Chapter 24

Mental Health Treatment for Survivors of Intimate Partner Violence

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KEY CONCEPTS

- Physical and emotional safety are primary concerns for survivors of intimate partner violence (IPV).
- Becoming knowledgeable about the dynamics of IPV and the strategies batterers use to control their partners is essential for working with survivors of IPV.
- Survivors face many obstacles in trying to leave an abusive relationship and/or to maintain their safety, credibility, and connections with others in the face of ongoing abuse.
- A combined IPV–trauma framework is potentially most helpful for understanding mental health symptoms in the context of ongoing trauma, entrapment, and danger.
- Respecting survivor self-determination and choice are key elements of both DV advocacy and trauma-informed treatment.
- Issues of culture, context, community, and spirituality play important roles in survivors' lives and need to be taken into account. Services should be culturally sensitive and relevant, as well as fully accessible.
- Maintaining confidentiality within the confines of the law and attending to DV-appropriate documentation are critical to survivors' safety.
- Intimate partner violence is not a psychiatric condition. No single treatment modality will meet the needs of all survivors.
- Limited research exists on mental health treatment in the context of ongoing IPV. Current best practice approaches involve combining core principles of IPV advocacy work with evidence-informed (and in some cases, evidence-based) trauma treatment. Research is needed to assess the types of interventions and treatment modalities that will be most helpful to survivors of IPV.

- Recognizing the need to play an advocacy as well as a clinical role may be a new concept for clinicians, but supporting individual survivors and influencing policy and practice is integral to improving mental health care and preventing future violence.

Because intimate partner violence (IPV) victimization is not, itself, a psychiatric condition, mental health treatment for survivors of IPV involves a combination of IPV-specific interventions related to safety, confidentiality, and access to resources, as well as treatment for the range of symptoms that can arise in the context of ongoing abuse. Although important strides have been made in addressing the general healthcare response to IPV, little research has specifically addressed treatment outcomes for the mental health sequelae of IPV. Over the past 30 years, recommendations for responding to IPV have evolved into consensus models of care that can be integrated into appropriate evidence-based and/or emerging multidimensional treatment approaches. This chapter reviews currently available intervention and treatment research, discusses the strengths and limitations of existing evidence-based models for addressing the range of issues faced by IPV survivors, and describes current consensus recommendations for IPV-specific interventions and trauma treatment.

This is review has several limitations. First, no evidence-based treatments exist for addressing mental health issues in the context of ongoing IPV, although a small number of intervention studies targeting safety and/or providing post-shelter advocacy have demonstrated efficacy in reducing mental health symptoms (1–3). Second, only two studies exist on posttraumatic stress disorder (PTSD) treatment for survivors of IPV—one pilot study of women in shelters and one randomized controlled trial of cognitive behavioral therapy (CBT) for women who were no longer in an abusive relationship (4,5). Third, few controlled studies exist of complex trauma treatment in general, and none specifically designed for survivors of IPV, although a number of trauma treatment trials have included women who had experienced physical abuse as adults in addition to other lifetime trauma (6–10). Given that IPV survivors have a wide variety of life experiences with a range of mental health effects, no single treatment model will fit the needs of all survivors.

PREPARING TO ADDRESS INTIMATE PARTNER VIOLENCE: ISSUES TO CONSIDER

Although evidence-based interventions for IPV are still needed, "best practice" models have emerged to address the particular concerns of individuals dealing with ongoing violence and abuse (11–13). Key elements include integrating questions about IPV and other lifetime trauma into mental health assessments, discussing the impact of the abuse along with survivors' strengths and goals, addressing immediate and long-term safety needs, providing information about trauma and IPV, and discussing options, priorities, and choices. Documenting in ways that do not place survivors in further jeopardy, incorporating IPV- and trauma-specific issues into clinical treatment, and helping link survivors to community resources are also important components of a IPV-specific response.

A number of issues must be kept in mind when working with a person who is being abused by her (or his) partner; these that have been identified through the collective experience of survivors, clinicians, and advocates over the past 30 years. They can be attended to in conjunction with a range of treatment modalities to provide a consensus-based framework for addressing the potential, but avoidable, dangers that IPV survivors may face in seeking mental health care (13–18).

Attending to Physical and Emotional Safety

Recommendations for creating safe and welcoming practice environments reflect the convergence of experience from a number of different fields, including IPV literature, with its emphasis on physical safety and confidentiality (19); trauma literature, with its attention to emotional safety and the creation of trauma-informed services (16); cultural competency literature that focuses on creating culturally welcoming environments and culturally relevant services (20); disability literature that stresses the importance of universal accessibility and inclusive design (21); and the mental health peer support recovery movement that highlights self-determination, noncoercive practices, and choice (22).

Specific elements of welcoming practice environments include displaying visual materials that reflect the range of cultures and communities being served, providing written information about trauma and IPV in multiple languages as well as large print and

Braille, hiring multilingual and multicultural staff and American Sign Language (ASL) interpreters, employing assistive technology, and working in collaboration with community-based groups to ensure that services reflect the needs of their communities. Establishing practice environments and policies that support clinicians' efforts to address complex issues, provide adequate supervision and peer support, and that reimburse more time-intensive treatment modalities, advocacy, and collaboration are also key to institutionalizing culturally effective responses to trauma and IPV (23).

For all survivors of abuse, the issue of safety is paramount. This means considering a survivor's physical and emotional safety while in the clinical setting, as well as helping to assess options for safety when leaving. Although the traditional focus of mental health interventions has been on safety from self-harm, ongoing danger from a current or former partner and prevention of revictimization are also critical safety issues. Abusers are typically skilled at manipulating both their partners and the systems to which their partners turn for help, so all possible interventions should be considered through the lens of safety, looking for practices that can potentially put survivors at risk.

Women consistently report that the quality of the clinical interaction is an important factor in their response to questions about abuse (24,25). For a person living with ongoing threats and intimidation, the experience of being treated with respect and feeling free to make choices without fear of judgment or retaliation can be therapeutic in itself and is often central to the healing process (26,27). Clinical interactions can provide an opportunity for survivors to experience other people as trustworthy and safe, to counter abuse-related dynamics they may have internalized, and to regain a sense of connection to themselves and others. For some survivors of IPV, any manifestation of themselves as an autonomous human being is met with further abuse and retaliation, forcing them to psychologically disappear from view. Creating an atmosphere of acceptance and validation can help to counter the batterer's ability to control and undermine a woman's perceptions of herself and can provide a safe place for her to reemerge. It can diminish shame and reduce the likelihood of retraumatization in the therapeutic encounter and provides a vehicle through which survivors can access information, resources, and support, and then build on existing strengths and develop new skills. For some survivors, particularly those whose trust has continually been betrayed, reestablishing trust may be part of a much longer therapeutic process.

The power imbalances inherent to clinical interactions also require conscious attention. Survivors of abuse are particularly vulnerable to reinjury and often are very attuned to relational dynamics. This is of particular concern for clinicians who have been trained in more directive treatment modalities or work in settings that require adherence to a specific treatment plan. Being able to tolerate feelings of fear and uncertainty that may arise when a person is in danger and chooses not to leave an abusive relationship can be particularly challenging. It is incumbent on clinicians to be aware of their own responses and manage them in ways that are not distancing or judgmental to the person seeking care.

Numerous studies have demonstrated that the manner in which clinicians ask about abuse and the nature of their responses to a disclosure impact women's level of comfort in discussing these issues (28–31). In addition, the clinical and research literature on trauma-informed services corroborates the importance of creating emotionally safe practice environments, particularly for survivors of abuse (9,10,16,32–34). Clinicians can facilitate this process by attending to the environment itself for potential ways a survivor could be retraumatized. For example, it is critical to establish privacy before inquiring about current IPV and to assure patients that what they say will remain confidential within the limits of the law. However, for a person who has experienced abuse, particularly if they were abused by someone in a caregiving role, being alone in a room with another person behind a closed door may evoke earlier experiences that were unsafe. Telling a patient "what goes on between us will not leave the room," may be frightening, rather than reassuring to someone who was sexually abused as a child (16). For others, routine history taking may feel too much like interrogation. Discussing these issues at the outset can help to mitigate some of these concerns.

Another set of issues germane to emotional safety is communicating in ways that help to destigmatize mental health symptoms, normalize responses to abuse, and offer information, choices, and hope. Survivors frequently report that one of the things they find most helpful in talking with advocates is learning that they aren't "crazy." There are a number of ways

one can communicate respect and understanding, by how questions are asked and framed and by conveying the following information:

- Abuse experiences are common.
- You are willing to listen.
- You believe her and are concerned.
- The abuse is not his fault; no one deserves to be treated that way.
- Resources are available to help them if they are currently in danger.
- They will not be judged or stigmatized as a result of what they have said to you.
- All information will be confidential within the confines of subpoenas and mandatory reporting laws (inform patients about the limitations of confidentiality in your state) (11,35).

Understanding the Dynamics of Abuse and Perpetrator Accountability

Understanding the dynamics of IPV and recognizing that abusive behavior is the responsibility of the perpetrator, not the victim, is another area in which mental health treatment models have had to be reexamined, particularly psychodynamic and family systems approaches. Actively counter the notion that the abuse is or was the fault of the person being victimized and make clear that, regardless of any seeming provocation, the perpetrator is ultimately responsible for his (or her) abusive behavior and also responsible for stopping it (15). Until the 1980s, the psychiatric literature generally viewed domestic violence (DV) as resulting, at least in part, from women's pathology (e.g., masochism), or from problematic dynamics within the relationship (36,37). This is no longer considered a legitimate understanding.

Although experiencing or witnessing abuse in childhood may place women at greater risk for being abused as adults, the major risk factor for partner abuse is living in a society that tolerates gender-based violence. Growing up in a situation in which protecting oneself was not an option or never having learned that a woman has rights in a relationship does not make a person responsible for another's criminal behavior. The use of abuse and violence is a choice of the perpetrator to maintain coercive control over an intimate partner. Although taking responsibility for *one's own behavior* is one of the hallmarks of a mental health recovery, if a woman is continually being told that she is responsible for *her partner's behavior*, hearing this in treatment is not only confusing but can be undermining and dangerous as well (e.g., helping survivors to understand why they unconsciously "chose" an abusive partner or labeling survivors as "codependent" or "enabling"). Working with a survivor to understand the psychological roots of her current feelings, symptoms, and situations, or working with patients on changing cognitions and behaviors that they feel are getting in their way, can be helpful in the right context. In the context of ongoing IPV, this is often problematic, particularly when a survivor's options for changing her situation are limited or the risks she faces are too great. The influence of earlier abusive relationships on survivors' ability to find safe, mutually respectful relationships as adults is best addressed in later phases of treatment when survivors are no longer worried about their immediate safety, being bullied by a partner, negotiating the legal system, or blaming themselves for experiences that were beyond their control.

