources, can also affect length of treatment. In general, longer treatment experiences should be expected for clients who have histories of multiple or early traumas, meet diagnostic criteria for multipleAxis I or Axis II diagnoses, and/or require intensive case management. Most of the empirically studied and/or manual-based models described in the next chapter are short-term models (e.g., lasting several months); however, ongoing care is indicated for clients with more complex co-occurring trauma disorders.

Memories of Trauma

Points for clinicians to remember are:

- Some people are not able to completely remember past events, particularly events that occurred during high-stress and destabilizing moments.
- In addition to exploring the memories themselves, it can be beneficial to explore how a memory of an event helps the client understand his or her feeling, thinking, and behaving in the present.
- Persistently trying to recall all the details of a traumatic event can impair focus on the present.

Traumatic Memories

One of the most controversial issues in the trauma field is the phenomenon of "recovered memories" or "traumatic amnesia" (Brewin). Practitioners working with traumatized individuals are particularly concerned about the possibility of new memories of the traumatic event emerging during the course of therapy and the possibility of these memories being induced by the clinician. Scientific reviews indicate that people can experience amnesia and delayed recall for some memories of a wide variety of traumas, including military combat and prisoner of war experiences, natural disasters and accidents, childhood sexual abuse, and political torture (Bowman & Mertz, Brewin, Karon & Widener, McNally). In some cases, the survivor will not remember some of what happened, and the clinician may need to help the client face the prospect of never knowing all there is to know about the past and accept moving on with what is known.

Legal Issues

Legal issues can emerge during trauma informed treatment. A client, for instance, could seek to prosecute a perpetrator of trauma (e.g., for IPV/Domestic violence) or

to sue for damages sustained in an accident or natural disaster. The counselor's role is not to provide legal advice, but rather, to offer support during the process and, if needed, refer the client to appropriate legal help. A legal matter can dominate the treatment atmosphere for its duration. Some clients have difficulty making progress in treatment until most or all legal matters are resolved and no longer act as ongoing stressors.

Forgiveness

Clients may have all sorts of reactions to what has happened to them. They may feel grateful for the help they received, joy at having survived, and dedication to their recovery. At the other extreme, they may have fantasies of revenge, a loss of belief that the world is a good place, and feelings of rage at what has happened. They may hold a wide variety of beliefs associated with these feelings.

One issue that comes up frequently among clinicians is whether to encourage clients to forgive. The issue of forgiveness is a very delicate one. It is key to allow survivors their feelings, even if they conflict with the clinician's own responses. Some may choose to forgive the perpetrator, whereas others may remain angry or seek justice through the courts and other legal means. Early in recovery from trauma, it is best to direct clients toward focusing on stabilization and a return to normal functioning; suggest that, if possible, they delay major decisions about forgiveness until they have a clearer mind for making decisions (Herman). Even in later stages of recovery, it's not essential for the client to forgive in order to recover. Forgiveness is a personal choice independent of recovery. Respect clients' personal beliefs and meanings; don't push clients to forgive or impose your own beliefs about forgiveness onto clients.

In the long-term healing process, typically months or years after the trauma(s), forgiveness may become part of the discussion for some people and some communities. For example, in South Africa, years after the bitter and bloody apartheid conflicts, a Truth and Reconciliation Commission was established by the Government. Public hearings created dialog and aired what had been experienced as a means, ultimately, to promote forgiveness and community healing. By addressing very difficult topics in public, all could potentially benefit from the discourse. Similarly, a parental survivor of the Oklahoma City bombing was, at first, bitter about his daughter's early, unfair, and untimely death. Today, he gives talks around the world about the abolition of the death penalty. He sat with convicted bomber Timothy McVeigh's father while the man's son was executed in Indiana at a Federal prison several years after the bombing. For this man, forgiveness and acceptance helped him attain personal peace. Other trauma survivors may choose never to forgive what happened, and this, too, is a legitimate response.

Culturally and Gender Responsive Services

Culture is the lens through which reality is interpreted. Without an understanding of culture, it is difficult to gauge how individuals organize, interpret, and resolve their traumas.The challenge is to define how culture affects individuals who have been traumatized.

Increased knowledge of PTSD (Wilson &Tang), mental illness, and substance use disorders and recovery (Westermeyer) requires behavioral health practitioners to consider the complicated interactions between culture, personality, mental illness, and substance abuse in adapting treatment protocols. This section offers some general guidelines for working with members of cultures other than one's own. Treatment for traumatic stress, mental illness, substance use disorders, and co-occurring trauma-related symptoms is more effective if it is culturally responsive.

The U.S. Department of Health and HumanServices has defined the term "cultural competence" as follows:

> *Cultural competence is a set of values, behaviors, attitudes, and practices within a system, organization, program, or among individuals that enables people to work effectively across cultures. It refers to the ability to honor and respect the beliefs, language, interpersonal styles, and behaviors of individuals and families receiving services, as well as staff who are providing such services. Cultural competence is a dynamic, ongoing, developmental process that requires a long-term commitment and is achieved over time*.

Cultural competence is a process that begins with an awareness of one's own culture and beliefs and includes an understanding of how those beliefs affect one's attitudes toward people of other cultures. It is rooted in respect, validation, and openness toward someone whose social and cultural background is different from one's own.

Cultural Competence

Cultural competence includes a counselor's knowledge of:

Whether the client is a survivor of cultural trauma (e.g., genocide, war, government oppression, torture, terrorism).

How to use cultural brokers (i.e., authorities within the culture who can help interpret cultural patterns and serve as liaisons to those outside the culture).

How trauma is viewed by an individual's sociocultural support network.

How to differentiate PTSD, trauma-related symptoms, and other mental disorders in the culture.

In some cultures, an individual's needs take precedence over group needs (Hui & Triandis), and problems are seen as deriving from the self. In other cultures, however, complex family, kin, and community systems take precedence over individual needs. Considerable heterogeneity exists within and across most ethnic subcultures and across lines of gender, class, age, and political groups (CSAT). Subcultures abound in every culture, such as gangs; populations that

are homeless or use substances; orphaned or disenfranchised people; religious, ethnic, and sexual minorities; indigenous people; and refugee and immigrant populations. Some subcultures have more in common with similar subcultures in other countries than with their own cultures (e.g., non heterosexual populations).

Trauma and substance abuse can themselves be a basis for affiliation with a subculture. De Girolamo reports that "disaster subcultures" exist within many cultures. These cultures of victimization, like all subcultures, have unique world views, codes of conduct, and perceptions of the larger society. In a disaster subculture, people are, to some extent, inured to disaster and heedless of warnings of impending disaster. For example, riverbank erosion inBangladesh displaces thousands of people each year, yet few believe that it is a serious problem or that the displacement will be permanent (Hutton). Israelis who have lived with unpredictable violence for many years behave differently in public areas and have adapted to different norms than people who don't commonly experience violence (Young).

Many people identify with more than one subculture. Some identify with a particular culture or subculture, but not with all of its values. Individual identities are typically a mosaic of factors, including developmental achievements, life experiences, behavioral health histories, traumatic experiences, and alcohol and illicit drug use; levels of acculturation and/or assimilation vary from one individual to the next as well.

Importance of the Trauma Aftermath

Clinicians working in the immediate aftermath of trauma—whether individual, group, or community in nature—face many challenges. For example, survivors may be forced to adjust without access to other health services, employment, support, or insurance. In these instances, clinicians must often work with individuals and communities coping with the trauma while struggling daily to meet basic needs. Research suggests that re-establishing ties to family, community, culture, and spiritual systems can not only be vital to the individual ,but can also influence the impact of the trauma upon future generations. For example, Baker and Gippenreiter studied the descendants of people victimized by Joseph Stalin's purge. They found that families who were able to maintain a sense of connection and continuity with grandparents affected by the purge experienced fewer negative effects than did those who were emotionally or physically severed from their grandparents. The researchers also found that whether the grandparents survived was less important than the connection the grandchildren managed to keep to their past. Ties to family and community can also have an adverse effect, especially if the family or community downplays the trauma or blames the victim. Clinicians need to have a full understanding of available support before advocating a particular approach.

Treatment Strategies

Many traditional healing ways have been damaged, forgotten, or lost—yet much wisdom remains. Drawing on the best traditional and contemporary approaches to

human distress and defining culturally competent curricula regarding identity and healing (Huriwai, Wilson & Tang) both require respect and appreciation for the many ways in which various people characterize and resolve trauma and how they use addictive substances to bear the burdens of human distress.

It is not yet known how well existing PTSD treatments work for individuals who identify primarily with cultures other than mainstream American culture. It is possible that such treatments do work for clients of other cultures, though some cultural adaptation and translation may be required. For example, some PTSD treatments that have been used with subculture groups without adaptation other than language translation and that appear to be effective across cultures include eye movement desensitization and reprocessing (Bleich, Gelkopf, & Solomon,) andSeeking Safety (Daouest et al).

Gender

Gender differences exist in traumatic stress, mental disorders, and substance use disorders. For example, women have higher rates ofPTSD, whereas men have higher rates of substance abuse (Kessler, Chiu, Demler, Merikangas, & Walters, Stewart, Ouimette, & Brown, Tolin & Foa). The types of interpersonal trauma experienced by men and by women are often different. A number of studies (Kimerling, Ouimette, &Weitlauf) indicate that men experience more combat and crime victimization and women experience more physical and/or sexual assault—implying that men's traumas often occur in public, whereas the traumatization of women is more likely to take place in a private setting, such as a home. Men's abusers are more often strangers. Those who abuse women, on the other hand, are more often in a relationship with them. Women (and girls) often are told, "I love you," during the same time period when the abuse occurs. However, women now serve in the military and thus are increasingly subject to some of the same traumas as men and also to military sexual trauma, which is much more common for women to experience. Similarly, men can be subject to domestic violence or sexual abuse.

In treatment, gender considerations are relevant in a variety of ways, including, but not limited to, the role and impact of societal gender stereotypes upon assessment processes, treatment initiation, and engagement of services (e.g., peer support systems); the selection and implementation of gender-specific and gender-responsive approaches for both men and women at each level of intervention; and the best selection of trauma-related interventions that account for gender-specific differences related to traumatic stress.

Beyond the complexities of gender considerations, one must also consider whether clients should be given the choice of working with a male or a female clinician. Some clients who have been traumatized have no preference, particularly if their trauma wasn't associated with gender (e.g., a natural disaster, act of terrorism, fire, serious accident). If gender did play a role in trauma (e.g., childhood sexual abuse), clients

can have strong fears of working with a clinician who is the same gender as the perpetrator. Many women who experienced sexual abuse (whose perpetrators are typically men) feel uncomfortable being treated by men because of the intense emotions that can be evoked (e.g., anger, fear). Men who experienced sexual abuse (whose perpetrators are also typically men) can feel uncomfortable for the same reasons, or they may feel shame when talking to men due to feelings evoked about masculinity, homosexuality, and so forth. However, not all clients with trauma histories prefer female therapists. Discuss with clients the possible risks (e.g.,initial emotional discomfort) and benefits of being treated by a woman or man (e.g., developing a therapeutic relationship with a man might challenge a client's belief that all men are dangerous), and, if possible, let them then choose the gender of their clinician.

For group therapy that focuses on trauma, similar considerations apply. Generally, gender-specific groups are recommended when possible, but mixed-gender groups also work. Gender also comes into play in substance abuse treatment. Research and clinical observation indicate that significant gender differences occur in many facets of substance abuse and its treatment. For example, men and women experience different physical repercussions of substance use (e.g., women have more health problems), different trajectories (e.g., women become addicted more quickly), and different treatment considerations (e.g., traditional substance abuse treatment was designed for men).

Sexual Orientation

Lesbian, gay, bisexual, and transgender (LGBT) clients face specific issues in behavioral health treatment settings, including histories of abuse and discrimination relating to sexual orientation, homophobia in treatment on the part of clinicians or other clients, potential difficulty addressing traumatic experiences related to their sexuality or sexual orientation, and often, a significant lack of trust toward others. LGBT people sometimes think that others can't understand them and their specific needs and thus are reluctant to engage in treatment programs in which the clientele is predominantly heterosexual. Some clients react with judgment, anger, or embarrassment when an LGBT client attempts to describe sexual trauma relating to homosexual behavior, making it even harder for LGBT clients to describe their experiences.

Often, individual counseling can address issues the LGBT client isn't comfortable discussing in group treatment. "Providing one-on-one services may decrease the difficulty of mixing heterosexual and LGBT clients in treatment groups and decrease the likelihood that heterosexism or homophobia will become an issue"(CSAT).

Making Referrals to Trauma-Specific Services

Many people who experience trauma do not exhibit persistent traumatic stress symptoms.In fact, people do recover on their own. So how do you determine who is

at higher risk for developing more persistent symptoms of traumatic stress, trauma-related disorders, and traumatic stress disorders? One main factor is the severity of symptoms at the time of screening and assessment. Other factors, beyond trauma characteristics and pre-trauma individual characteristics, to consider in making referrals include (Ehlers & Clark):

- Cognitive appraisals that are excessively negative regarding trauma sequelae, including consequences, changes after the event(s), responses of other people to the trauma, and symptoms.
- Acknowledgment of intrusive memories.
- Engagement in behaviors that reinforce or prevent resolution of trauma, including avoidance, dissociation, and substance use.
- History of physical consequences of trauma(e.g., chronic pain, disfigurement, health problems).
- Experiences of more traumas or stressful life events after the prior trauma.
- Identification of co-occurring mood disorders or serious mental illness.

The next chapter provides an overview of trauma-specific services to complement this chapter and to provide trauma-informed clinicians with a general knowledge of trauma-specific treatment approaches.

7.4 Trauma-Specific Intervention and Treatment Models

This section covers various treatment approaches designed specifically to treat trauma-related symptoms, trauma-related disorders, and specific disorders of traumatic stress. The models presented do not comprise an exhaustive list, but rather, serve as examples.These models require training and supervised experience to be conducted safely and effectively. The chapter begins with a section on trauma-specific treatment models, providing a brief overview of interventions that can be delivered immediately after a trauma, as well as trauma-specific interventions for use beyond the immediate crisis. The second segment focuses on integrated care that targets trauma-specific treatment for mental, substance use, and co-occurring disorders. Even though entry-level, trauma-informed behavioral health service providers are unlikely to be in a position to use these interventions, having some knowledge of them is nevertheless important. Currently, more research is needed to tease out the most important ingredients of early interventions and their role in the prevention of more pervasive traumatic stress symptoms. More science-based evidence is available for trauma-specific treatments that occur and extend well beyond the immediate reactions to trauma. The last part of the chapter provides a brief review of selected emerging interventions.

Trauma-specific therapies vary in their approaches and objectives.Some are present focused, some are past focused, and some are combinations (Najavits). Present-focused approaches primarily address current coping skills, psychoeducation, and managing symptoms for better functioning. Past-focused approaches primarily focus

on telling the trauma story to understand the impact of the trauma on how the person functions today, experiencing emotions that were too overwhelming to experience in the past, and helping clients more effectively cope in the present with their traumatic experiences. Clients participating in present-focused approaches may reveal some of their stories; past-focused approaches emphasize how understanding the past influences current behavior, emotion, and thinking, thereby helping clients cope more effectively with traumatic experiences in the present.

The distinction between these approaches lies in the primary emphasis of the approach. Depending on the nature of the trauma and the specific needs of the client, one approach may be more suitable than the other. For instance, in short-term treatment for clients in early recovery from mental illness and/or substance abuse, present-focused, cognitive–behavioral, or psychoeducational approaches are generally more appropriate. For clients who are stable in their recovery and have histories of developmental trauma where much of the trauma has been repressed, a past-focused orientation may be helpful. Some clients may benefit from both types, either concurrently or sequentially.

This chapter discusses a number of treatment models, general approaches, and techniques. A treatment model is a set of practices designed to alleviate symptoms, promote psychological well-being, or restore mental health. Treatment techniques are specific procedures that can be used as part of a variety of models. Some models and techniques described in this chapter can be used with groups, some with individuals, and some with both. This chapter is selective rather than comprehensive; additional models are described in the literature. See, for example, the PILOTS database on the Web site of the National Center for PTSD (NCPTSD; http://www.ptsd.va.gov) for treatment literature related to trauma and posttraumatic stress disorder (PTSD). For an overview of models for use with both adult and child populations, refer to *Models for Developing Trauma-Informed Behavioral HealthSystems and Trauma-Specific Services* (Center for Mental Health Services).

Some treatments discussed in this chapter are described as evidence based. Because research on integrated treatment models is so new, many have only been examined in a few studies. Given these circumstances and the fact that an outcome study provides only limited evidence of efficacy, the term “evidence based” should be interpreted cautiously. Additional scientific study is needed to determine whether some treatments discussed herein are, in fact, evidence based. A good resource for evaluating evidence-based, trauma-specific treatment models is *Effective Treatments for PTSD* (Foa, Keane, Friedman, & Cohen). Although evidence-based interventions should be a primary consideration in selecting appropriate treatment models for people with symptoms of trauma that co-occur with mental and substance use disorders, other factors must also be weighed, including the specific treatment needs of the client; his or her history of trauma, psychosocial and cultural background, and experiences in prior trauma treatment; the overall treatment plan for the client; and the competencies of the program’s clinical staff.

Evidence Related to Immediate Interventions

Evidence related to immediate interventions suggests that:

- Early, brief, focused psychotherapeutic intervention provided in an individual or group format can reduce distress in bereaved spouses, parents, and children.
- Selected cognitive-behavioral approaches may help reduce the incidence, duration, and severity of acute stress disorder (ASD), PTSD, and depression in trauma survivors.
- A one-session individual recital of events and expression of emotions evoked by a traumatic event does not consistently reduce risk of later developing PTSD. In fact, it may increase the risk for adverse outcomes. Perhaps CISD hinders the natural recovery mechanisms that restore pretrauma functioning (Bonanno).
- The focus initially should be upon screening with follow-up as indicated.

The Substance Abuse and Mental Health Services Administration (SAMHSA) has created the National Registry of Evidence-Based Pro-grams and Practices (NREPP) as a resource for reviewing and identifying effective treatment programs. Programs can be nominated for consideration as co-occurring disorders programs or substance abuse prevention or treatment programs, and their quality of evidence, readiness for dissemination, and training considerations are then reviewed. For more detailed information, including details about several evidence-based co-occurring trauma treatment programs, visit the NREPP Web site (http://www.nrepp.samhsa.gov). Program models for specialized groups, such as adolescents, can also be found on the NREPP Web site.

Trauma-Specific Treatment Models

Immediate Interventions

Intervention in the First 48 Hours

The acute intervention period comprises the first 48 hours after a traumatic event. In a disaster, rescue operations usually begin with local agencies prior to other organizations arriving on the scene. Law enforcement is likely to take a primary role on site. Whether it is a disaster, group trauma, or individual trauma (including a trauma that affects an entire family, such as a house fire), a hierarchy of needs should be established: survival, safety, security, food, shelter, health (physical and mental), orientation of survivors to immediate local services, and communication with family, friends, and community (National Institute of Mental Health). In this crucial time, appropriate interventions include educating survivors about resources; educating other providers, such as faith-based organizations and social service groups, to screen for increased psychological effects including use of substances; and use of a trauma response team that assists clients with their immediate needs. No formal interventions should be

Core Actions in Preparing To Deliver Psychological First Aid

Contact and engagement
Safety and comfort
Stabilization
Information gathering: Current needs and concerns
Practical assistance
Connection with social supports
Information on coping
Linkage with collaborative services

Source: National Child Traumatic Stress Network & NCPTSD

attempted at this time, but a professionally trained, empathic listener can offer solace and support (Litz & Gray).

Basic Needs

Basic necessities, such as shelter, food, and water, are key to survival and a sense of safety.It is important to focus on meeting these basic needs and on providing a supportive environment. Clients' access to prescribed medications may be interrupted after a trauma, particularly a disaster, so providers should identify clients' medication needs for preexisting physical and mental disorders, including methadone or other pharmacological treatment for substance use. For example, after September 11, 2001, substance abuse treatment program administrators in New York had to seek alternative methadone administration options (Frank, Dewart, Schmeidler, & Demirjian).

Psychological First Aid

The psychological first aid provided in the first 48 hours after a disaster is designed to ensure safety, provide an emotionally supportive environment and activities, identify those with high-risk reactions, and facilitate communication, including strong, reassuring leadership immediately after the event. The primary helping response of psychological first aid is to provide a calm, caring, and supportive environment to set the scene for psychological recovery. It is also essential that all those first responding to a trauma—rescue workers, medical professionals, behavioral health workers (including substance abuse counselors), journalists, and volunteers—be familiar with relevant aspects of traumatic stress. Approaching survivors with genuine respect, concern, and knowledge increases the likelihood that the caregiver can (NCPTSD):

- ➡ Answer questions about what survivors may be experiencing.
- ➡ Normalize their distress by affirming that what they are experiencing is normal.
- ➡ Help them learn to use effective coping strategies.
- ➡ Help them be aware of possible symptoms that may require additional assistance.
- ➡ Provide a positive experience that will increase their chances of seeking help if they need it in the future.

Clinical experience suggests that care be taken to respect a survivor's individual method of coping; some may want information, for example, whereas others do not. Similarly, some may want to talk about the event, but others won't. An excellent guide to providing psychological first aid is available online from theTerrorism and Disaster Branch of the National Child Traumatic Stress Network (http://www.nctsn.org/content/psychologicalfirst-aid).

Critical Incident Stress Debriefing

Initially developed for work with first responders and emergency personnel, critical incident stress debriefing (CISD; Mitchell & Everly) is now widely used and encompasses various group protocols used in a variety of settings. This facilitator-led group intervention is for use soon after a traumatic event with exposed people. The goal is to provide psychological closure by encouraging participants to talk about their experiences and then giving a didactic presentation on common stress reactions and management.

The widespread use of CISD has occurred despite the publication of conflicting results regarding its efficacy. Claims that single-session psychological debriefing can prevent development of chronic negative psychological sequelae are not empirically supported (van Emmerik, Kamphuis, Hulsbosch, & Emmel kamp). Some controlled studies suggest that it may impede natural recovery from trauma (McNally, Bryant, & Ehlers). Other research suggests emphasizing screening to determine the need for early interventions. Mitchell and Everly point out that many of the studies showing negative results were not conducted with first responders; that is, CISD may be appropriate for some, but not all, groups. A recent study of 952 U.S. peacekeepers and CISD by the U.S.Army Research Unit–Europe (Adler et al.) found mixed results.