Freeing oneself from the tyranny of the past *is* empowering. Timing and sensitivity are critical. That is why certified batterer intervention programs, accompanied by criminal sanctions rather than individual or couples therapy, are the preferred mode of intervention for abusers, where the need for ongoing accountability and attention to victim safety are always in the forefront (38).

Utilizing an Intimate Partner Violence-informed Trauma Framework

There is a growing consensus that mental health treatment is best delivered within a framework that incorporates an understanding of the pervasive experience of trauma among people seeking mental health services. This includes the ways in which a history of trauma can affect survivors' symptoms and presentations, their experience of clinical relationships, and their responses to treatment (16,39). Trauma theory offers a perspective that acknowledges strengths, views individuals as survivors rather than victims, and recognizes symptoms as adaptive responses to intolerable experiences when real protection is unavailable and coping mechanisms are overwhelmed or never had a chance to develop (27,40). Although efforts to infuse a trauma perspective into mental health services have mainly focused on the long-term effects of childhood abuse, a trauma framework is also useful for understanding the mental health effects of IPV. The recognition that external events can have

a psycho-physiological impact has helped alleviate survivor concerns about a diagnostic system that did not take into account the context in which symptoms developed. When viewed through a trauma lens, symptoms are understood, at least in part, as responses to repetitive trauma that affects a person's expectations about human relationships and causes both physical and psychological harm.

Ongoing abuse and violence can also induce feelings of shock, disbelief, confusion, terror, isolation, and despair, and can undermine a person's sense of self. This, in turn, can manifest as psychiatric symptoms and disorders. For those who have also experienced abuse in childhood, the ability to manage painful internal states (affect regulation) may be disrupted, leaving survivors with coping mechanisms (e.g., self-cutting, suicide attempts, risky behavior, substance use) that incur further harm. Trusting others, particularly those in caretaking roles, may be especially difficult.

However, for a person who is still at risk, symptoms may also reflect a realistic response to ongoing danger and entrapment. For example, from a trauma perspective, an "overreaction" to minor stimuli is seen as symptomatic of a trauma-related psychiatric disorder (e.g., PTSD) rather than an appropriate response to ongoing threats, danger, and terrorization. What may be interpreted as "triggering" through a trauma lens, might, from an advocacy perspective, reflect a response to ongoing victimization. When dealing with ongoing abuse, operating from a framework that addresses both internal and external threats is essential. Although wariness, lack of trust, or seemingly paranoid reactions may be a manifestation of previous abuse and/or a response to the trauma of current victimization, heightened sensitivity may also be a necessity for survival.

Other, seemingly passive behaviors may represent survival strategies as well. For example, over the course of an abusive relationship, survivors often exhibit considerable strength and ingenuity, attempting to remedy their situations through talking, seeking help, fighting back, and trying to change the conditions that they either perceive or are told cause the abuse. When those attempts fail, however, they may retreat into a mode that appears more passive and "compliant" but which actually reflects strategies designed to reduce their immediate danger by meeting the coercive demands of an abusive partner (41). A primary example of this is the decision to stay in an abusive relationship: although some mental health models conceptualized this as passive dependent behavior, leaving an abusive partner can involve great risk to the victim. In fact, the majority of IPV homicides occur after the victim has left the relationship (42). Choosing to remain in an abusive relationship is often based on a strategic analysis of safety and risk.

Responses such as dissociation, avoidance, and/or use of drugs or alcohol may protect against feelings that have become unbearable, particularly if survivors' options are limited. Although these responses may make it possible to survive intolerable conditions, they can also restrict a person's capacity to reach out for help. Societal constraints, such as the ongoing trauma of social discrimination, lack of basic resources, and revictimizing experiences within the systems a survivor turns to and/or the legacies of historical or cultural trauma, are other factors that affect a survivor's ability to heal from the abuse and mobilize the resources necessary to create safety and stability in her life. Utilizing a IPV-informed trauma framework to address coping strategies such as substance abuse or seeming passivity in the face of ongoing threats not only provides perspective for survivors on behaviors they may experience as shameful, but also reduces the likelihood of responding in ways that are unintentionally judgmental or pathologizing.

In addition, trauma theory affords a more balanced approach to treatment—one that focuses on resiliency and strengths as well as psychological harm. Trauma-focused interventions help survivors to recognize their own abilities, develop new skills, and enhance their capacities to manage previously overwhelming feelings. A trauma framework regards collaborative therapeutic relationships as central to the process of healing, requiring that providers be attuned to the impact of their own responses on the person seeking help. Utilizing a trauma framework enhances the prospect for therapeutic success by fostering an awareness of the impact of this work on providers. Self-awareness, consultation, and peer support are hallmarks of this approach.

Attending to Issues of Culture, Community, and Spirituality

Intimate partner violence affects people across cultures, communities, races, sexual orientations, gender identities, religions, spiritual and political beliefs, ages, abilities, socioeconomic status, educational

backgrounds, and occupations (43). There is general consensus among the mental health, trauma, and IPV fields that to be effective, interventions need to be sensitive to the range of experiences and values survivors bring to treatment (39,44). Clearly, many factors affect personal choices and realistic options, including how individuals view mental health and mental illness, the types of stressors they encounter, the decisions they make in seeking help, the symptoms and concerns presented to clinicians, and their coping styles and sources of social support (45). Recognizing these concerns and addressing them directly can help reduce some of the barriers survivors face in obtaining help. There may also be specific sources of support survivors can access through their membership in particular communities. Understanding how particular cultures and communities uniquely affect each survivor entails talking with them about how their experience of culture, as they define it, affects their perceptions of abuse, access to services, response to interventions, perspective on staying with an abusive partner, and the constraints they may face in leaving. For male victims, these issues may be more complicated.

Attending to Privacy and Confidentiality

Although assessment is often looked upon as the first phase of treatment, it is also an ongoing component of the treatment process. Even when IPV is present, survivors may have compelling reasons for not disclosing the abuse. A woman could lose custody of her children if she is identified as having mental health problems—or if it is discovered that she lives in a violent household. Her partner may have threatened to kill her or her children if she reports the abuse or tries to leave. A woman may also experience intense guilt and shame, particularly about sexual assault and abuse. This can make it difficult for her to raise or discuss these issues until she feels safe in a therapeutic relationship or more secure in her own life. Thus, it is important that providers continue to be mindful of IPV as a possibility and inquire about it periodically even when abuse is not initially reported.

Because disclosure of abuse carries the risk of retaliatory violence, asking about IPV requires that every measure be taken to maintain privacy and confidentiality. Consensus guidelines are clear with regard to not asking about abuse in the presence of a possible perpetrator, or in the presence of another person whom a patient has not privately identified as someone she or he can trust, with that information, including an untrained translator, a personal assistant, guardian, a friend, or a child. In addition, these questions should not be asked during a couple's therapy session, or in the presence of a person who is providing collateral information—even if a patient is unable to respond herself at the time. It is common practice when a person is being evaluated for a psychiatric emergency to try to obtain additional information from the accompanying party or a family member, who may, turn out to be abusing them. It is better to ask patients whom they would prefer information be obtained from and whom they trust the clinician to talk with about their situation. Questions about abuse also should not be included in forms that are sent to a patient's home. Online questions about abuse are also potentially unsafe, as abusers can track their partners Internet activity. Patients should be told that the information they give is confidential and, within the confines of the law, will not be revealed to their partner or anyone else without their permission. For those clinicians who practice in states with mandatory reporting laws for DV, it is essential to inform clients of this requirement in the beginning of the evaluation, preferably before they have discussed the abuse, so that they can determine whether it will be safe to disclose. It is also important to discuss reporting obligations before inquiring about child abuse (46).

In addition, because batterers are often resistant to being separated from their partners, strategies for safely separating clients from abusers should be developed in advance, so that inquiry can take place. If there does appear to be an immediate threat from a client's abusive partner, clinicians should be prepared to notify the police or security, outlining any potential risk. If a patient calls on the phone, it is prudent to establish whether or not it is safe for them to discuss these issues before inquiring about abuse. Once initial safety is established, however, a patient's wish to have another person present should be respected.

Incorporating an Advocacy Approach and Emphasizing Survivors' Goals and Concerns

Incorporating an advocacy stance adds an important dimension to traditional clinical interactions—one that is consistent with recovery approaches (47). For example, advocacy involves facilitating rather than

directing change by actively helping survivors to become aware of their options, gain access to community resources, make their own choices about how to best reduce their exposure to ongoing violence, and mitigate the impact of abuse on their lives. Awareness of both the internal and external barriers survivors face in ending abuse and recovering from its traumatic effects is necessary to advocate with other systems. Clinicians can also play a critical role in preventing future violence by participating in professional, community, and public policy activities that address these issues.

To clarify priorities, plan treatment, and determine advocacy needs, it is also important to understand survivors' immediate concerns and long-term goals, how they envision achieving those goals, and the assistance and resources they feel would be helpful. Some authors have found it useful to apply the transtheoretical "stages of change" model (e.g., precontemplation, contemplation, preparation, action, maintenance), developed by Prochaska and DiClimente for treating addictions, to the process of leaving an abusive relationship (48–50). The original model was based on the assumption that changing—that is, stopping—the harmful behavior is the desired goal and that the barriers to doing so reside within the patient. In situations of ongoing IPV, this is often not the case (e.g., a survivor may not want to leave or options for doing so may be limited or possible only at great cost).

A number of concepts derived from this model can be useful to consider in this context (e.g., decisional balance, process of change). The goal of the transtheoretical model was to examine how change takes place and what helps patients in that process. The danger of applying this model directly to work with IPV survivors is that they do not control the dangerous behavior, nor is it their responsibility to change it. The recognition that relapse is often an integral part of the process of change is also both useful and problematic. Domestic violence survivors frequently leave abusive relationship multiple times before gathering the internal and external resources to support a permanent separation. Understanding this process helps reduce frustration and blame. However, framing these decisions as "relapses" implies that the problem is located in the woman's ability to change, rather than in circumstances that may in fact be out of her control. More recent adaptations of this concept, however, have been used to foster recognition that deciding to leave can be a longer process, that "precontemplation" may actually be a survival mechanism, and that moving from "contemplation" to "action" involves many factors that are not always under a survivor's control (51).