Interventions Beyond the Initial Response to Trauma

In the interest of increasing your overall familiarity with relevant approaches, the following sections review several traumatic stress treatment approaches that counselors will most likely encounter when collaborating with clinicians or agencies that specialize in trauma-specific services and treating traumatic stress.

Client-centered approaches are associated with a number of benefits including reduced IPV. The evidence, however, is mixed, potentially due to variability in the nature of intervention models tested, populations studied, loss to follow-up, and other methodological factors. A systematic review of primary care-based interventions for IPV found brief, women-focused interventions delivered mostly in the primary care office by non-physician healthcare workers were successful at reducing IPV, improving physical and emotional health, increasing safety-promoting behaviors, and positively affecting the use of IPV and community-based resources. Other systematic reviews have noted significant benefits of counseling interventions in reducing IPV and improving birth outcomes for pregnant women, reducing pregnancy coercion, and women's involvement in unsafe relationships. One rigorous study of a prenatal counseling intervention found that women in the intervention group (compared with usual care) were 52% less likely to have recurrent episodes of IPV during pregnancy and postpartum; had reduced rates of very low birthweight infants (0.8% vs 4.6%), and longer mean gestational age at delivery (38.2 weeks versus 36.9 weeks). In another rigorous intervention study conducted in four clinics, family planning counselors asked about IPV and reproductive coercion when determining reason for visit and then assisted patients in identifying strategies specific to the reason for the

clinic visit (e.g., offering a more hidden form of birth control if partner has been influencing birth control use; offering emergency contraception if indicated; educating client about local IPV and sexual assault resources and facilitating their use). The control group received standard care consisting of a brief IPV screen without any questions on reproductive coercion and were provided a list of IPV resources. In this study, the intervention group was 71% less likely to experience pregnancy reproductive coercion among female patients who had experienced IPV within the past three months compared to a control group. In a subsequent, larger cluster randomized controlled trial of the intervention across 25 family planning clinics, Miller et al.found improvements in knowledge of partner violence resources and self-efficacy to enact harm reduction behaviors among the intervention group (relative to the control group) at the 12-month follow-up. While there were no differences in IPV or reproductive coercion among the full sample at follow-up, the intervention led to a significant reduction in reproductive coercion among women reporting the highest levels of reproductive coercion at baseline. Another intervention study embedded an IPV intervention into home visitation programs for pregnant women and new mothers, where women in the intervention group were screened by home visitors who had received special training on IPV and the intervention. If women screened positively for IPV, the nurse delivered a brochure based empowerment intervention during six sessions of the home visiting program. The intervention consisted of a standardized assessment of the level of danger from IPV, a discussion of safety and response options with the participant, assistance with choosing a response, and provision of referrals to services. Women in the intervention group reported a significantly larger decrease in IPV from baseline to two or more year follow-up than women in a service-as-usual control group.Treatment and support for survivors of IPV, including TDV. Supportive interventions are associated with improved psychological health and long-term positive impact for survivors of IPV. For example, Cognitive Behavioral Therapy (CBT) is an example of a treatment for survivors of IPV who experience PTSD and depression. CBT includes treatments such as Cognitive Processing Therapy (CPT) to help the patient learn to recognize and challenge cognitive distortions (i.e., negative ways of thinking about a situation that makes things appear worse than they really are). A randomized clinical trial that assessed participants before treatment, six times during treatment, and at a 6-month follow-up, found that women who received CBT for treatment of PTSD experienced reductions in PTSD and depression. Reductions in Patient-centered approaches are associated with a number of benefits including reduced IPV. The evidence, however, is mixed, potentially due to variability in the nature of intervention models tested, populations studied, loss to follow-up, and other methodological factors. A systematic review of primary care-based interventions for IPV found brief, women-focused interventions delivered mostly in the primary care office by non-physician healthcare workers were successful at reducing IPV, improving physical and emotional health, increasing safety-promoting behaviors, and positively affecting the use of IPV and community-based resources. Other systematic reviews have noted significant benefits of counseling interventions in reducing IPV and improving birth outcomes for

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Cognitive–behavioral Therapies

Most PTSD models involve cognitive–behavioral therapy (CBT) that integrates cognitive and behavioral theories by incorporating two ideas: first, that cognitions (or thoughts) mediate between situational demands and one's attempts to respond to them effectively, and second, that behavioral change influences acceptance of altered cognitions about oneself or a situation and establishment of newly learned cognitive–behavioral interaction patterns. In practice, CBT uses a wide range of coping strategies.

There are many different varieties of CBT. CBT originated in the 1970s (Beck, Rush, Shaw & Emery, 1979; Ellis & Harper, 1975) and has expanded since then to address various populations, including people who use substances, people who experience anxiety, people with PTSD or personality disorders, children and adolescents, individuals involved in the criminal justice system, and many others. CBT has also been expanded to include various techniques, coping skills, and approaches, such as dialectical behavior therapy (DBT; Linehan), Seeking Safety (Najavits), and mindfulness (Segal, Williams, & Teasdale). Traditional CBT emphasizes symptom reduction or resolution, but recent CBT approaches have also emphasized the therapeutic relationship, a particularly important dynamic in trauma treatment (Jackson, Nissenson, & Cloitre).

CBT has been applied to the treatment of trauma and has also been widely and effectively used in the treatment of substance use. Areview of efficacy research on CBT for PTSDis provided by Rothbaum, Meadows, Resick, and Foy. Najavits and colleagues and O'Donnell and Cook offer an overview of CBT therapies for treatingPTSD and substance abuse. In addition, a free online training resource incorporating CBT for traumatized children within the community, Trauma-Focused CBT, is available from the Medical University of South Carolina(http://tfcbt.musc.edu/).

Cognitive Processing Therapy

Cognitive processing therapy (CPT) is a manualized 12-session treatment approach that can be administered in a group or individual setting (Resick & Schnicke). CPT was developed for rape survivors and combines elements of existing treatments for PTSD, specifically exposure therapy (see the "Exposure Therapy" section later in this chapter) and cognitive therapy. The exposure therapy component of treatment consists of clients writing a detailed account of their trauma, including thoughts, sensations, and emotions that were experienced during the event. The client then reads the narrative aloud during a session and at home. The cognitive therapy aspect of CPT uses six key PTSD themes identified by McCann and Pearlman: safety, trust, power, control, esteem, and intimacy. The client is guided to identify cognitive distortions in these areas, such as maladaptive beliefs.

Results from randomized, placebo-controlled trials for the treatment of PTSD related to interpersonal violence (Resick, Resick,Nishith, Weaver, Astin, & Feuer) support the use of CPT. CPT and prolonged exposure therapy models are equally and highly positive in treating PTSD and depression in rape survivors; CPT is superior in reducing guilt (Nishith, Resick, & Griffin, Resick et al., Resick, Nishith, &Griffin). CPT has shown positive outcomes with refugees when administered in the refugees' native language (Schulz, Marovic-Johnson, & Huber) and with veterans (Monson et al.). However, CPT has not been studied with high-complexity populations such as individuals with substance dependence, homelessness, current domestic violence, serious and persistent mental illness, or suicidality. CPT requires a 3-day training plus consultation (Karlin et al.). Resick and Schicke published a CPT treatment manual, *Cognitive Processing Therapy forRape Victims: A Treatment Manual*.

Exposure Therapy

Exposure therapy for PTSD asks clients to directly describe and explore trauma-related memories, objects, emotions, or places. Intense emotions are evoked (e.g., sadness, anxiety) but eventually decrease, desensitizing clients through repeated encounters with traumatic material. Careful monitoring of the pace and appropriateness of exposure-based interventions is necessary to prevent retraumatization (clients can become conditioned to fear the trauma-related material even more). Clients must have ample time to process their memories and integrate cognition and affect, so some sessions can last for 1.5 hours or more. For simple cases, exposure can work in as few as 9 sessions; more complex cases may require 20 or more sessions (Foa, Hembree, &Rothbaum). Various techniques can expose the client to traumatic material. Two of the more common methods are exposure through imagery and in vivo ("real life") exposure.

The effectiveness of exposure therapy has been firmly established (Rothbaum et al.); however, adverse reactions to exposure therapy have also been noted. Some individuals who have experienced trauma exhibit an exacerbation of symptoms during or following exposure treatments. Even so, the exacerbation may depend on clinician variables during administration. Practitioners of exposure therapy need comprehensive training to master its techniques (Karlin et al.) a clinician unskilled in the methods of this treatment model can not only fail to help his or her clients, but also cause symptoms to worsen.

Exposure therapy is recommended as a first-line treatment option when the prominent trauma symptoms are intrusive thoughts, flashbacks, or trauma-related fears, panic, and avoidance. However, counselors should exercise caution when using exposure with clients who have not maintained stability in managing mental illness symptoms or abstinence from substance use disorders. Studies and routine use of exposure have consistently excluded high-complexity clients such as those with substance dependence, homelessness, current domestic violence, serious and persistent mental illness, or suicidality. The only trial of exposure therapy with a substance dependence

Relaxation Training, Biofeedback, and Breathing Retraining Strategies

Relaxation training, biofeedback, and breathing retraining strategies may help some clients cope with anxiety, a core symptom of traumatic stress. However, no evidence supports the use of relaxation and biofeedback as effective standalone PTSD treatment techniques (Cahill, Rothbaum, Resick, & Follete). Both are sometimes used as complementary strategies to manage anxiety symptoms elicited by trauma-related stimuli. Breathing retraining uses focused or controlled breathing to reduce arousal. Breathing retraining and relaxation, along with other interventions when necessary, can help clients with ASD. An important caution in the use of breath work with trauma clients is that it can sometimes act as a trigger–for example, given its focus on the body and its potential to remind them of heavy breathing that occurred during assault. Biofeedback, which requires specialized equipment, combines stress reduction strategies (e.g., progressive muscle relaxation, guided imagery) with feedback from biological system measures (e.g., heart rate, hand temperature) that gauge levels of stress or anxiety reduction. Relaxation training, which requires no specialized equipment, encourages clients to reduce anxiety responses (including physiological responses) to trauma-related stimuli; it is often part of more comprehensive PTSD treatments (e.g., prolonged exposure and stress inoculation training [SIT]).

sample found that it did not outperform standard substance abuse treatment on most variables (Mills et al.).

Prolonged exposure therapy for PTSD is listed in SAMHSA's NREPP. For reviews of exposure therapy, also see Najavits and Institute of Medicine. In addition to prolonged exposure therapy, other therapies incorporate exposure and desensitization techniques, including eye movement desensitization and reprocessing (EMDR; Shapiro), cognitive processing, and systematic desensitization therapies (Wolpe).

Eye Movement Desensitization and Reprocessing

EMDR (Shapiro) is one of the most widely used therapies for trauma and PTSD. The treatment protocols of EMDR have evolved into sophisticated paradigms requiring training and, preferably, clinical supervision.EMDR draws on a variety of theoretical frameworks, including psychoneurology, CBT, information processing, and nonverbal

representation of traumatic memories. The goal of this therapy is to process the experiences that are causing problems and distress. It is an effective treatment for PTSD (Seidler &Wagner) and is accepted as an evidence-based practice by the U.S. Department ofVeterans Affairs (VA), the Royal College ofPsychiatrists, and the International Society for Traumatic Stress Studies (Najavits); numerous reviews support its effectiveness (e.g., Mills et al.). EMDR values the development of "resource installation" (calming procedures) and engages in exposure work to desensitize clients to traumatic material, using external tracking techniques across the visual field to assist in processing distressing material. Training in EMDR, available through theEMDR Institute, is required before counselors use this treatment. It is listed in SAMHSA's NREPP (EMDR Network). Thus far, there is no study examining the use of EMDR with clients in substance abuse treatment.