For a person faced with multiple, complex survival issues, the abuse they are currently experiencing may not be their most immediate concern. Being able to understand how a woman feels about her relationship and to discuss this openly and nonjudgmentally will ideally make it safer for her to reassess her situation over the course of treatment. Although the choice of whether or not to leave an abusive partner may seem like a clear-cut decision, it is often a lengthy process filled with enormous barriers—one that involves continually weighing a complex set of risks and concerns that a survivor may have little ability to change. Thus, decision-making is not just a question of whether she wants to stay in the relationship, but a complex process of careful risk assessment. Issues such as negotiating safety and retaining custody of children are constantly in the balance. Davies, Lyon, and Monti-Catania developed a conceptual framework for addressing these issues that allows practitioners to help a survivor sort through the complex and potentially competing demands she faces (19).

ROUTINE INQUIRY AND ASSESSMENT

Because presentations of IPV vary widely, inquiring only when abuse is suspected will miss significant numbers of individuals who are at risk. Although some controversy persists over routine screening for IPV in healthcare settings, consensus documents in the United States continue to recommend routine inquiry of all women patients and, although less studied, men who may be at risk—men with disabilities, older men, and men in gay relationships (11,14,18,52–56). It is important to note that many survivors are still in danger at the time they seek help, and if they decide to leave, the danger may increase significantly. Some are at increased risk because they have left or their partner is aware of their intention to leave. Assessing ongoing safety and risk for harm is an essential component of working with IPV survivors and should be incorporated into both the initial and ongoing assessment process. An in-depth review of research on danger assessment is addressed elsewhere in this text, and can also be found in the well-regarded volume on safety planning by Davies, Lyon, and Monti-Catania (19).

Mental Health Crisis Calls or Phone Intakes

Although routine inquiry about IPV in healthcare settings is addressed elsewhere in this volume, a number of specific issues arise in mental health settings. How initial inquiry and assessment take place will vary by setting, but attention to immediate safety is always a priority. Integrating IPV inquiry into emergency mental health assessments may necessitate the revision of standard intake procedures. For example, typical mental health crisis assessment involves determining whether a patient is *a danger to* herself or others. Crisis evaluation should also assess whether or not a person is *in danger from* others. If a person does state they are in imminent danger from another person, addressing immediate safety needs take precedence. Asking questions that can be answered with a "yes" or "no" may be safer under these circumstances

Integrating Questions About Intimate Partner Violence into Mental Health Assessments

Introducing the subject of abuse may feel awkward, particularly if there are no obvious indications a patient has been victimized. There are many ways to frame abuse-related questions that let patients know that this is a common experience and that you are interested in knowing (e.g.,"I don't know if this has happened to you, but because so many women experience abuse and violence in their lives, it's something I always ask about," or "Tell me about your relationship."). It is, however, important to ask explicit questions about specific abusive experiences. Simply asking a woman "Have you ever been abused?" places her in the doubly difficult position of having to evaluate her assailant's behavior, as well as report it. For an example of an IPV assessment tool, see the *National Consensus Guidelines on Identifying and Responding to Domestic Violence Victimization in Health Care Settings* (11).

Because abusers frequently use mental health issues to control and undermine their partners, these issues need to be addressed specifically. Clients who are currently experiencing IPV should be asked the following:

- Has your partner ever used mental health issues against you? Does your partner try to control your medication or your treatment? Does he blame you for his abusive behavior by telling you you're "crazy"? Does he tell you that no one will believe you? That you'll lose your children if you try to leave? Has he used your mental health condition as a way to undermine you with other people? Does he tell people that your claims of abuse are delusional, or that you aren't to be trusted? Has he ever forced you to take an overdose or kept you from routines that are healthy for you (eating, sleeping, resting, seeing other people, exercising)? Has he ever lied about your condition to have you involuntarily committed? Has he strangled or otherwise assaulted you and then claimed that you were out of control and needed to be restrained? Has he engaged in behaviors that were designed to play on your particular vulnerabilities or undermine your sense of reality (e.g., lies, distortion, doing and saying things and then denying them, taunting, abandoning, trying to turn the children against you, threatening to take or harm your children, or telling you that you should kill yourself)?
- Does your partner try to prevent you from stopping drinking or using drugs? Does he try to keep you from attending treatment or going to meetings?

As well as eliciting a history of physical assaults and sexual violation, obtain a more detailed history of the forms of psychological abuse and the level of control the abuser has over a survivor's life, including social isolation, stalking and harassment, economic abuse, destruction of property, use of children, and abuse of animals or pets. It is also helpful to ask survivors about the *pattern* of abuse they've been subjected to, such as when it started; its duration, frequency, severity, pace of escalation; and its relation to events such as pregnancy, separations, unemployment, or substance abuse. Working collaboratively to identify patterns related to the use of and degree of control, isolation, and fear, as well as identifiable signs of impending violence and other criminal behaviors, can be particularly useful. Discussing these patterns can help to clarify the ongoing nature of the abuse both for the clinician and survivor, and reduce some of the denial, avoidance, or dissociation a woman may have needed to survive.

Keep in mind that women seeking help who are currently being abused by an intimate partner may have already been asked to provide detailed accounts of their experience to emergency room personnel

and to the police. It is important to assess the nature of the trauma that may have precipitated treatment; however, acquiring more detailed information should be paced to the survivor's needs. Asking about a patient's experience of IPV can serve a number of important functions beyond informing treatment. It allows clinicians to document critical information for women seeking legal protection, redress, or custody and provides a safe opportunity to examine the ongoing nature of the abuse and its impact. In addition, asking a woman what she has done to try to remedy her situation and how others have responded to her efforts creates a chance to explore new options and to acknowledge the resourcefulness she has exhibited in coping with her situation.

The same caveats apply to asking about previous trauma. Traumatic childhood experiences may also play a significant role in patients' current mental health symptoms, increasing their risk for revictimization and affecting how they experience current abuse. Over time, understanding and demystifying the long-term effects of prior abuse can be both freeing and empowering. In general, inquiry about childhood abuse and other lifetime trauma should be part of a comprehensive mental health assessment, preferably in the context of an ongoing clinical relationship in which trust has been established. During the initial assessment process, asking a general question about the relationship of previous trauma to current symptomatology can be helpful. For example, "Are there other painful or frightening experiences you've had recently or in the past that you think may be related to what you are feeling now?"

Previous Trauma History

The timing of questions about abuse experiences should be geared toward an individual's ability to respond without being flooded or overwhelmed, particularly if currently experiencing a crisis. Although the symptoms or issues that emerge during an assessment may seem to point to a history of trauma, an individual survivor may not see it that way. Although some women may seek treatment for symptoms or issues explicitly related to a particular traumatic experience, not everyone will link their current distress to such events. Many will not recall earlier traumas until later in the course of treatment, and survivors may avoid thinking and talking about trauma-related topics because the feelings associated with the trauma can be overwhelming (57).

General consensus from the trauma field suggests that it is incumbent upon clinicians to keep an open mind about the potential presence of trauma in a patient's history, to attend to abuse-related information as it arises, and to validate those perceptions without "digging" for memories or assuming that because a woman has a particular constellation of symptoms she has been sexually abused as a child. Similar to inquiry about current IPV, questions about previous trauma should be designed not to uncover, but to let patients know that these experiences are common, and that they can discuss them, if and when they feel comfortable doing so. Inquiry should take place at a time when there is room for patients to talk about how they were affected by those experiences, whether or not they are experiencing symptoms currently, and what would be most helpful to them now.

Because conducting a trauma history can in itself be traumatizing, informing patients of what will be asked and why, checking to see if they are comfortable with proceeding, attending to signs (such as increased anxiety or dissociation) that prior traumatic experiences are being triggered, and ensuring that they have someone to talk with should the need arise after they leave, are critical (58,59). A number of tools are available for obtaining a trauma history that have primarily been used for research purposes (60–64). In clinical practice, this type of information is often better elicited by asking more general questions accompanied by gentle probing when indicated. Questions embedded in self-administered general health questionnaires have also been found acceptable (65). Often this information emerges gradually during the narrative retelling of an individual's life history. The aim is to let patients know that many people have experienced trauma in their lives, that these experiences may have some bearing on their health and well-being, and that the clinician is interested in knowing about the things in their life that have affected them (Table 24.1).

ASSESSING SAFETY

Immediate Safety and Risk of Future Harm

For any patient who is at risk, safety issues should be addressed during the initial interview, and access to a

Table 24.1 Previous Trauma History: Questions to Consider

- Has this person experienced abuse prior to her/his current relationship?
- Was she/he physically, sexually, or emotionally abused, bullied, or neglected as a child? Was she ever removed from her home?
- Was she/he sexually assaulted or harassed as an adult?
  - Have you had other experiences that left you feeling frightened and alone? For example, have you ever been physically or sexually assaulted by someone other than your partner? With who? When? What happened?
  - How did that affect you, and how are you now?
  - Have you ever been pressured to engage in sexual activities that made you uncomfortable or been forced to have sex against your will, such as unwanted kissing, hugging, touching, nudity, exposure, attempted intercourse, trading sex for drugs?)
- Has she/he experienced other types of trauma in the past?
  - Have you had other painful or frightening experiences, such as:
  - Living through a disaster?
  - Being the victim of a crime?
  - Having someone close to you die or seeing someone being abused, injured, or killed?
  - Having had a family member who used drugs or alcohol, who committed or attempted suicide, or who was incarcerated?
  - Having been homeless, incarcerated, or institutionalized?
  - Having had your children taken from you?
  - Been harassed or discriminated against in any way? Been a combat veteran, lived through war as a civilian, or experienced acts of political torture, terrorism, or other violations of your human rights?
  - Experienced discrimination or harassment? Experienced seclusion and/or physical or chemical restraint in a hospital, institution, or other setting?
- If a person is here as an immigrant or refugee, has she/he has ever experienced torture, terrorism, or other violations of her human rights either at home or in the process of coming to this country?
  - Did you ever live in a refugee camp?
  - Were you ever separated from your family, clan, or other close social network?
- How does she/he feel these experiences have affected her/him? At the time? Now?