A Brief Description of EMDR Therapy

Treatment involves three main concentrations (past memories, present disturbances, future actions) and eight phases. Counselors may work with several phases in one session. Each phase is meant to be revisited either in every session or when appropriate (e.g., the closure process is meant to be conducted at the end of every session, in preparation for the next).

Phase 1: History and Treatment Planning (1-2 sessions)
Phase 2: Preparation
Phase 3: Assessment and Reprocessing
Phase 4: Desensitization
Phase 5: Installation
Phase 6: Body Scan
Phase 7: Closure
Phase 8: Reevaluation

Narrative Therapy

Narrative therapy is an emerging approach to understanding human growth and change; it is founded on the premise that individuals are the experts on their own lives and can access their existing intrapsychic and interpersonal resources to reduce the impact of problems in their lives. Developed for the treatment ofPTSD resulting from political or community violence, narrative therapy is based on CBT principles, particularly exposure therapy (Neuner, Schauer, Elbert, & Roth, Neuner, Schauer, Klaschik, Karunakara, & Elbert). This approach views psychotherapy not as a

scientific practice, but as a natural extension of healing practices that have been present throughout human history.For a trauma survivor, the narrative, as it is told and retold, expresses the traumatic experience, puts the trauma in the context of the survivor's life, and defines the options he or she has for change. Narrative structure helps clients connect events in their lives, reveals strings of events, explores alternative expressions of trauma, evokes explanations for clients' behaviors, and identifies their knowledge and skills. The use of stories in therapy, with the client as the storyteller, generally helps lessen suffering (McLeod, 1997; White).

Skills Training in Affective and Interpersonal Regulation

Skills training in affective and interpersonal regulation (STAIR) is a two-phase cognitive–behavioral model that adapts therapies developed by others into a new package (Cloitre, Koenen, Cohen, & Han). Phase 1 consists of eight weekly sessions of skills training in affect and interpersonal regulation derived from general CBT and DBT (Linehan) and adapted to address trauma involving childhood abuse. Session topics are labeling and identifying feelings, emotion management, distress tolerance, acceptance of feelings, identifying trauma-based interpersonal schemas, identifying conflict between trauma-generated feelings and current interpersonal goals, role-plays on issues of power and control, and role-plays on developing flexibility in interpersonal situations. Phase 2 features eight sessions of modified prolonged exposure using a narrative approach. Cloitre and colleagues assigned women with PTSD related to childhood abuse randomly to STAIR or a minimal attention wait-list, excluding clients with current substance dependence as well as other complexities. STAIR participants showed significantly greater gains in affect regulation, interpersonal skills, and PTSD symptoms than the control participants. These gains were maintained through follow-up at 3 and 9 months. However, it is not clear from this study whetherDBT and exposure were both needed. Phase 1therapeutic alliance and negative mood regulation skills predicted Phase 2 exposure success in reducing PTSD, suggesting the importance of establishing a strong therapeutic relationship and emotion regulation skills before conducting exposure work with people who have chronic PTSD.

Stress Inoculation Training

SIT was originally developed to manage anxiety (Meichenbaum, Meichenbaum & Deffenbacher). Kilpatrick, Veronen, and Resick modified SIT to treat rape survivors based on the idea that the anxiety and fear that rape survivors experience during their trauma generalizes to other objectively safe situations. SIT treatment components include education, skills training

SIT has been used to help individuals cope with the aftermath of exposure to stressful events and on a preventative basis to "inoculate" individuals to future and ongoing stressors (Meichenbaum). This practice as a preventive strategy is similar to promoting disease resistance through immunizations.

(muscle relaxation training, breathing retraining, role-playing, guided self-talk, assertiveness training, and thought stopping [i.e., actively and forcefully ending negative thoughts by thinking "STOP" and then redirecting thoughts in a more positive direction]), and skills application. The goal is to help clients learn to manage their anxiety and to decrease avoidant behavior by using effective coping strategies.Randomized controlled clinical trials have indicated that SIT reduces the severity ofPTSD compared with waitlist controls and shows comparable efficacy to exposure therapy.At follow-up (up to 12 months after treatment), gains were maintained (Foa et al., Foa, Rothbaum, Riggs, & Murdock).

Other Therapies

Numerous interventions introduced in the past 20 years focus on traumatic stress. For some interventions, the evidence is limited, and for other others, it is evolving. One example is the traumatic incident reduction (TIR) approach. This brief memory-oriented intervention is designed for children, adolescents, and adults who have experienced traumatic stress (Valentine & Smith). Listed in SAMHSA's NREPP, the intervention is designed to process specific traumatic incidents or problematic themes related to the trauma, including specific feelings, emotions, sensations, attitudes, or pain. It involves having clients talk through the traumatic incident repeatedly with the anticipation that changes in affect will occur throughout the repetitions.TIR is a client-centered approach.

Integrated Models for Trauma

This section covers models specifically designed to treat trauma-related symptoms along with either mental or substance use disorders at the same time. Integrated treatments help clients work on several presenting problems simultaneously throughout the treatment, a promising and recommended strategy (Dass-Brailsford & Myrick, Najavits, Nixon & Nearmy). Thus far, research is limited, but what is available suggests that integrated treatment models effectively reduce substance abuse, PTSD symptoms, and other mental disorder symptoms. Similar to single models, integrated treatment models are designed for use in a variety of settings (e.g., outpatient, day treatment, and/or residential substance abuse and mental health clinics/programs). Most models listed are manual-based treatments that address trauma-related symptoms, mental disorders, and substance use disorders at the same time. Additional approaches and further details on the selected approaches can be found atNREPP (http://www.nrepp.samhsa.gov).

Addiction and Trauma Recovery Integration Model

The Addiction and Trauma Recovery Integrated Model (ATRIUM; Miller & Guidry) integrates CBT and relational treatment through an emphasis on mental, physical, and spiritual health. This 12-week model for individuals and groups blends psychoeducational, process, and expressive activities, as well as information on the body's responses to addiction and traumatic stress and the impact of trauma and addiction on the mind and spirit. It helps clients explore anxiety, sexuality, self-harm,

depression, anger, physical complaints and ailments, sleep difficulties, relationship challenges, and spiritual disconnection. It was designed primarily for women and focuses on developmental (childhood) trauma and interpersonal violence, but it recognizes that other types of traumatic events occur.

The ATRIUM model consists of three phases of treatment. The first stage, or "outer circle,"consists of the counselor collecting data from the client about his or her trauma history, offering psychoeducation on the nature of trauma, and helping the client assess personal strengths. ATRIUM actively discourages the evocation of memories of abuse or other trauma events in this phase. The second stage, or"middle circle," allows clients and counselors to address trauma symptoms more directly and specifically encourages clients to reach out to and engage with support resources in the community. The middle circle also emphasizes learning new information about trauma and developing additional coping skills. The third stage of the program, the "inner circle," focuses on challenging old beliefs that arose as a result of the trauma. For instance, the concept of "non-protecting bystander" is used to represent the lack of support that the traumatized person experienced at the time of the trauma.This representation is replaced with the "protective presence" of supportive others today.

ATRIUM was used in one of the nine study sites of SAMHSA's Women, Co-OccurringDisorders and Violence Study. Across all sites, trauma-specific models achieved more favorable outcomes than control sites that did not use trauma-specific models (Morrissey et al). There has not yet been a study of ATRIUM per se, however. A manual describing the theory behind this model in greater depth, as well as how to implement it, is published under the title *Addictions and Trauma Recovery: Healing the Body, Mind, and Spirit* (Miller & Guidry).

Beyond Trauma: A Healing Journey for Women

Beyond Trauma (Covington) is a curriculum for women's services based on theory, research, and clinical experience. It was developed for use in residential, outpatient, and correctional settings; domestic violence programs; and mental health clinics. It uses behavioral techniques and expressive arts and is based on relational therapy. Although the materials are designed for trauma treatment, the connection between trauma and substance abuse in women's lives is a theme throughout. Beyond Trauma has a psychoeducational component that defines trauma by way of its process as well as its impact on the inner self (thoughts, feelings, beliefs, values) and the outer self (behavior and relationships, including parenting). Coping skills are emphasized; specific exercises develop emotional wellness.

Integrated CBT

Integrated CBT is a 14-session individual therapy model designed for PTSD and substance use. It incorporates elements such as psychoeducation, cognitive restructuring, and breathing retraining (McGovern, Lamber-Harris, Alterman, Xie, & Meier). A randomized controlled trial showed that both integrated CBT and individual

addiction treatment achieved improvements in substance use and other measures of psychiatric symptom severity with no difference between the treatments.

Seeking Safety

Seeking Safety is an empirically validated, present-focused treatment model that helps clients attain safety from trauma and substance abuse (Najavits). The Seeking Safety manual (Najavits) offers clinician guidelines and client handouts and is available in several languages.Training videos and other implementation materials are available online (http://www.seekingsafety.org). Seeking Safety is flexible; it can be used for groups and individuals, with women and men, in all settings and levels of care, by all clinicians, for all types of trauma and substance abuse.

Seeking Safety covers 25 topics that address cognitive, behavioral, interpersonal, and case management domains. The topics can be conducted in any order, using as few or as many as are possible within a client's course of treatment. Each topic represents a coping skill relevant to both trauma and substance abuse, such as compassion, taking good care of yourself, healing from anger, coping with triggers, and asking for help. This treatment model builds hope through an emphasis on ideals and simple, emotionally evocative language and quotations. It attends to clinician processes and offers concrete strategies that are thought to be essential for clients dealing with concurrent substance use disorders and histories of trauma.

More than 20 published studies (which include pilot studies, randomized controlled trials, and multi-site trials representing various investigators and populations) provide the evidence base for this treatment model. For more information, see SAMHSA's NREPP Web site (http://www.nrepp.samhsa.gov) as well as the"Outcomes" section of the Seeking Safety Web site (http://www.seekingsafety.org/3-0306/studies.html). Study samples included people with chronic, severe trauma symptoms and substance dependence who were diverse in ethnicity and were treated in a range of settings (e.g., criminal justice, VA centers, adolescent treatment, homelessness services, public sector). Seeking Safety has shown positive outcomes on trauma symptoms, substance abuse, and other domains (e.g., suicidality, HIV risk, social functioning, problem-solving, sense of meaning); consistently outperformed treatment as usual; and achieved high satisfaction ratings from both clients and clinicians. It has been translated into seven languages, and a version for blind and/or dyslexic individuals is available.

The five key elements of Seeking Safety are:

- ➡Safety as the overarching goal (helping clients attain safety in their relationships, thinking, behavior, and emotions).
- ➡ Integrated treatment (working on trauma and substance abuse at the same time).
- ➡A focus on ideals to counteract the loss of ideals in both trauma and substance abuse.
- ➡ Four content areas: cognitive, behavioral, interpersonal, and case management.
- ➡Attention to clinician processes (addressing countertransference, self-care, and other issues).