DV hotline should be ensured before they leave the clinical setting. Patients who are in imminent danger are likely to require assistance in finding a safe place to go, either by the mental health provider or through referral to a DV program or hotline. At the same time, many women do leave abusive relationships, although this may be a long and complicated process. For women who choose to stay, interventions can help to increase their safety. Domestic violence advocates can be a critical resource in helping survivors to conduct a risk analysis. (Again, see the book by Davies and colleagues [19] for more information on safety planning and risk assessment, as well as other chapters in this volume.)

Suicide Risk

Another critical safety issue is the relationship between IPV and suicidality. Being battered by an intimate partner places women at increased risk for attempted and completed suicide (66–69). For example, 13% of women who committed suicide in the state of Washington in 2003 had a court-documented history of experiencing domestic abuse. Other states are reporting similar findings from their DV fatality reviews (70). Some women do not feel they have any other options for ending the abuse and pain they are experiencing. They may have made multiple attempts to protect themselves, to stop the abuse, or to leave, without success. For other women, the risk of suicide may increase after they have left the relationship, before they have had a chance to recover their sense of self-worth and ability to function on their own. Whether the separation is by choice or because the batterer has left them for another partner, the experience of abandonment and loss may become too painful to tolerate (14). Women with early trauma histories, particularly those who meet criteria for

complex PTSD/disorders of extreme stress not otherwise specified (DESNOS) may have particular difficulty with threats of abandonment, even in the face of ongoing abuse. For survivors who are also dealing with a mental illness that carries increased risks for suicide, being abused by a partner (and/or experiencing abuse in childhood) adds to these risks. Although some suicide attempts may reflect a considered response to untenable circumstances, others may reflect a more spur-of-the- moment attempt by a survivor to alter her immediate situation and/or state of mind.

For some survivors, a suicide attempt may lead to the help they need (i.e., recognition of what they are experiencing, access to support, safety, resources, and treatment). For others, feelings of depression, hopelessness, and despair may take longer to resolve. When hospitalization is indicated, care should be taken to not involve the abuser in treatment unless a survivor specifically requests otherwise. Domestic violence advocacy and safety planning should be provided prior to discharge, whether by someone on staff who is trained to do so or in collaboration with a local DV program.

For perpetrators, suicidality is strongly associated with IPV homicide and risk factors for murder–suicide include depression, pathological jealousy, and facing abandonment or separation (71–73). The presence of any one risk factor should prompt a full assessment.

Homicidality

Homicidal ideation also warrants emergency psychiatric evaluation. Actual homicide attempts by survivors against an abusive partner, are however, very rare. In the majority of cases, women who kill their partners have been severely abused for long periods of time, feel that they are in imminent danger, and see no other way out. They believe they have no other choice but to kill their partner to prevent the murder or serious injury of themselves or their children. Experienced clinicians have found that it is very rare for battered women to premeditate the murder of an abusive partner. Rather, they develop self-defense strategies (e.g., carrying a weapon) that have potentially lethal outcomes both for themselves and their partners (14). Assessing a woman's level of danger and discussing the risk of lethality, the likelihood of incarceration, and the range of other alternatives can help diffuse the immediate danger if she raises these issues. Discussing the possibility of safety measures such as being transported to out-of-state shelters, relocation, witness protection plans, and temporary hospitalization can provide alternatives to homicide when she is in danger. In fact, as alternatives for women have become more prevalent (i.e., shelter, police/court services, etc.), homicides of male batterers have decreased significantly (74).

Try to determine if such circumstances reflect a woman's current situation. Ask her to describe how she perceives her options for safety. If homicide is a possible scenario, ask her directly if she has plans to kill or harm her partner. If she says "yes," she should be asked specifically if she has a weapon or plan for how to carry out that action. If she does have a plan, "duty to warn" considerations come into play. A clinician's duty to warn is based on state statute and case law. The Tarasoff decision (*Tarasoff vs. Regents of the University of California*, 1976) requires clinicians to take reasonable steps to protect a third party from harm, including victims of IPV and their abusers. When the patient is being abused by a current or former partner, and the intent to harm is perceived as a desperate means of self-defense, clinicians must intervene to protect *the patient* as well as their intended victim (i.e., their abusive partner). That might include hospitalization or sheltering of a victim who sees homicide as the only way to be safe. As with a suicide assessment, the clinician should assess whether the survivor has a plan and access to the means to carry out that plan. When IPV victims perceive homicide as their only option for safety, discussing other options available to them may minimize the homicide threat. Patients must be told of your intention and offered protective services. Alternate safety strategies should be discussed. Voluntary or involuntary psychiatric hospitalization may obviate the duty to warn the third party as long as they are not in danger from the patient.

In cases in which the patient is known to be a perpetrator of IPV, voluntary or involuntary commitment to a psychiatric facility is one way to achieve temporary safety until other measures can be put in place. A patient who is openly discussing his intent may be more open to intervention, but this is not necessarily the case. Temporary psychiatric hospitalization or assessment, particularly for a determined abuser, may not prevent homicidal action. Treating acute psychiatric conditions (e.g., depression, suicidality, paranoia) is an important part of intervention. However, consultation with experts in abuser treatment should be

sought and legal interventions put in place as well. In addition to warning an intended victim of an abusive partner's intent to harm them, it is also critical to discuss safety planning and provide access to community resources such as DV programs, hotlines, and shelters.

ISSUES THAT AFFECT OPTIONS AND CHOICES

Although women often share similar experiences, individual responses to abuse will also differ based on a range of personal, cultural, and societal factors. For example, a woman may be reluctant to discuss abuse if she perceives this as betraying her community or likely to invoke discriminatory criminal justice responses toward the perpetrator. Cultural or religious constraints and experiences of racism may make it difficult for a woman to discuss the abuse with someone outside her community. Alternatively, women may be afraid to discuss these issues with someone from the same cultural background. Issues of privacy, shame, safety, and confidentiality can all influence a woman's decision to reveal that she is being abused. Mental health treatment may be stigmatized, thus making it more difficult for women to seek help for trauma-related symptoms. Women may face social isolation and ostracism if they attempt to leave an abusive spouse, which makes it harder for them to consider this as a possibility. The idea of breaking marriage vows may create spiritual conflicts for some women as well.

Women who are immigrants also face obstacles to treatment. Those who are undocumented may find it even more difficult to reveal a history of partner abuse, in part because they are afraid of bringing attention to their situation, and in part because batterers threaten to have them deported if they tell or threaten to leave them without resources or support. Some batterers control their wives by deliberately failing to file their petitions for permanent residency. State Domestic Violence Coalitions are usually aware of services that specifically address these issues. Women who enter the United States as refugees have often experienced "triple trauma"—the trauma and loss in their home countries that caused them to flee, trauma that occurred during their transit, and the trauma of displacement and loss of familiarity and home (75). Yet, for many survivors, talking to a stranger about personal experiences is not something they find acceptable, and talking to someone in a position of authority is not perceived as safe.

Discussing partner abuse may also be difficult for women in lesbian relationships who have experienced homophobic responses outside the gay and lesbian community and denial about IPV within. It may be more difficult for lesbians to find confidential sources of help, particularly when their abusive partner is involved in organizations that provide services to battered women. Gay and lesbian batterers may attempt to control their partners by threatening to "out" them if they reveal the abuse or try to leave, or by defining their partners' efforts to defend themselves as "mutual combat," thus undermining their efforts to get help (76–78). Internalized responses to homophobia and violence in a woman's family of origin may contribute both to perpetration and to an increased vulnerability to victimization once it occurs. Although there are couples in which the abuse or violence is mutual, or in which one partner initiates and the other fights back, for many women, the pattern of one partner systematically controlling the other is no different from that in abusive heterosexual relationships, although positions may change in a subsequent relationship (79). It is important to ask for explicit examples of what actually happens in the relationship when these questions arise. Abusers typically use tactics of denial and distortion, and do not take responsibility for their behaviors. Any therapist working with gay or lesbian couples must interview each partner separately to ask about abuse.

Clinicians should also be aware that lesbian, gay, and transgender survivors of childhood sexual abuse may have some unique concerns about the therapeutic relationship. They may be grappling, for example, with their sense of psychological safety as a lesbian or gay man within the therapy. This may manifest as a need to know about a therapist's view of homosexuality or familiarity and comfort in working with lesbian, gay, bisexual, transgender, queer, and questioning (LGBTQ) individuals. A client's sense of safety may be undermined by a therapist's refusal to disclose her own views and experiences, by a therapist's interpretation of lesbianism as a response to the incest, or by a therapist's inability to identify the homophobia faced by the client as a potential cause of trauma-related disorders (80).

As noted previously, women already diagnosed with mental health or substance abuse disorders contend with an additional set of concerns. They may fear not being taken seriously because of previous experiences with helping professionals or because abusers have convinced them this is so. These issues may affect a

woman's ability to process information and sort out her options, and may limit her access to shelter.

In addition, women with physical disabilities or disabling medical conditions, some of which have been caused by the abuse, may find it even more difficult to leave a partner or family member she depends on for access to services and basic care. People who have a disability are even more likely to feel trapped in abusive relationships, particularly when jobs and transportation are limited or when their only alternative is to live in an institution or return to an abusive family. Personal assistants may also turn out to be abusers, further decreasing women's options for living independently. People with disabilities may face unique forms of abuse, such as neglect, refusal to provide essential care, manipulation of medications, withholding or destroying equipment, or preventing access to mobility or communication. In addition, women with disabilities are often perceived as asexual and de-gendered, reducing the likelihood that partner abuse will be recognized. Those relationships may also be harder to give up (81). Men with disabilities may also be at greater risk for abuse. Therapists can learn more about the specific needs of people with nonpsychiatric disabilities and find ways to make their own practice settings more accessible by contacting a disability rights advocacy group such as the Americans with Disabilities Act Technical Assistance Program, or the OVW Accessing Safety Initiative (http://www.verainstitute.org). Applying concepts of universal access/inclusive design and making sure agencies and practice settings have the appropriate assistive technology can help mitigate the barriers survivors face in accessing necessary resources.