Trauma Recovery and Empowerment Model

The trauma recovery and empowerment model (TREM) of therapy (Fallot & Harris, Harris & Community Connections TraumaWork Group) is a manualized group intervention designed for female trauma survivors with severe mental disorders. TREM addresses the complexity of long-term adaptation to trauma and attends to a range of difficulties common among survivors of sexual and physical abuse. TREM focuses mainly on developing specific recovery skills and current functioning and uses techniques that are effective in trauma recovery services. The model's content and structure, which cover 33 topics, are informed by the role of gender in women's experience of and coping with trauma.

TREM Program Format

Each session includes an experiential exercise to promote group cohesiveness. The 33 sessions are divided into the following general topic areas:

- **Part I–empowerment** introduces gender identity concepts, interpersonal boundaries, and self-esteem.
- **Part II–trauma recovery** concentrates on sexual, physical, and emotional abuse and their relationship to psychiatric symptoms, substance abuse, and relational patterns and issues.
- **Part III–advanced trauma recovery issues** addresses additional trauma issues, such as blame and the role of forgiveness.
- **Part IV–closing rituals** allows participants to assess their progress and encourages them to plan for their continued healing, either on their own or as part of a community of other survivors.
- **Part V–modifications or supplements for special populations** provides modifications for subgroups such as women with serious mental illness, incarcerated women, women who are parents, women who abuse substances, and male survivors.

Source: Mental Health America Centers for Technical Assistance,

TREM can be adapted for shorter-term residential settings and outpatient substance abuse treatment settings, among others. Adaptations of the model for men and adolescents are available. The model was used in SAMHSA's Women, Co-Occurring Disorders and Violence Study for three of the nine study sites and in SAMHSA's Homeless Families program, and it is listed in SAMHSA's NREPP. This model has been used with clients in substance abuse treatment; research by Toussaint, VanDeMark, Bornemann, and Graeber shows that women in a residential substance abuse treatment program showed significantly better trauma treatment outcomes using TREM than they did in treatment as usual, but no difference in substance use.

Triad Women's Project

The Triad Project was developed as a part of SAMHSA's Women, Co-Occurring Disorders and Violence Study. It is a comprehensive, trauma-informed, consumer-responsive integrated model designed for female trauma survivors with co-occurring substance use and mental disorders who live in semi-rural areas. Triad integrates motivational enhancement for substance use disorders, DBT, and intensive case management techniques for co-occurring mental disorders. This program is a 16-week group intervention for women that uses integrated case management services, a curriculum-based treatment group, and a peer support group (Clark & Fearday).

Emerging Interventions

New interventions are emerging to address traumatic stress symptoms and disorders. The following sections summarize a few interventions not highlighted in prior chapters; this is not an exhaustive list. In addition to specific interventions, technology is beginning to shape the delivery of care and to increase accessibility to tools that complement trauma-specific treatments.

Couple and Family Therapy

Trauma and traumatic stress affects significant relationships, including the survivor's family. Although minimal research has targeted the effectiveness of family therapy with trauma survivors, it is important to consider the needs of the individual in the context of their relationships. Family and couples therapy may be key to recovery. Family members may experience secondary traumatization silently, lack understanding of traumatic stress symptoms or treatment, and/or have their own histories of trauma that influence their willingness to support the client in the family or to talk about anything related to trauma and its effects. Family members can engage in similar patterns of avoidance and have their own triggers related to the trauma being addressed at the time. A range of couple and family therapies have addressed traumatic stress and PTSD, but few studies exist that support or refute their value. Current couple or family therapies that have some science-based evidence include behavioral family therapy, behavioral marital therapy, cognitive–behavioral couples treatment, and lifestyle management courses (Riggs, Monson, Glynn, & Canterino).

Mindfulness Interventions

Mindfulness is a process of learning to be present in the moment and observing internal experience (e.g., thoughts, bodily sensations) and external experience (e.g., interactions with others) in a nonjudgmental way. Mindfulness challenges limiting beliefs that arise from trauma, quells anxiety about future events, and simply helps one stay grounded in the present. It plays a significant role in helping individuals who

have been traumatized observe their experiences, increase awareness, and tolerate uncomfortable emotions and cognitions.

To date, mindfulness-based interventions appear to be valuable as an adjunct to trauma-specific interventions and in decreasing arousal (Baer). It may also help individuals tolerate discomfort during exposure-oriented and trauma processing interventions. Overall, mindfulness practices can help clients in managing traumatic stress, coping, and resilience.In a study of firefighters, mindfulness was associated with fewer PTSD symptoms, depressive symptoms, physical symptoms, and alcohol problems when controlling for other variables (Smith et al.)
For clients and practitioners who want to develop a greater capacity for mindfulness, see Kabat-Zinn's books *Wherever You Go, There You Are: Mindfulness Meditation In Everyday Life* and *Full Catastrophe Living: Usingthe Wisdom of Your Body and Mind to FaceStress, Pain, and Illness*. For clinical applications of mindfulness, see *Mindfulness-Based Cognitive Therapy for Depression: A NewApproach to Preventing Relapse* (Segal et al) and *Relapse Prevention: Maintenance Strategies in the Treatment of Addictive Behaviors* (Marlatt & Donovan).

Pharmacological Therapy

Pharmacotherapy for people with mental, substance use, and traumatic stress disorders needs to be carefully managed by physicians who are well versed in the treatment of each condition. Medications can help manage and control symptoms; however, they are only apart of a comprehensive treatment plan. There are no specific "anti-trauma" drugs; rather, certain drugs target specific trauma symptoms. Clients receiving pharmacotherapy need careful assessment. Some clients with pre-existing mental disorders may need further adjustment in medications due to the physiological effects of traumatic stress. In addition, sudden withdrawal from a pattern of self-administered substances can not only lead to dangerous levels of physical distress, but also exacerbate the emergence of more severe PTSD symptoms. Distress after trauma often lessens over time, which can sometimes make the use of medications unnecessary for some individuals. Some trauma survivors do not develop long-term psychological problems from their experiences that require medication; others may simply refuse the initiation of pharmacotherapy or the use of additional medications.

Behavioral health providers can best serve clients who have experienced trauma by providing integrated treatment that combines therapeutic models to target presenting symptoms and disorders. Doing so acknowledges that the disorders interact with each other. Some models have integrated curricula; others that address trauma alone can be combined with behavioral health techniques with which the counselor is already familiar.

In part, the choice of a treatment model or general approach will depend on the level of evidence for the model, the clinician's training, identified problems, the potential for prevention, and the client's goals and readiness for treatment. Are improved relationships with family members a goal? Will the client be satisfied if sleep problems decrease, or is the goal resolution of broader issues? Are there substance use

or substance-related disorders? Is the goal abstinence? Collaborating with clients to decide on goals, eliciting what they would like from treatment, and determining what they expect to happen can provide some clues as to what treatment models or techniques might be successful in keeping clients engaged in recovery.

7.5 Crisis Intervention

Core Elements for Responding to Mental Health Crises

Crises have a profound impact on people with serious mental health or emotional problems. Adults, children and older adults with a serious mental illness or emotional disorder often lead lives characterized by recurrent, significant crises. These crises are not the inevitable consequences of mental disability, but rather represent the combined impact of a host of additional factors, including lack of access to essential services and supports, poverty, unstable housing, coexisting substance use, other health problems, discrimination and victimization.

Homelessness, police contact, institutionalization and other adverse events are in themselves crises, and may also contribute to further crises. The statistics below paint a sobering picture of how crises affect the lives of people who have mental or emotional disabilities:

- From one third to one half of homeless people have a severe psychiatric disorder.
- Approximately 7 percent of all police contacts in urban settings involve a person believed to have a mental illness.
- The likelihood of mental illness among people confined in state prisons and local jails is three to four times higher than in the general population3 and, compared with other inmates, it is at least twice as likely that these individuals will be injured during their incarceration.
- About 6 percent of all hospital emergency department visits reflect mental health emergencies.
- Due to a lack of available alternatives, 79 percent of hospital emergency departments report having to “board” psychiatric patients who are in crisis and in need of inpatient care, sometimes for eight hours or longer.
- Almost one in 10 individuals discharged from a state psychiatric hospital will be readmitted within 30 days; more than one in five will be readmitted within 180 days.
- About 90 percent of adult inpatients in state psychiatric hospitals report histories of trauma.
- About three quarters of youth in the juvenile justice system report mental health problems and one in five has a serious mental disorder.
- Mothers with serious mental illnesses are more than four times as likely as other mothers to lose custody of their children.
- People with serious mental illnesses die, on average, 25 years earlier than the general population.

These statistics are incomplete; they reflect just a sampling of scenarios that, while commonplace, constitute significant life crises for individuals with serious mental illnesses. Many such individuals experience a cascade of crisis events that place them in more than one of these statistical groups. For instance, readmission to a psychiatric institution—a high probability for adults who have been discharged from a state psychiatric hospital, based on these data—may feature a series of crisis events for the individual: the psychiatric emergency itself; forcible removal from one's home; being taken into police custody, handcuffed and transported in the back of a police car; evaluation in the emergency department of a general hospital; transfer to a psychiatric hospital; a civil commitment hearing; and so on. And at multiple points in this series of interventions, there is a likelihood that physical restraints, seclusion, involuntary medication or other coercion may be used. Intense feelings of disempowerment are definitional of mental health crises, yet as the individual becomes the subject of a "disposition" at each juncture, that person may experience a diminishing sense of control.

While no one with a mental or emotional disorder is immune from crises, people with what are termed serious mental illnesses—defined as schizophrenia, bipolar disorder and major depression—may be most reliant on public systems. They also may be at great risk of recurrent crises and interventions that exacerbate their clinical and social problems. These guidelines focus most specifically on individuals with serious mental or emotional problems who tend to encounter an assortment of governmental or publicly funded interveners when they are in crisis. Nevertheless, the values, principles and strategies embedded in the guidelines that follow are applicable to all individuals with mental healthcare needs, across populations and service settings.

Individuals whose diagnoses do not fit "serious mental illnesses" may be vulnerable to serious mental health crises that can have devastating outcomes. Interventions on their behalf are more likely to occur within the private healthcare sector, which mirrors public mental health systems' problems in providing early and meaningful access to help. Within these parallel systems, crisis services are provided in a broad array of settings that ultimately will require translation of the guidelines presented here into specific protocols that break cycles of crises and advance the prospects of recovery for people with mental illnesses.

What It Means to be In a Mental Health Crisis

Too often, public systems respond as if a mental health crisis and danger to self or others were one and the same. In fact, danger to self or others derives from common legal language defining when involuntary psychiatric hospitalization may occur—at best, this is a blunt measure of an extreme emergency. A narrow focus on dangerousness is not a valid approach to addressing a mental health crisis. To identify crises accurately requires a much more nuanced understanding and a perspective that

looks beyond whether an individual is dangerous or immediate psychiatric hospitalization is indicated.

While behaviors that represent an imminent danger certainly indicate the need for some sort of an emergency response, these behaviors may well be the culmination of a crisis episode, rather than the episode in its entirety. Situations involving mental health crises may follow trajectories that include intense feelings of personal distress (e.g., anxiety, depression, anger, panic, hopelessness), obvious changes in functioning (e.g., neglect of personal hygiene, unusual behavior) or catastrophic life events (e.g., disruptions in personal relationships, support systems or living arrangements; loss of autonomy or parental rights; victimization or natural disasters).