Summary

To summarize, research and experience in the field indicate that during a routine inquiry or assessment, any mental health symptoms should be considered in relation to current or past abuse and other traumatic experiences. Developmental and biological issues should be examined from a trauma perspective as well. If a patient does disclose a history of current or past victimization, a more in-depth assessment of her situation is indicated. Additional information is also needed about the nature of a woman's traumatic experience(s) and the scope of their impact on her life; her current safety status; how the abuse has affected her and her children and how she protects her children and herself (documenting this information can be particularly helpful when custody is an issue); the presence of medical illnesses and psychiatric symptoms, particularly conditions known to be related to trauma as well as coexisting health or mental health problems; and the coping strategies she uses and how they affect her daily life (currently and at the time of the trauma).

Abuse that is targeted toward patient's mental health condition should be asked about specifically (i.e., withholding medication, coerced overdose, telling her no one will believe her because she's mentally ill), as well as the relationship of abuse to symptom exacerbation (e.g., recurrence of panic attacks, worsening depression or acute psychotic episode in the face of escalating threats or recent assault). In addition, presenting symptoms should be considered in light of any social discrimination a patient has experienced, as well as any cultural differences and language barriers that may be present. Although in some settings it may be necessary to gather large amounts of information in a relatively short period of time, clinicians can help to destigmatize the process by explaining what they are thinking and why they are asking particular questions. Engaging survivors as partners in the assessment process is generally experienced as more respectful and empowering (16,29).

ASSESSING THE MENTAL HEALTH IMPACT OF INTIMATE PARTNER VIOLENCE AND OTHER LIFETIME TRAUMA

Conceptual Issues

Although in the course of obtaining a mental health history, particular attention to trauma-related symptoms and disorders is warranted, emerging neuroscience research on the effects of trauma across the lifespan indicates that responses to trauma are best viewed along a multi-axial continuum rather than as discrete diagnoses. Briere and Spinazzola, in a 2005 review on complex trauma assessment, underscore that given the many types of trauma, the number of domains that can be affected, and the array of potential intervening factors, assessment may better achieved by looking at the range of possible posttraumatic responses in conjunction with a survivor's particular experiences and risks (e.g., impact of adult single-event trauma versus chronic severe abuse and neglect in early childhood; secure attachment and supportive caregivers

versus disorganized attachment and abusive, nonattuned caregivers; no genetic vulnerabilities versus significant genetic vulnerabilities; presence or absence of resilience/mitigating factors; positive versus adverse subsequent experiences/life trajectory) (82). A survivor of IPV might fall anywhere on this continuum.

Harris and Fallot distinguish between a *PTSD/diagnostic model* that views trauma as a discrete event (sexual assault, disaster) and responses to trauma as a discrete set of symptoms, and a *complex trauma model* that views trauma as a core set of developmental experiences around which individuals organize their identity, sense of self, and beliefs about the world, and which affects people in multiple and sometimes seemingly unrelated ways (16). Neuroscience research is beginning to corroborate these clinically based understandings by examining the effects of trauma on key brain regions, circuits, and neurotransmitters (83–89). Research also supports the long-held clinical recognition that a person's developmental trajectory is shaped by a combination of genetic endowment and life experiences (e.g., nurturing and attachment, early trauma or stress, resilience-promoting qualities of individuals and their environments, etc.). Having a developmental perspective is useful for understanding the long-term effects of childhood trauma, as well as positive adaptations to traumatic experiences (i.e., developing capacities one might not otherwise have developed) and posttraumatic growth (i.e., positive change as result of crisis such as personal strength, greater appreciation of life, renewed sense of spirituality, etc.) (90).

However, a number of issues must be considered in regard to how the relationship between previous trauma and IPV is conceptualized. Because IPV is primarily an adult (or adolescent)-onset phenomenon, survivors have raised concerns that linking IPV to earlier childhood experiences can be construed as victim blaming (something inherent to the victim that caused the abuse) or as a way to not hold batterers accountable (attributing abusive behavior to childhood trauma and its effects on the brain, conflating childhood etiology with adult responsibility). As noted earlier, research on the mental health sequelae of IPV has not applied a complex trauma lens. Whether this model will mainly prove helpful to survivors who have experienced significant childhood abuse or if its dimensional approach to a range of potential effects make it useful for assessing and responding to the consequences of adult as well as childhood trauma, remains to be determined.

Disorders of extreme stress not otherwise specified criteria formed the initial construct for current thinking on complex PTSD (also referred to as *complex developmental trauma disorder*) and complex posttraumatic self-dysregulation (58,91,92). Hallmarks of complex trauma or DESNOS include alterations in emotional (and impulse) regulation (e.g., suicide attempts, high-risk behavior, self-cutting); states of consciousness (dissociation) and self-perception (self-hatred and shame); alterations in perceptions of the perpetrator (idealizing, preoccupation with); alterations in relations with others (fear, rage, abandonment); and alterations in system of meanings (no one can be trusted). When DESNOS was initially conceptualized, it was meant to describe the changes that can take place when a person is entrapped in a longstanding abusive relationship, whether in childhood or as an adult (91). However, most subsequent research has focused on the developmental effects of trauma that begins in childhood. In some senses, DESNOS was a critical reframing of the diagnosis of borderline personality disorder—as the developmental sequelae of chronic abuse in childhood and adaptive attempts to manage intolerable feelings without optimal internal resources or psychological survival strategies that emerge when entrusted early caretakers are the ones causing the distress. Researchers have developed a number of different constructs in an attempt to organize these wide-ranging effects. For example, functional magnetic resonance imaging (fMRI) research has begun to examine the different kinds of responses survivors may have to chronic interpersonal trauma (e.g., distinguishing between responses that primarily involve fear and hyperarousal versus those that involve numbing and dissociation) (84,86).

Assessment Tools

A number of validated trauma assessment tools are available, such as the Trauma Symptom Inventory (93,94), the Clinician Administered PTSD Scale (CAPS) (95), the Interview for Disorders of Extreme Stress (SIDES) (96), Trauma and Attachment Belief Scale (TABS) (97), and Dissociative Experiences Scale (DES) (98), to name a few. They can usually be obtained by contacting the authors (99–102). Tools such as the Posttraumatic Stress Scale for Family Violence (103) provide questions that specifically link PTSD symptoms to ongoing abuse. The Posttraumatic Growth Inventory (104) offers a way to assess more

positive aspects of survivors' experiences. For a review of additional screening tools associated with PTSD, see Brewin (105) or complex trauma, see Briere (82); for a review of trauma screening tools for children and adolescents, see Strand, Sarmiento, and Pasquale (82,105,106). Assessment for other commonly occurring trauma-related symptoms and conditions should be included as well (depression, other anxiety disorders, substance abuse, etc.). For clinical purposes, questions can be adapted from existing instruments and integrated into mental health assessments tailored to individual survivor responses and needs. When used for research or diagnostic purposes, however, handpicking individual questions will clearly affect the statistical reliability of these measures.

One tool for assessing the impact of more severe early trauma (The Trauma Recovery Empowerment Profile, or TREP) emerged from the work of Harris, Fallot, Beyer, and Berley as part of the Substance Abuse and Mental Health Services Administration (SAMHSA) Violence Against Women with Co-Occurring Disorders study (107). They identified 11 core skill dimensions that women in their program with histories of childhood trauma, substance abuse, and psychiatric disabilities often found themselves struggling with. These domains included basic self- and relational-capacities (self-awareness, self-protection, self-soothing, emotional modulation, relational mutuality, accurate labeling of self and others), as well as higher-order functions (such as a sense of agency and initiative taking, consistent problem solving, reliable parenting, possessing a sense of purpose and meaning, decision making and judgment). They also developed specific skill-building exercises that women could use to develop their capacities in arenas that had been affected. For some women, a lifetime of abuse and neglect had disrupted the development of fundamental aspects of themselves, what Saakvitne and her colleagues refer to as *self-capacities* or *feeling skills* (feeling internally connected over time to caring others; experiencing oneself as deserving and worthwhile); and affect regulation (recognizing, tolerating, modulating, and integrating feelings) (27). *Affect regulation* refers to being able to experience feelings without becoming overwhelmed or having to manage them in ways that are potentially harmful or restricting, that become walled off and then evoked unexpectedly, or that leave survivors without access to important parts of themselves and their experience (108). This type of information can be used to tailor both assessments and treatment to more accurately match the arenas in which a particular survivor may have been affected and the skills that will be most helpful to her in accessing safety, recovering from trauma and/or mental illness, and rebuilding her life (14).

Another tool that has been used to assess the nature of early caregiver experiences to help explain current responses is the Trauma Antecedents questionnaire (108). In addition to identifying types of traumatic experiences, it assesses areas of competence as well as feelings of safety with potentially protective people at different stages of development as a way of determining what experiences and capacities a survivor already has and what needs to be worked on through a variety of treatment modalities. Other researchers emphasize the importance of balancing trauma assessments with assessments of resilience. The concept of resilience refers to the capacity for successful adaptation despite challenging or threatening circumstances (109).

In practice, teasing out these connections means assessing the relationship of current or past abuse to new symptoms and/or to the exacerbation of a co-existing psychiatric condition and exploring how current or past abuse has affected survivors in other relevant ways, such as how they feel about themselves, their ability to trust themselves or other people, their perceptions of others, their capacity to manage feelings, their ability to take in and process information, and the beliefs they hold about the future. In addition to the domains just mentioned, trauma can affect beliefs, spirituality, systems of meaning, and states of consciousness, as well as the ways in which individuals solve problems and protect themselves from harm. It can be helpful to both normalize and inquire about the specific kinds of feelings that may have resulted from ongoing or past abuse such as anger, fear, confusion, guilt, or despair. Discussing coping mechanisms that may be harmful (such as posttraumatic avoidance, numbing or dissociation, self-injury, and substance use) and reframing them as survival strategies rather than pathology can help reduce shame and increase openness to exploring other ways of coping. It also helps survivors to build on their own resources and strengths.

ADDITIONAL ASSESSMENT CONSIDERATIONS

The following section provides a brief overview of additional issues that would be included in a

comprehensive mental health assessment for survivors of IPV, but which are discussed in greater depth elsewhere in this volume.