Because only a portion of real-life crises may actually result in serious harm to self or others, a response that is activated only when physical safety becomes an issue is often too little, too late or no help at all in addressing the root of the crisis. And a response that does not meaningfully address the actual issues underlying a crisis may do more harm than good.

The Need for Crisis Standards

Individuals experiencing mental health crises may encounter an array of professionals and non-professionals trying to intervene and help: family members, peers, healthcare personnel, police, advocates, clergy, educators and others. The specific crisis response offered is influenced by a number of variables, among them:
✓At what time of day it occurs
✓Where the intervention occurs
✓When it occurs within the course of the crisis episode
✓The familiarity of the intervener with the individual or with the type of problem
✓Interveners' training relating to crisis services
✓Resources of the mental health system and the ready availability of services and supports, and professional, organizational or legal norms that define the nature of the encounter and the assistance offered.

The guidelines presented here define appropriate responses to mental health crises across these variables. They were developed by a diverse expert panel that includes individuals with and without serious mental illnesses who are leaders within mental health professions and mental health advocacy.

These crisis guidelines promote two essential goals:
✓Ensuring that mental health crisis interventions are guided by standards consistent with recovery and resilience and
✓Replacing today's largely reactive and cyclical approach to mental health crises with one that works toward reducing the likelihood of future emergencies and produces better outcomes.

Responding to a Mental Health Crisis Ten Essential Values

Ten essential values are inherent in an appropriate crisis response, regardless of the nature of the crisis, the situations where assistance is offered or the individuals providing assistance:

1. Avoiding harm. Sometimes mental health crises place the safety of the person, the crisis responders or others in jeopardy. An appropriate response establishes physical safety, but it also establishes the individual's psychological safety. For instance, restraints are sometimes used in situations where there is an immediate risk of physical harm, yet this intervention has inherent physical and psychological risks that can cause injury and even death. Precipitous responses to individuals in mental health crises—often initiated with the intention of establishing physical safety—sometimes result in harm to the individual. An appropriate response to mental health crises considers the risks and benefits attendant to interventions and whenever possible employs alternative approaches, such as controlling danger sufficiently to allow a period of "watchful waiting." In circumstances where there is an urgent need to establish physical safety and few viable alternatives to address an immediate risk of significant harm to the individual or others, an appropriate crisis response incorporates measures to minimize the duration and negative impact of interventions used.

2. Intervening in person-centered ways. Mental health crises may be routine in some settings and, perhaps, have even come to be routine for some people with serious mental health or emotional problems. Nevertheless, appropriate crisis assistance avoids rote interventions based on diagnostic labels, presenting complaint or practices customary to a particular setting. Appropriate interventions seek to understand the individual, his or her unique circumstances and how that individual's personal preferences and goals can be maximally incorporated in the crisis response.

"To promote patient-centered care, all parties involved in health care for mental or substance-use conditions should support the decision-making abilities and preferences for treatment and recovery of persons with mental/substance use problems and illnesses" Institute of Medicine Committee on Crossing the Quality Chasm: Adaptation to Mental Health and Addictive Disorders.

3. Shared responsibility. An acute sense of losing control over events or feelings is a hallmark of mental health crises. In fact, research has shown "feeling out of control" to be the most common reason consumers cite for being brought in for psychiatric emergency care. An intervention that is done to the individual— rather than with the individual—can reinforce these feelings of helplessness. One of the principal rationales for person-centered plans is that shared responsibility promotes engagement and better outcomes. While crisis situations may present challenges to implementing shared, person-centered plans, ultimately an intervention that considers

and, to the extent possible, honors an individual's role in crisis resolution may hold long-term benefits. An appropriate crisis response seeks to assist the individual in regaining control by considering the individual an active partner in—rather than a passive recipient of—services.

4. Addressing trauma. Crises, themselves, are intrinsically traumatic and certain crisis interventions may have the effect of imposing further trauma—both physical and emotional. In addition, people with serious mental illness have a high probability of having been victims of abuse or neglect. It is essential that once physical safety has been established, harm resulting from the crisis or crisis response is evaluated and addressed without delay by individuals qualified to diagnose and initiate needed treatment. There is also a dual responsibility relating to the individual's relevant trauma history and vulnerabilities associated with particular interventions; crisis responders should appropriately seek out and incorporate this information in their approaches, and individuals should take personal responsibility for making this crucial information available (for instance, by executing advance directives).

5. Establishing feelings of personal safety. An individual may experience a mental health crisis as a catastrophic event and, accordingly, may have an urgent need to feel safe. What is regarded as agitated behavior may reflect an individual's attempts at self-protection, though perhaps to an unwarranted threat. Assisting the individual in attaining the subjective goal of personal safety requires an understanding of what is needed for that person to experience a sense of security (perhaps contained in a crisis plan or personal safety plan previously formulated by the individual) and what interventions increase feelings of vulnerability (for instance, confinement in a room alone). Providing such assistance also requires that staff be afforded time to gain an understanding of the individual's needs and latitude to address these needs creatively.

6. Based on strengths. Sharing responsibility for crisis resolution means understanding that an individual, even while in crisis, can marshal personal strengths and assist in the resolution of the emergency. Individuals often understand the factors that precipitated a crisis as well as factors that can help ameliorate their impact. An appropriate crisis response seeks to identify and reinforce the resources on which an individual can draw, not only to recover from the crisis event, but to also help protect against further occurrences.

7. The whole person. For individuals who have a mental illness, the psychiatric label itself may shape—even dominate—decisions about which crisis interventions are offered and how they are made available. An individual with a serious mental illness who is in crisis is a whole person, whose established psychiatric disability may be relevant but may—or may not—be immediately paramount. That the individual may have multiple needs and an adequate understanding of the crisis means not being limited by services that are compartmentalized according to healthcare specialty. An individual's emergency may reflect the interplay of psychiatric issues with other

health factors. And while the individual is experiencing a crisis that tends to be addressed as a clinical phenomenon, there may also be a host of seemingly mundane, real world concerns that significantly affect an individual's response: the whereabouts of the person's children, the welfare of pets, whether the house is locked, absence from work, and so on.

8. The person as credible source. Assertions or complaints made by individuals who have been diagnosed with a serious mental illness tend to be viewed skeptically by others. Particularly within the charged context of mental health crises, there may be a presumption that statements made by these individuals are manifestations of delusional thinking. Consequently, there is a risk that legitimate complaints relating to such matters as medical illness, pain, abuse or victimization will go unheeded. Even when an individual's assertions are not well grounded in reality and represent obviously delusional thoughts, the "telling of one's story" may represent an important step toward crisis resolution. For these reasons, an appropriate response to an individual in mental health crisis is not dismissive of the person as a credible source of information—factual or emotional—that is important to understanding the person's strengths and needs.

9. Recovery, resilience and natural supports. Certain settings, such as hospital emergency departments, may see individuals only transiently, at a point when they are in acute crisis and in a decidedly high-stress environment. Even when not occurring within hospitals, mental health emergency interventions are often provided in settings that are alien to the individual and the natural supports that may be important parts of his or her daily life. It is important not to lose sight of the fact that an emergency episode may be a temporary relapse and not definitional of the person or that individual's broader life course. An appropriate crisis response contributes to the individual's larger journey toward recovery and resilience and incorporates these values. Accordingly, interventions should preserve dignity, foster a sense of hope, and promote engagement with formal systems and informal resources.

10. Prevention. Too often, individuals with serious mental illnesses have only temporary respite between crises. An appropriate crisis response works to ensure that crises will not be recurrent by evaluating and considering factors that contributed to the current episode and that will prevent future relapse. Hence, an adequate crisis response requires measures that address the person's unmet needs, both through individualized planning and by promoting systemic improvements.

The National Consensus Statement on Mental Health Recovery identifies recovery as an individual's journey of healing and transformation enabling a person with a mental health problem to live a meaningful life in a community of his or her choice while striving to achieve his or her full potential. It also cites 10 fundamental components for systems:

➡Self-Direction

➡Individualized and Person-Centered
➡Empowerment
➡Holistic
➡Non-Linear
➡Strengths-Based
➡Peer Support
➡Respect
➡Responsibility
➡Hope

Principles for Enacting the Essential Values

Several principles are key to ensuring that crisis intervention practices embody these essential values:

1. Access to supports and services is timely. Ready access to assistance is important not only because it holds the promise of reducing the intensity and duration of the individual's distress, but also because as a crisis escalates, options for interventions may narrow. Timely access presupposes 24-hour/7-days-a-week availability and a capacity for outreach when an individual is unable or unwilling to come to a traditional service site.

2. Services are provided in the least restrictive manner. Least restrictive emergency interventions not only avoid the use of coercion, but also preserve the individual's connectedness with his or her world. Individuals should not be unnecessarily isolated from their routine networks of formal and natural supports and should be encouraged to make contact with outside professionals, family and friends who can provide assistance through the crisis event and beyond.

3. Peer support is available. Services should afford opportunities for contact with others whose personal experiences with mental illness and past mental health crises allow them to convey a sense of hopefulness first hand. In addition, peers can offer opportunities for the individual to connect with a supportive circle of people who have shared experiences—an option that may have particular relevance given feelings of isolation and fear that may accompany a mental health crisis.

4. Adequate time is spent with the individual in crisis. In settings such as hospital emergency departments, there may be intense pressure to move patients through quickly. People who provide assistance must have an adequate understanding of the crisis situation, not only objectively, but also as it is being experienced by the individual who is in crisis. Unfortunately, individuals in acute crisis—particularly following involuntary transport to an evaluation setting—may not be in a position to discuss their presenting complaints clearly and concisely. Personnel in healthcare and similar settings must regard face-to-face time with the individual not as a distraction, but as a core element of quality crisis care. Settings that cannot accommodate the

individual in this way may not be appropriate venues for psychiatric crisis intervention; as is discussed elsewhere in these guidelines, such a determination should be regarded as a problem in care and drive performance improvement at both the organizational and systemic levels.

Staff behaviors that consumers feel Are most important to individuals in a mental health crisis:
• Having the staff listen to me, my story and my version of events
• Being asked about what treatment I want
• Trying to help me calm down before resorting to forced treatment
• Being asked about what treatments were helpful and not helpful to me in the past.

5. Plans are strengths-based. It may be fairly routine for professional staff to concentrate on clinical signs and other deficits to be addressed, particularly when an individual is in a crisis state and, therefore, "symptomatic." Yet appropriate crisis intervention gives at least equal attention to the individual's immediately available and potentially available assets. A strengths based plan helps to affirm the individual's role as an active partner in the resolution of the crisis by marshalling his or her capabilities. A strengths based approach also furthers the goals of building resilience and a capability for self managing future crises.

6. Emergency interventions consider the context of the individual's overall plan of services. Many individuals with serious mental illnesses go into mental health crises while receiving some sort of services and supports. Appropriate crisis services consider whether the crisis is, wholly or partly attributable to gaps or other problems in the individual's current plan of care and provide crisis measures in ways that are consistent with services the individual receives (or should receive) in the community. In addition, appropriate crisis services place value on earlier efforts by the individual and his or her service providers to be prepared for emergencies, for instance, by having executed psychiatric advance directives or other crisis plans. Incorporating such measures in a crisis response requires that interveners be knowledgeable about these approaches, their immediate and longer-term value, and how to implement them. Appropriate crisis interventions also include post-event reviews that may produce information that is helpful to the individual and his or her customary service providers in refining ongoing services and crisis plans.

7. Crisis services are provided by individuals with appropriate training and demonstrable competence to evaluate and effectively intervene with the problems being presented. Crisis intervention may be considered a high end service, that is high-risk and demanding a high level of skill. Within the course of a psychiatric emergency, various types of crisis interventions may occur—some by healthcare professionals, some by peers and some by personnel (such as police) who are outside of healthcare. Throughout, the individual experiencing a mental health crisis should be assured that all interveners have an appropriate level of training and competence.

What that means may vary considerably between scenarios. For instance, a significant number of instances of police involvement with individuals in mental health crises result in injuries or even death. Accordingly, some police departments have taken special measures to train officers in identifying and de-escalating mental health crises. Many have also established links with mental health professionals who can provide timely on-site assistance. These efforts have required police and health care professionals to connect across traditional bureaucratic boundaries.

8. Individuals in a self-defined crisis are not turned away. People who seek crisis services but do not meet the service criteria of an organization should receive meaningful guidance and assistance in accessing alternative resources. This is particularly applicable in organizations or programs that carry out a screening or gatekeeping function. For instance, it is not sufficient, upon determining that an individual fails to meet the criteria for hospitalization, to tell the individual or family members to make contact again if the situation worsens. Such practices tacitly encourage the escalation of crises. Individuals and their families should be assisted in accessing services and supports that resolve issues early on, and an organization providing screening or gate keeping services should be fluent with alternatives for when service thresholds are not met. When these alternatives are lacking, the organization should consider this a problem in care and take action accordingly. Likewise, an organization providing early intervention that routinely receives referrals from hospital gatekeepers might consider improving its outreach so that individuals seeking help are more likely to access their services directly, without placing demands on programs designed for late-stage emergencies.

An Alternative Approach “The Hospital Diversion Program at the Rose House is currently available to residents of Orange and Ulster counties [New York State]. This peer-operated house is designed to assist fellow peers in diverting from psychiatric distress, which may lead to a hospitalization. The program is located in a three-bedroom home set up and furnished for comfort. The house is equipped with a variety of traditional self help and proactive tools to maintain wellness. Trained peer companions are the key ingredients in helping others learn self help tools. Peer companions are compassionate, understanding and empowering. We exist to fill a gap in the mental health system that can break the cycle of going from home to crisis to hospital. The ROSE HOUSE offers a stay of up to five days to take control of your crisis or potential crisis and develop new skills to maintain your wellness. Peer companions staff the house 24 hours a day to address the needs of guests as they arise. Participation in the program is completely voluntary and free of charge. You are free to come and go as you please. We also will maintain contact and support for you, at your request, after you finish your stay. We have found that occasional calls and visits reinforce recovery and self determination.”

9. Interveners have a comprehensive understanding of the crisis. Meaningful crisis response requires a thorough understanding of the issues at play. Yet, for people

with serious mental illnesses, interventions are commonly based on a superficial set of facts: behaviors are seen to present a safety issue, the individual has reportedly failed to take medications as prescribed, or an encounter with the police has occurred. An appropriate understanding of the emergency situation not only includes an appreciation for what is happening at the moment, but also why it is happening and how an individual fares when he or she is not in crisis. Crises—particularly recurrent crises—likely signal a failure to address underlying issues appropriately. When crisis intervention occurs outside of the individual's customary setting, such as in a hospital emergency department or a psychiatric inpatient unit, it may be challenging to gain a good picture of the individual's circumstances.

10. Helping the individual to regain a sense of control is a priority. Regaining a sense of control over thoughts, feelings and events that seem to be spinning out of control may be paramount for an individual in mental health crisis. Staff interventions that occur without opportunities for the individual to understand what is happening and to make choices among options (including the choice to defer to staff) may reinforce feelings that control is being further wrested away. The individual's resistance to this may be inaccurately regarded as additional evidence of his or her incapacity to understand the crisis situation. Incorporating personal choice in a crisis response requires not only appropriate training, but also a setting with the flexibility to allow the exercise of options. Informed decision-making in this context is not a matter of simply apprising the individual of the empirically derived risks and benefits associated with various interventions; it also includes an understanding among staff that an ostensibly sub-optimal intervention that is of the individual's choosing may reinforce personal responsibility, capability and engagement and can ultimately produce better outcomes. The specific choices to be considered are not limited to the use of medications, but also include the individual's preferences for what other approaches are to be used where crisis assistance takes place, involving whom and with what specific goals. While the urgency of a situation may limit the options available, such limitations may also highlight how earlier interventions failed to expand opportunities to exercise personal control. Post-crisis recovery plans or advance directives developed by the individual with assistance from crisis experts are important vehicles for operationalizing this principle.

11. Services are congruent with the culture, gender, race, age, sexual orientation, health literacy and communication needs of the individual being served. Given the importance of understanding how an individual is experiencing a crisis and engaging that individual in the resolution process, being able to effectively connect with the individual is crucial. A host of variables reflecting the person's identity and means of communicating can impede meaningful engagement at a time when there may be some urgency. Establishing congruence requires more than linguistic proficiency or staff training in cultural sensitivity; it may require that to the extent feasible, an individual be afforded a choice among staff providing crisis services.

12. Rights are respected. An individual who is in crisis is also in a state of heightened vulnerability. It is imperative that those responding to the crisis be versed in the individual's rights, among them: the right to confidentiality, the right to legal counsel, the right to be free from unwarranted seclusion or restraint, the right to leave, the right for a minor to receive services without parental notification, the right to have one's advance directive considered, the right to speak with an ombudsman and the right to make informed decisions about medication. It is critical that appropriately trained advocates be available to provide needed assistance. Correctly or not, many individuals with serious mental illnesses have come to regard mental health crisis interventions as episodes where they have no voice and their rights are trampled or ignored. Meaningfully enacting values of shared responsibility and recovery requires that the individual have a clear understanding of his or her rights and access to the services of an advocate. It is also critical that crisis responders not convey the impression that an individual's exercise of rights is a hostile or defiant act.

13. Services are trauma-informed. Adults, children and older adults with serious mental or emotional problems often have histories of victimization, abuse and neglect, or significant traumatic experiences. Their past trauma may be in some ways similar to the mental health crisis being addressed. It is essential that crisis responses evaluate an individual's trauma history and the person's status with respect to recovery from those experiences. Similarly, it is critical to understand how the individual's response within the current crisis may reflect past traumatic reactions and what interventions may pose particular risks to that individual based on that history. Because of the nature of trauma, appropriately evaluating an individual requires far more sensitivity and expertise than simply asking a series of blunt, potentially embarrassing questions about abuse and checking off some boxes on a form. It requires establishing a safe atmosphere for the individual to discuss these issues and to explore their possible relationship to the crisis event.

"Confounding and complicating the prevalence of trauma in public mental health service recipients is the fact that mental health services themselves are often experienced as traumatic. The use of coercive interventions such as seclusion and restraint, forced involuntary medication practices, and philosophies of care based on control and containment vs. empowerment and choice often cause unintentional re-traumatization in already vulnerable populations." (National Association of State Mental Health Program Directors NASMHPD Position Statement on Services and Supports to Trauma Survivors).

The American Psychiatric Association (APA) played an important role in redefining trauma. Diagnostic criteria for traumatic stress disorders have been debated through several iterations of the Diagnostic and Statistical Manual of Mental Disorders (DSM) with a new category of Trauma- and Stressor-Related Disorders, across the life-span, included in the DSM-V (APA, 2013). Measures and inventories of trauma exposure, with both clinical and research applications, have proliferated since the 1970's. National trauma research and practice centers have conducted significant

work in the past few decades, further remaining the concept of trauma, and developing effective trauma assessments and treatments. With the advances in neuroscience, a bio-psychosocial approach to traumatic experiences has begun to delineate the mechanisms in which neurobiology, psychological processes, and social attachment interact and contribute to mental and substance use disorders across the lifespan.

8. Legal Considerations

Local Laws: Civil Protection and Restraining Orders

The most common and easily obtainable mechanism of relief for victims of domestic violence is the civil protection order. This general term includes any injunction or other order (such as a restraining order) that is issued for the purpose of preventing violent or threatening acts against another person. Generally, these orders prohibit harassment, contact, communication, or physical proximity. Protection orders may be temporary or final and may be issued by a civil or a criminal court. Protection orders can be issued independently or as part of another proceeding, such as a divorce or criminal complaint, but are separate from support or child custody orders.

Statutes and case law in all States and the District of Columbia allow an abused adult to petition the court for an order of protection, and in most State courts, a parent or another adult can file for a civil protection order on behalf of a minor child (Klein and Orloff). Depending on the relevant statutes and case law on the books of any given jurisdiction, conduct sufficient to support issuance of a civil protection order can include:

- Criminal acts (most commonly battery, but also criminal trespass, robbery, burglary, kidnapping, malicious mischief, and reckless endangerment)
- Sexual assault and marital rape
- Interference with personal liberty
- Interference with child custody
- Assaults involving motor vehicles
- Legal Issues
- Harassing behaviors
- Stalking
- Emotional abuse
- Damage to property
- Transferred intent (in which someone other than the petitioner is injured by violence directed toward the petitioner) (Klein and Orloff).

State courts have consistently upheld the constitutionality of IPV statutes. Civil protection order statutes have been held to rationally and reasonably uphold the State's interest in preventing domestic abuse, because these statutes do not:

- Deprive abusers of liberty and interest in their homes
- Deprive abusers of their families or reputations

- Inflict cruel and unusual punishment
- Violate equal protection, due process, freedom of association, or free space.

In addition, courts have found that procedural aspects of civil protection orders do not violate the defendant's right to a jury trial. Most jurisdictions allow an individual to petition for civil protection with or without the aid of a lawyer. In fact, some courts have upheld laws that permit court clerks to assist petitioners in filing for protection orders.

Although the assistance of legal counsel is preferable, *pro se* representation—or self-representation—is an option for victims who cannot afford the services of an attorney. Pro se actions allow domestic violence survivors to seek the immediate protection of the courts, and it can also empower them as they seek to gain control of their lives. Furthermore, many areas lack attorneys who are able and willing to act as advocates for battered women, although in some jurisdictions lay advocates are available to counsel victims of domestic violence, help prepare court papers, and handle uncomplicated cases in court.

Other Legal Issues

For many clients, treatment includes an effort to acknowledge—to themselves and perhaps to others—the harm they have visited on family and friends. A victim of IPV will explore the role substance abuse played in the abusive relationship. A perpetrator of IPV may have agreed to enter treatment in lieu of trial or incarceration; he will need to examine that aspect of his behavior as well as his substance abuse. Finally, a client who enters treatment presenting an entirely different constellation of issues may disclose during the course of counseling that he or she has either assaulted or been assaulted by an intimate partner. During the course of counseling victims—or perpetrators—of IPV, substance abuse program staff will hear about violent behavior. What is the program's legal obligation in such circumstances? How should programs deal with inquiries from lawyers or criminal justice officials? What should a program do when a clinician or client records are subpoenaed or the police come armed with a search warrant? This section discusses these issues and the tension between the need to protect people from harm and the need to respect the client's confidentiality.