Substance Use Assessment in Context

Alcohol and other drugs are often used as form of self-medication to numb the pain of current or past abuse. In addition, some survivors grow up in families in which substance abuse is a problem or in communities where drug use is common, thus putting them at greater risk for early use of drugs themselves, and for exposure to violent relationships. Some abusers coerce their partners into illegal drug activity and may then exert further control by withholding or threatening to withhold the drug(s) she has become dependent on. This common scenario creates an additional layer of entrapment for the woman; by calling the police to avert a violent assault by her partner, she risks her own arrest for drug possession and/or usage. Attempts to stop using may be met with increasing threats and violence. Understanding the role of substance abuse in a particular survivor's life and its relationship to current or past abuse is essential for developing an integrated treatment approach. Standard substance abuse screening questions can also be adapted to a survivor's experience of IPV (for an example, see Figure 24–1). A more in-depth discussion of this issue is found elsewhere in this text.

Health Impact of Intimate Partner Violence and Other Trauma

A mental health history should also include questions about the impact of IPV and previous trauma on patients' physical health. In addition to addressing the abuse-related injuries, medical problems (including chronic pain, autoimmune or cardiovascular disorders, exacerbations of previous medical conditions, symptoms associated with stress, anxiety disorders, and depression), complications of pregnancy or unprotected sex, or hospitalizations secondary to the abuse or medical conditions that might place a person at greater risk (i.e., dependency on an abuser for transportation, mobility or care) must be assessed. In assessing the health impact of abuse, careful attention should be paid to the sequelae of head and strangulation injuries, such as loss of consciousness, postconcussive syndromes, and cognitive impairment, as well as conditions that might impact the choice of psychotropic medication, as indicated (110). Not only is this information important to document for a patient's legal case, but it is also important to factor into mental health treatment—how a survivor's life has been

Standard substance abuse screening questions (e.g., the CAGE questionnaire) can be adapted to a survivor's experience of IPV, CAGE: "Have your ever tried to *c*ut down on your drinking?" "Have you ever been *a*nnoyed by someone criticizing your drinking?" "Have you ever felt *g*uilty about your drinking?" and "Have you ever had an *e*ye-opener in the morning?" For example:

1. "Has your partner ever tried to stop you from cutting down on your drinking?"
2. "Have you ever been made to feel afraid by someone's criticizing your drinking? Has your partner used your drinking as a way to threaten you?"
3. "Have you ever felt coerced into drinking (or using drugs) or engaging in illegal activities or other behaviors you weren't okay with or that compromised your integrity, and then felt guilty about it?"
    a. "Have you ever used drugs or alcohol to manage painful feelings and/or numb yourself from pain, and then felt guilty about doing that?"
    b. "Have you ever had to trade sex for drugs, and then felt bad about that?"
    c. "Were drugs or alcohol ever involved in the abuse you experienced as an adult? As a child?"
4. "Have you ever had a drink in the morning, because things felt so hopeless or because that felt like the only way you could survive or get through the day?"

Figure 24.1 Adaptation of the CAGE questionnaire for intimate partner violence questioning.

altered by these sequelae, the extent to which they continue to serve as traumatic reminders, the effects of capacity-limiting conditions on a batterer's ability to exert control, the role of stress/depression in the development (and maintenance) of physical symptoms, and the like. A more in-depth discussion of the health impact of IPV is found elsewhere in this text.

Impact on Children

Asking a survivor about what the children have been exposed to and how they have been affected raises a number of potentially challenging issues, particularly if custody is a concern. Taking an informed-consent approach to asking about IPV and other abuse means letting women know upfront about mandatory reporting requirements. At the same time, children often play a primary role in women's decision-making, and creating a safe place for women to talk about their concerns is critical (111,112). Questions about whether she has noticed changes in her children or in her relationship with them and what fears she may have about her children's safety, behavior, or emotional states can be asked in a way that invites collaboration. Inquiring about and documenting what a woman does to protect the children's safety and attend to their needs can be particularly helpful in building her custody case, as well as supporting her as a parent (113). Ultimately, being able to support the parenting capacity of and attachment to the nonabusive parent is most helpful to children's development (114,115). Other questions include whether the children have developed any medical or behavior problems or psychiatric symptoms that might be related to the abuse or if young children have regressed from a previous level of development. A more in-depth discussion of the impact of IPV on children is found elsewhere in this text.

Coping Mechanisms and Survival Strategies

A key component of empowerment-based interventions involves discussing a survivor's sources of strength and support, as well as the additional skills and resources a survivor may need. One way to do this is to help survivors identify the strengths they rely on to survive and resist the abuse, access the capacities that have been buried or undermined by their abusive partner (and possibly others), and reframe perceived weaknesses as abuse-related coping strategies or sequelae and/or actual survival strategies. A strengths-based assessment provides a fuller picture of the individual and of her potential. It also provides an opportunity to discuss and acknowledge patients' spiritual beliefs and practices, their hopes for creating a better life, and their persistence and determination in the face of uncertainty and fear. A detailed review of the literature on coping styles and IPV is beyond the scope of this chapter.

Considerations for Survivors Who Are Living with a Chronic Mental Illness

The stigma of mental illness is often used by the abuser and internalized by the person being victimized, particularly if her sense of self has been organized around experiences of abuse and mental illness (e.g., she is the problem, she is being paranoid, no one will believe her, she deserves it, she does not have any rights). In addition to safety, treatment should be designed to address stigma as well as abuse-related issues. As discussed by Harris and her colleagues, when a survivor's very sense of self has been undermined by a combination of stigmatized conditions and circumstances, these issues need to be attended to gradually but directly (16). Treatment in this context attends to aspects of the self that have been undermined and capacities that a survivor may not yet have had the opportunity to develop.

For women who are living with a mental illness, abuse may come at the hands of people in their social networks, not necessarily a partner (e.g., someone in their residential setting, a family member, a "friend"). Women who are homeless are at even greater risk for abuse by both strangers and acquaintances. Intimate relationships may be transient and may involve high-risk activities such as trading sex for drugs, cigarettes, food, or housing. Working with survivors to recognize and name the abuse and to develop alternate social networks can be a critical part of the work (16).

Psychotic episodes may reflect a crisis in a woman's network, such as abuse or abandonment. If these are recognized and addressed proactively, it may prevent crises from occurring (16). With the exception of a few model programs across the country, virtually no trauma- and IPV-sensitive crisis or transitional housing is available for women with a serious mental illness (116). The Americans with Disabilities Act and Fair Housing laws require DV shelters to serve women who

have psychiatric disabilities and who do not present a danger to themselves or other people. Most shelters will take in women with psychiatric histories providing they are relatively stable and ongoing psychiatric support is available. Alternatively, with sufficient staff training, local respite or crisis beds could become safe havens for women who are currently in danger and experiencing psychiatric or abuse-related mental health crises.

Women who have a mental illness often face significant custody hurdles that are exacerbated by the abuse and manipulated by abusers. Women with mental illness can be capable parents, particularly if they have adequate supports. Yet, stigma associated with mental illness makes this more difficult to achieve and increases the ability of an abuser to control his partner through custody-related threats. Parenting support is a critical component of mental health interventions.

Psychiatric hospitalization can be made more empowering by providing an opportunity for women to refuse calls or visits from an abusive partner and by providing advocacy interventions and safety planning onsite. Encouraging women to maintain phone contact with children, when possible, helps demonstrate their commitment and capacity to parent. Having women notify employers of their absence increases the likelihood of retaining their jobs post hospitalization (117). All patients should be asked about abuse and safety issues on admission and at discharge from psychiatric hospitalizations. Abusers should not be given information as to their partner's whereabouts or involved in treatment unless the patient indicates this is what she wants.

Issues of Documentation

Any information that becomes available to the batterer can increase a woman's danger and can be used to control her or be used against her in court around custody issues, thus making sensitivity to the nuances of documentation essential. It is important to document women's descriptions of abusive experiences in their own words, particularly when the potential for legal action exists. Guidelines have been developed by a number of responsible professional and advocacy organizations to help clinicians negotiate this complex terrain (Family Violence Prevention Fund; American Psychiatric Association; American Psychological Association; International Society for Traumatic Stress Studies; AMA Guidelines on Mental Health Consequences of Family Violence) (11,13,113,118).

Documenting symptoms that result from or are aggravated by abuse, and the potential for them to subside once a woman is safe, can be particularly helpful to survivors in custody battles, with attention to how information about diagnoses and medications might be used. For example, one might consider using "acute stress disorder" or "adjustment disorder NOS" rather than "PTSD" if a woman is still being abused and is dealing with custody issues. On the other hand, careful documentation, regardless of diagnosis, can be helpful to a survivor in court, depending on her legal representation. Discussion should be framed around the relationship of symptoms to the abuse and should describe a woman's strengths, her coping strategies, her ability to care for her children, and the efforts she has made to protect them. Indications of her parenting ability and the children's attachment to their mother (e.g., observations of interactions with her children, discussions that demonstrate her attunement and concern) should also be clearly documented.

For clinicians involved in custody evaluations, it is important to recognize the appropriateness of a woman's anger toward the abuser and her reluctance to expose her children to a violent, abusive parent. Women are often penalized in these situations for being the less cooperative parent. Clinicians must also take care not to be fooled by the seeming health of an abuser, whose partner may look more symptomatic than the person who has been abusing them for years (119). Abusers frequently use custody battles and visitation as ways to control a partner who is attempting to leave. Prolonged custody battles are particularly devastating to survivors and their children. Abusers often continue to drag their partners to court, depleting their legal funds and threatening the safety and well-being of their children.

APPROACHES FOR WORKING WITH INTIMATE PARTNER VIOLENCE SURVIVORS

This section provides an overview of current approaches for working with survivors of IPV and lifetime trauma. Included in this overview are IPV-specific interventions, trauma treatment interventions (both therapeutic and pharmacological), substance abuse treatment in the context of IPV, potentially harmful interventions, and legal issues that need to be considered by clinicians and other service providers when working with survivors.

INTIMATE PARTNER VIOLENCE-SPECIFIC INTERVENTIONS

Providing Information

Many battered women are either numb or in a state of terror and confusion at the time they seek help, and have not had room to do more than survive. Providing information about the dynamics of abuse; about typical battering tactics; about common sequelae; about the pattern of abuse and likelihood that it will continue; about the impact of abuse on children; about risk, danger, and safety planning; and about available options and resources, is also a powerful intervention tool. It helps decrease isolation and shame, helps women gain perspective, aids in decreasing psychological entrapment, and offers a sense of hope and connection.

If a woman is seeking help for her abusive partner, discuss what is known about perpetrators, about the limits of treatment programs, the possibility of his continued controlling behavior even if he stops his violence, and his need for long-term commitment to counseling and change. The importance of a genuine commitment to change cannot be overestimated. When a women's abusive partner is in counseling, she may stay with him longer in the hope that he will stop the abuse. Many batterers enter counseling solely to keep their partners from leaving. It may be necessary to revisit these issues during the course of therapy ensure her safety.

In addition, by explaining the common traumatic sequelae of abuse, clinicians can mitigate the effect of abusers' undermining behaviors and impart relief to survivors who truly fear they are going crazy. Information about trauma and its impact also helps survivors gain perspective on their own responses, anticipate potential difficulties, and develop tools to manage feelings, behaviors, and states of consciousness that may interfere with their ability to achieve desired goals.

Women often want their children to grow up in intact homes, but are deeply concerned about their children's safety. They may wish to remain in the relationship with the abuser if the children are not at risk for physical harm and if they believe that their partner is essentially a good father. Discussing the long-term traumatic effects of witnessing one parent perpetrate violence against the other (e.g., developmental regression, behavior problems, poor school performance, social withdrawal, psychiatricsymptomatology, increased risk of becoming a victim or perpetrator) can help a survivor weigh her options about whether to stay or leave. If the children are in need of treatment, plan the treatment in partnership with her, rather than just making a referral. Try to ensure access to a child therapist who understands the issues faced by both children and their mother, and who works in ways that support her capacities as a parent (120).

Discuss what written material will be safe for a woman to take home. Many batterers check the odometers on their partners' cars and go through their partners' purses, briefcases, pockets, and drawers. Insurance information sent to the home may also put her in danger. It is also important to ask if precautions need to be taken to avoid having written information about the abuse on materials he may see. She may need to write important phone numbers on scraps of paper or memorize them, or she may be able to leave the information at work or with a friend.

Safety Planning: Building Collaboration to Enhance Safety

Safety planning strategies are based on the consensus experiences of survivors and advocates over the past 30-plus years. Research on this issue is limited, but some randomized controlled trials have indicated positive effects (121). This issue is discussed in greater depth elsewhere in this text. Some dimensions of safety are best addressed by advocates, others by mental health providers, and some clearly by both. Most clinicians are already familiar with helping patients develop strategies for keeping themselves safe at times when mental health symptoms place them in jeopardy (i.e., when they are feeling suicidal, experience triggers that are likely to evoke overwhelming feelings, are starting to feel destabilized, etc.). A person who is being victimized by an intimate partner can also benefit from having someone to work with in analyzing her situation, identifying risks and thinking through specific strategies to increase her and her children's safety.

Advocates who work for a local DV program can be particularly helpful in this area. For example, advocates are best able to provide linkages to immediate shelter and discuss a range of safety options, including legal protections, alternatives to shelter, options for LGBTQ and immigrant survivors, and ways to be safer if the survivor remains at home. They actively participate in the process of negotiating with bureaucratic sysems, including child protective services,the welfare system, and the courts. In addition

toconsiderable experience assisting women to increase safety through shelter, relocation, and legal interventions, DV programs are also knowledgeable about other safety issues, such as the responses of law enforcement and judges in a community.

Clinicians, however, should be skilled at helping patients assess their danger, discuss their options, and access advocacy resources, particularly when advocates are not immediately available. For example, if a patient is in immediate danger, DV hotlines are accessible 24 hours a day and can assist with safety planning. If state or local hotlines are not readily available, the National Domestic Violence Hotline can always be accessed [1–800–799-SAFE (7233), 1–800–787–3224 (TTY)].

Patients currently in danger should be encouraged to develop safety and escape plans if they are staying with an abusive partner or he has access to them, and to consider options for safety if leaving. It is helpful for survivors to rehearse their plans, so that they will be in place when needed. Survivors can do a number of things in addition to calling the police or a crisis line or getting a protective order from the courts. They can review previous episodes for information that identifies predictable patterns and locations that may be dangerous, think about how to anticipate and reduce danger if possible, make provisions for their children (rehearse escape strategies, places to stay, numbers to call); locate (in advance) a safe place to go in an emergency; and make provisions for leaving quickly and have necessary items and papers packed, accessible, and if at all possible, hidden from the abuser. Police can escort a woman back to her home if she needs to gather belongings but if an abuser suspects his partner is leaving, he may destroy valuable items and papers. A woman can also develop and rehearse an escape plan, and develop a plan for getting help when she cannot escape (signal to neighbors, teach the children to dial 911).

It is important that safety planning be seen as a process that a survivor adjusts in response to changing circumstances, rather than as an actual document or work product. In addition, creating a written safety plan that is incorporated into formal treatment planning and placed in the clinical record can be used against a woman in custody cases or other situations if she has not followed the steps outlined in her safety plan. Therefore, while having a written plan may be useful for a given survivor to make for herself, at her discretion, documentation in the mental health record should be more circumspect (e.g., "Strategies for increasing safety were discussed, they included . . . Janna will continue to weigh the risks and benefits over time").

For survivors who are living with a psychiatric disability, there are a number of additional dimensions to consider. For example, safety planning should address safety from ongoing abuse by members of their social network (i.e., friends, roommates, family members, staff, or others in residential settings) as well as by a partner. In addition to addressing physical, emotional, and sexual safety, it should attend to mental health–specific forms of abuse, such as withholding medication, sleep deprivation, coerced treatment, custody threats, threats of commitment, control of finances, guardianship, and advance directives. Plans should be adapted to a survivor's cognitive abilities and her ability to process information during a crisis (i.e., account for symptoms of dissociation, anxiety, depression, psychosis, mania, developmental disabilities, traumatic brain injury, etc.). Examples of this include using simpler, more concrete language; adjusting the pace of talking; checking in to make sure information is understood; asking a patient if she can let you know what she heard, so that you can make sure you are conveying information in a way that is most effective for her; helping a survivor recognize when she is with you and when she has dissociated, and identifying strategies she can use to bring herself back (i.e., grounding techniques); or helping the person develop ways to calm herself if anxiety is making it difficult to concentrate—in other words, helping survivors stay connected to themselves and to the clinician while engaging in a way that is optimally paced for them. Safety issues need to be addressed before an IPV survivor is discharged from an inpatient unit or leaves a community mental health setting.

Intimate partner violence safety planning can also be incorporated into existing mental health recovery, self-help/peer support tools that survivors may be using. One example is the Wellness Recovery Action Plan ™ (WRAP; Mary Ellen Copeland, PhD), which was "developed by and for people with mental health difficulties to take charge of their own recovery and well-being." It is designed to "decrease and prevent intrusive or troubling feelings and behaviors, increase personal empowerment, improve quality of life, and assist people in achieving their own life goals and dreams" through a structured system of "planned responses that includes responses from others when

individuals need help to make a decision, take care of themselves, or keep themselves safe" (122). Although the focus of WRAP™ is on achieving and maintaining wellness from mental health symptoms, much like IPV safety plans, it is structured to enable people to notice, anticipate, and plan for potential threats to their well-being, and to create and modify as needed an action plan for themselves and for the people they can safely rely on for support. It is currently undergoing a randomized control trial as a peer support tool. An IPV safety planning version is also being developed (123). Individual safety plans should also include survivors' preferred methods of calming themselves during a crisis to reduce the likelihood that an abuser will be able to exert control in those situations and to reduce the use of coercive interventions by mental health personnel.

Psychiatric advance directives offer another tool that can be utilized in conjunction with IPV safety planning to make provisions for who survivors do or do not want informed about and/or involved in their treatment, and who they want named as the attorney-in-fact to make decisions on their behalf at a time when they are unable to do so. Psychiatric advance directives also delineate treatment modalities that are or are not acceptable to them (i.e., medications, hospitals, electroshock therapy, etc.) if they are ever in a position in which they are not able to make competent decisions for themselves. As part of safety planning, it is important to find out if a survivor does have an existing psychiatric advance directive and, if so, who is the designated attorney-in-fact and what their relationship is to the abusive party. If a survivor does not have a psychiatric advance directive, it might be worth considering one as a way to ensure that the abuser is not involved in treatment or decision-making or is not informed about her location if she is hospitalized and she wishes her whereabouts to remain unknown.

Working with Local Domestic Violence Programs

Local DV programs, as well as online DV resources can also play an important role in a survivor's overall strategy for accessing safety and support, which in turn has salutary effects on mental health. The majority of research on nonclinical interventions for survivors (as opposed to perpetrators) of DV has focused on shelter and/or post-shelter services. Several studies, including one randomized controlled trial, have found that DV advocacy counseling reduced violence, increased quality of life, enhanced safety and well-being, and helped women expand their networks of support (124). Other studies have found significant reductions in depression among women who were able to end the violence and some reductions even among women who were still exposed (125–129).

In one longitudinal randomized control study, Sullivan and colleagues found women who received free services from trained college student-advocates for 10 weeks post-shelter experienced less physical violence over time and reported increased quality of life, greater social support, less emotional attachment to the abuser, fewer depressive symptoms, less fear and anxiety, and increased effectiveness in obtaining resources, although differences in anxiety and depression were not sustained over time (3,130). Social support, however, has been associated with better self-perceived mental health status, lower psychological distress, and lower rates of psychiatric disorders among survivors of IPV, including anxiety, depression, PTSD, and suicide attempts (131,132). One additional series of studies found brief nursing interventions delivered during prenatal visits to be effective in increasing safety behaviors for IPV survivors (133). Methodological designs limit generalizing to some extent but do provide preliminary evidence that both hospital- and shelter-based interventions can be effective for some women (124). Overall, studies have begun to demonstrate that flexible, survivor-centered interventions providing advocacy and social support may be more effective strategies for improving quality of life and helping women to be safe (134,135).

Domestic violence advocacy programs and shelters provide a variety of services for battered women and their children, as well as public education and training for service providers. They are the major source of support for many survivors. Others may feel most safe when connected to a mental health provider, with advocacy playing an important but adjunctive role, and still others, in peer support groups. The majority of DV survivors do not stay in shelters, either because of insufficient resources or because they have other options, but they do utilize a wide range of services available through DV programs.