Confidentiality is protected under 42 *Code of Federal Regulations* (C.F.R.), Part 2, implementing 42 U.S.C. §290dd-2. (All references to §2 . . . below refer to these regulations.) Although the Federal confidentiality regulations may prohibit reporting IPV to law enforcement authorities, treatment providers should still ask about it. Whether the information is passed along or not, it still bears on treatment. Providers should acknowledge the abuse; help the client separate her responsibility from that of the batterer; counsel her that the violence may escalate; help assess her safety and offer available options; clearly document the abuse (enlisting the aid of a forensic examiner, if necessary); provide referrals to shelter, legal services, and counseling; and facilitate such referrals with her consent. *Treatment providers must not let*

confidentiality restrictions prevent them from routinely inquiring about IPV in the course of providing appropriate care to clients.

Reporting Child Abuse and IPV

What should a program do when a client admits he has battered his spouse at some time in the past—or during his participation in treatment? Does the program have a duty to call law enforcement officials if a woman threatens to assault her husband or child—an act the clinician knows she has committed in the past? What can a program do if a client attacks his wife at the program? These are three very different questions that require separate analysis.

Is there a legal duty to report past crimes?

The general question about the duty to report past criminal activity is one that arises frequently for treatment and treatment programs. Many substance abusers engage in criminal behavior while they are abusing drugs and even during the course of treatment. In a situation in which a client has told a clinician that he or she has battered a spouse or child in the past, there are generally three questions the program needs to ask as it considers whether to make a report:

(1) Does State law require the program to make a report?
(2) Does State law permit the program to make a report?
(3) How can a report be made without violating the Federal law and regulations governing confidentiality of patients' records (42 U.S.C. §§290dd-2 and 42 C.F.R. Part 2)?

Reporting child abuse

All States (and the District of Columbia) require a broad range of care providers—including substance abuse treatment programs—to report when there is reasonable cause to believe or suspect child abuse or neglect. While many State statutes are similar, each has different rules about what kinds of conditions must be reported, who must report, and when and how reports must be made. In most States, failure to report may result in civil or criminal charges. All States extend immunity from prosecution to persons reporting child abuse and neglect; in other words, a person who reports abuse cannot be sued.

While all States require agencies to report child abuse, most alcohol and drug programs are limited by Federal law in the kind and amount of information they may disclose to anyone without a patient's written consent. (The regulations require that a particular form of written consent be used. Appendix B contains a full discussion of these regulations as well as a sample consent form.) However, the Federal confidentiality regulations do permit substance abuse treatment programs to comply with State mandatory child abuse reporting laws.

Note, however, that this is a narrow exception to the regulation's general rule prohibiting disclosure of any information about a client. It permits only initial reports

of child abuse or neglect. Programs may not respond to followup requests for information or subpoenas for additional information, even if the records are sought for use in civil or criminal proceedings resulting from the program's initial report, unless the client consents or the appropriate court issues an order under §2.64 or §2.65 of the regulations.

Reporting IPV against adults

Assault of another person, including a spouse, is a crime. Few States impose a duty to report a crime committed in the past, although some States do require physicians treating certain types of injuries incurred as the result of a violent criminal act (e.g., a shotgun wound) to make a report to the police. Even those States that still have laws that require reports of past criminal acts rarely prosecute violations of the law. Therefore, unless a particular State should mandate reporting of spousal abuse by health care providers and mental health counselors, it is unlikely that a substance abuse treatment counselor will have a legal obligation to report.

When is reporting permitted?

Does State law permit clinicians to report a crime involving IPV to law enforcement authorities? Whether or not there is a legal obligation imposed on citizens to report past crimes to the police, occasions may arise when clinicians feel a personal obligation to report an admission of IPV to law enforcement authorities. However, State law may protect conversations between clinicians and their clients (by making them privileged) or exempt clinician from any requirement to report past criminal activity by clients. Such laws are important to clients in substance abuse treatment, many of whom have committed offenses during their years of alcohol or drug abuse. Laws protecting conversations between clinicians and their clients are designed to protect that relationship, an important part of the treatment process. Survivor clients as well as batterers protected.

State laws vary widely in the protection they accord communications between patients and clinicians. In some States, admissions of past crimes may be considered privileged and clinicians may be prohibited from reporting them; in others, admissions may not be privileged. Moreover, each State defines the kinds of relationships protected differently. Whether a communication about past criminal activity is privileged (and therefore cannot be reported without the patient's consent) may depend on the type of professional the clinician/counselor is and whether he or she is licensed or certified by the State.

Any program that is especially concerned about this issue should ask a local attorney for an opinion letter about whether there is a duty to report and whether any counselor-patient privilege exempts counselors from that duty.

Is there a duty to report threats?

In working with batterers, treatment programs may face questions about their "duty to

warn" someone of a client's threat to harm his spouse or child. Even when a clinician has no legal obligation to report a client's threat, a treatment professional may feel an ethical, professional, or moral obligation to try to prevent a crime.
Over the past 20 years, States across the nation have adopted a principle—through legislation or court decision—requiring psychiatrists and other therapists to take "reasonable steps" to protect an intended victim when they learn that a patient presents a "serious danger of violence to another." This trend started with the case of *Tarasoff v. Regents of the University of California*, 17 Cal.3d 425 (1976), in which the California Supreme Court held a psychologist liable for money damages because he failed to warn a potential victim his patient threatened to, and then did, kill. The court ruled that if a psychologist knows that a patient poses a serious risk of violence to a particular person, the psychologist has a duty "to warn the intended victim or others likely to apprise the victim of the danger, to notify the police, or to take whatever other steps are reasonably necessary under the circumstances."

In most States, therapists and other care providers must warn a victim or the police when a patient makes a credible threat of violence to another identified person. (Of course, not every threat uttered by a patient should be taken seriously. It is only when a patient poses a serious threat of violence toward a particular person that the duty to warn arises.) Clinicians who fail to warn either the intended victim or the police may be liable for money damages or license revocation.

In a situation where a client threatens to assault a spouse, and the clinician believes he is serious, the clinician must ask him- or herself at least two—and sometimes three—questions:

1. Is there a legal duty to warn in this particular situation under State law?
2. Even if there is no State requirement that the program warn an intended victim or the police, do I feel a moral obligation to do so? The first question can only be answered by an attorney familiar with the law in the State in which the program operates. If the answer to the first question is "no," it is advisable to discuss the second question with a knowledgeable lawyer too.
3. If the answer to the two questions above is "yes," can the counselor warn the victim or someone likely to be able to take action without violating the Federal confidentiality regulations?

The problem is that there is an apparent conflict between the "duty to warn" imposed by the many States that have adopted the principles of the *Tarasoff* case and the Federal confidentiality requirements. Simply put, the Federal confidentiality law and regulations prohibit the type of disclosure that *Tarasoff* and similar cases require unless a substance abuse program can use one of the Federal regulations' narrow exceptions. These aside, the Federal regulations make it clear that Federal law overrides any State law that conflicts with the regulations (§2.20). In the only case, as of this writing, that addresses this conflict between Federal and State law (*Hasenie v. United States*, 541 F. Supp. 999 (D. Md. 1982)), the court ruled that the Federal

confidentiality law prohibited any report.

As in other areas where there are no clear-cut answers and the law is in flux, programs should find a lawyer familiar with State law who can provide advice on a case-by-case basis. Programs would also be well advised to establish a protocol ensuring that the clinical or program director has a chance to review the situation before a report is made. "Duty to warn" issues are an area in which staff training may be helpful.

Communicating With The Legal System

Clinicians working with victims—or perpetrators—of IPV may find that lawyers, law enforcement officials, and others view them as a good source of information. A call from a lawyer asking about a client, a visit from a law enforcement officer asking to see records, or the arrival of a subpoena to testify or produce treatment records—what should a program do in each of these circumstances? The answer is (1) consult the client, (2) use common sense, and (3) as a last resort, consult State law (or a lawyer familiar with State law).

Responding to Lawyers' Inquiries

Starting with the first scenario—a lawyer calls and asks about Jane White's treatment history or treatment. As a first approach to the question, Jane's clinician must tell the lawyer, "I don't know that I have a client with that name. I'd have to check my records." This is because the Federal confidentiality regulations prohibit any other response without the client's written consent. The regulations view any response indicating that Jane White is the clinician's client as an unauthorized disclosure that Jane White is in treatment. Even if the clinician has the client's written consent to speak with the lawyer, she may find it helpful to consult with the client before having a conversation about her: "I'm sure you understand that I am professionally obligated to speak with Jane White before I speak with you." It will be hard for any lawyer to disagree with this statement.

The clinician should then speak with the client to ask whether the client knows what information the caller is seeking and whether the client wants her to disclose that or any other information. She should leave the conversation with a clear understanding of the client's instructions—whether she should disclose the information, and if so, how much and what kind. It may be that the lawyer is representing the client and the client wants the counselor to share all the information she has. On the other hand, the lawyer may represent the client's spouse or some other party with whom the client is not anxious to share information. There is nothing wrong with refusing to answer a lawyer's questions, but a polite tone is best. If confronted by what could be characterized as "stonewalling," a lawyer may be tempted to subpoena the requested information and more. The clinician will not want to provoke the lawyer into taking action that will harm the client.

If the lawyer represents the client and the client asks the clinician to share all information, the clinician can speak freely with the lawyer once the client signs a proper consent form. However, if the clinician is answering the questions of a lawyer who does not represent the client (but the client has consented in writing to the disclosure of some information), the clinician should listen carefully to each question, choose her words with care, limit each answer to the question asked, and take care not to volunteer information not called for.

Responding to Subpoenas

Subpoenas come in two varieties. One is an order requiring a person to testify either at a deposition out of court or at a trial. The other— known as a subpoena *duces tecum*—requires a person to appear with the records listed in the subpoena. Depending upon the State, a subpoena can be signed by a lawyer or a judge. Unfortunately, it can neither be ignored nor automatically obeyed. In this instance, the clinician's first step should be to call Jane White—the client about whom she is asked to testify or whose records are sought—and ask what the subpoena is about. It may be that the subpoena has been issued by or on behalf of Jane's lawyer with Jane's consent. However, it is equally possible that the subpoena has been issued by or on behalf of the spouse's lawyer (or the lawyer for another adverse party). If that is the case, the clinician's best option is to consult with Jane's lawyer (after getting Jane's written consent) to find out whether the lawyer will object—ask the court to "quash" the subpoena—or whether the clinician should simply get the client's written consent to testify or turn over her records. An objection can be based on a number of grounds and can be raised by any party, including the person whose medical information is sought. Often, the counselor may assert the client's privilege for the client.

Orders of Protection

The most common and easily obtainable mechanism of relief for victims of IPV is the civil protection order. This general term includes any injunction or other order (such as a restraining order) that is issued for the purpose of preventing violent or threatening acts against another person. Generally, these orders prohibit harassment, contact, communication, or physical proximity. Protection orders may be temporary or final and may be issued by a civil or a criminal court. Protection orders can be issued independently or as part of another proceeding, such as a divorce or criminal complaint, but are separate from support or child custody orders.

Statutes and case law in all States and the District of Columbia allow an abused adult to petition the court for an order of protection, and in most State courts, a parent or another adult can file for a civil protection order on behalf of a minor child. Depending on the relevant statutes and case law on the books of any given jurisdiction, conduct sufficient to support issuance of a civil protection order can include.

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About the Course Presenter:

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