Typical offerings include a 24-hour hotline and crisis intervention counseling; assistance in evaluating options, resources, safety planning, and referrals; information about legal remedies and legal and court advocacy (such as assistance with protective

orders, etc.); emergency shelter, hotel vouchers, safe homes; counseling, support groups, and referrals for therapy; immigrant rights information advocacy with child protective services; literacy programs, job training, and transitional housing; and referrals for perpetrators/abusers. It is important to note that some of theses services may not be available in the woman's community. Culturally specific DV services and services designed for lesbian, gay, bisexual, and transgender survivors exist across the country but are much fewer in number. Developing a working relationship with community DV programs can offer support to clinicians as well, and can increase the likelihood that women will receive the range of services they need. For example, not all DV programs have the resources to shelter women with more acute mental health symptoms. However, working closely with a mental health provider who can provide consultation, access to referrals, backup support for shelter staff. and/or access to medication and mobile crisis services can make a difference in the extent to which shelters are able to serve women who are also dealing with a mental illness or more severe trauma related symptoms.

EXISTING TRAUMA TREATMENT APPROACHES

Recognition of the impact of abuse and violence against women has led to the emergence of a number of approaches to trauma treatment, only a handful of which are specific to IPV. And, although some PTSD treatment studies have included survivors of IPV, trauma models generally target symptoms associated with abuse that occurred in the past. Complex trauma treatment models address many, but not all of the dimensions of trauma just discussed. This section will focus on the trauma treatment/recovery component of these approaches by reviewing existing research, controversies, and consensus on treatment for PTSD and complex trauma (DESNOS/complex traumatic stress) and discussing their applicability for survivors of IPV. Women experiencing ongoing IPV are generally excluded from clinical trials due to safety and accessibility concerns and because these treatment modalities may be less appropriate when a person is still under siege. The richest literature on the intersection of trauma and IPV, although not yet evidence-based, derives from the combined experience of advocates and clinicians working with survivors over time and from survivors themselves (14,17). These approaches interweave the IPV-specific interventions discussed earlier with elements of empowerment-based trauma recovery models described next.

The trauma treatment literature is essentially divided into two categories (although a number of models are starting to bridge this gap): evidence-based treatment for PTSD, and a combination of controlled, promising, and consensus-based treatments for complex trauma.

Evidence-based treatments for PTSD was originally developed for survivors of single-event trauma (e.g., sexual assault) and have since proven effective in treating PTSD among survivors of IPV who are no longer in an abusive relationship, for female combat veterans, and for some survivors of childhood abuse. Evidence-based treatment includes medication and protocol based CBT. Forms of CBT with the strongest evidence are prolonged exposure (PE), cognitive processing therapy (CPT), eye movement desensitization reprocessing (EMDR), and cognitive trauma therapy for battered women (CTT-BW), all of which involve working through memories of the traumatic event. More recently, several hybrid models have emerged that combine affect regulation and interpersonal skills training with attenuated exposure interventions for adult or adolescent survivors of childhood abuse (6,136,137). These models evolved to address concerns that exposure techniques may further disrupt pathways that have been chronically dysregulated by early trauma (138).

Current consensus approaches to treating complex trauma or DESNOS incorporate evidence-based techniques into a variety of multidimensional phased treatment models that attend to the domains affected by chronic, interpersonal trauma, particularly the developmental effects of childhood neglect and abuse. Research has not yet begun to explore the differential impact of trauma, such as IPV, that is experienced primarily as an adult or adolescent versus abuse that occurs during critical developmental periods in childhood. Therefore, these models may be most applicable for the subset of IPV survivors who are also experiencing the long-term effects of childhood trauma. However, since complex trauma models offer a more comprehensive framework for understanding and responding to the various effects of chronic abuse as well as a more flexible multimodal treatment approach, they may ultimately prove to be more useful to IPV survivors as well, particularly those whose experiences of abuse were more prolonged and severe.

In other words, complex trauma models attend to many of the domains that can be affected by interpersonal trauma that are not addressed by the PTSD diagnosis or PTSD treatment, although they do not address IPV-specific concerns.

COGNITIVE BEHAVIORAL THERAPIES FOR POSTTRAUMATIC STRESS DISORDER IN GENERAL

Until relatively recently, published PTSD treatment studies mainly focused on cognitive behavioral interventions following single-event sexual assaults (139,140). These modalities have demonstrated considerable success in preventing or reducing the severity of PTSD and, to some extent, associated depression and anxiety. Focal short-term psychodynamic therapies have also demonstrated some efficacy in treating PTSD (141). Research looking specifically at whether and under what circumstances these models are helpful to IPV survivors is still needed; the current research literature includes one randomized controlled trial of CBT for survivors of IPV and a handful of quasi-experimental studies.

Cognitive Processing Therapy

Cognitive processing therapy provides survivors with controlled exposure to traumatic memories and trains them to recognize and modify "maladaptive" cognitions (meanings and "lessons" one has taken from the traumatic experience such as "walking outside is dangerous") that cause unnecessary pain and constrict women's lives. Participants are encouraged to write about the traumatic event and are taught how to reconfigure their thinking about the trauma in ways that modify its impact on daily functioning. This technique has been effective in reducing PTSD and depression (8,140,142–145). It was designed to address inaccessible cognitive beliefs generated by the trauma as well as rape-related fears. Compared to controls, women who received this intervention had a significantly greater reduction in symptoms 3 months following the training.

Prolonged Exposure Therapy

Prolonged exposure (PE) therapy is based on Foa and Kozak's emotional processing theory, in which memories of a traumatic event are encoded in pathological fear structures that, once formed, generalize to other situations (146). Physiologic arousal and avoidant responses are then evoked by harmless stimuli which, in turn, interfere with the ability to place the experience in perspective and recover from its traumatic effects. Prolonged exposure therapy involves education about PTSD, breath retraining, imaginal exposure (detailed recounting of the rape and its aftermath plus discussion of responses with opportunities to correct fear-related cognitions within a highly structured intensive treatment program), and in vivo exposure to safe but feared (and avoided) stimuli (repetitive descriptions of the traumatic event) (147). Its effectiveness has been examined in several studies applying PE to victims of rape who were suffering from PTSD immediately after an assault (63,139,148,149). Foa and colleagues compared the effectiveness of stress inoculation training (SIT) to the use of PE techniques and supportive counseling (150). They found that all three led to posttreatment improvement. Stress inoculation training was most effective in reducing fear, anxiety, and depression, but exposure was most effective for reducing PTSD at 3 months. In another 1999 study, Foa and colleagues compared PE, SIT, and combined PE/SIT. In this study, PE alone demonstrated superior results (139). Any contact with a therapist was found to reduce many forms of rape-induced distress, but active treatment seems to be necessary to prevent PTSD (119).

Eye Movement Desensitization Reprocessing

Eye movement desensitization reprocessing involves the deconditioning of anxiety through reactivation and reexposure to traumatic memories and the transformation of pervasive abuse-related beliefs about one's self and one's world into more adaptive cognitions (151). In EMDR treatment, exposure is under the control of the patient. This is designed to engender a sense of mastery in the face of the traumatic experience. Some studies have suggested unusually rapid therapeutic responses using three to four sessions of therapy to treat isolated trauma. Although a growing body of research supports the efficacy of EMDR (152–156), others have questioned these findings, citing studies that suggest that the eye movements do not contribute to the therapeutic effects (157,158). More recently, Rothbaum, Astin, and Marsteller compared

PE treatment to EMDR for sexual assault survivors with PTSD. Both treatments led to clinically and statistically significant improvements immediately following treatment; 95% of PE participants and 75% of EMDR participants no longer met the criteria for PTSD at the conclusion of treatment (138). The difference between the two treatment groups was not statistically significant. These gains were maintained at a 6-month follow-up, although PE participants reported better end-state functioning than EMDR participants. The authors of the study suggest that EMDR and PE are both exposure techniques that simply diverge in administration and instructions for work between sessions.

COGNITIVE BEHAVIORAL THERAPY SPECIFIC TO SURVIVORS OF INTIMATE PARTNER VIOLENCE

Only two studies have examined the efficacy of PTSD treatment for battered women. Johnson and Zlotnick conducted a small pilot study of CBT for women living in DV shelters (4). Although they did not have a control group for comparison, they found that the women who participated in treatment experienced significant decreases in PTSD and depression symptoms, as well as significant increases in the level of social functioning and effective use of resources. The most significant improvement occurred between women's stay at the shelter and 1 week after their departure, but gains were maintained up to 6 months later. Because of the small sample size and the lack of a control group, however, it is unclear whether these gains are due specifically to their participation in treatment or to advocacy services utilized during their shelter stay. Some gains could represent participants' successful use of shelter resources or reflect a natural course of PTSD for battered women.

Kubany and co-workers, in the only rigorously controlled treatment study specifically focused on survivors of IPV, also tested the efficacy of cognitive trauma therapy for PTSD (CTT-BW) (5). Their model, along with more standard modalities such as psychoeducation about PTSD, stress management, and exposure (talking about the trauma, homework), includedcomponents to address four unique areas of concern they had identified as salient to battered women. These included (a) trauma-related guilt that many survivors reported (guilt about failed marriage, effects on children, decisions to stay or leave); (b) histories of other traumatic experiences; (c) likelihood of ongoing stressful contact with the abuser in relation to parenting; and (d) the risk for subsequent revictimization. Modules were designed to address these concerns (assessing and reframing negative beliefs about the self and inaccurate cognitions that help to maintain trauma symptoms; assertiveness and self-advocacy skills training; and strategies for managing contact with former partners, particularly around custody and visitation, and strategies for identifying and avoiding potential perpetrators in the future).

Women were assigned to either immediate or delayed treatment groups. The researchers found that 87% of women who completed immediate treatment no longer met diagnostic criteria for PTSD at the final assessment at the conclusion of treatment, whereas PTSD and depression among women in the delayed treatment group did not diminish during the 6-week period prior to the start of their treatment. These improvements were maintained at 3- and 6-month follow-up assessments. Sixty-nine percent of participants no longer met the criteria for both PTSD and depression, which is comparable to the findings of Resick and colleagues (140). Of particular note, 85% of women who completed treatment no longer met the Diagnostic and Statistical Manual of Mental Health Disorders (*DSM-IV*) PTSD criterion for numbing/avoidance. This is significant because PTSD treatments have generally been less successful in eliminating this symptom constellation. The authors also reported that the treatment was effective in an ethnically and educationally diverse group of women, and worked equally well when delivered by clinically and non–clinically trained therapists.

To participate in the study, however, women had to have been out of an abusive relationship for at least 30 days, with no intention of reconciling, and to have not experienced physical or sexual abuse or stalking during that time. The mean time since last physical abuse among women in this study was 5 years. The authors note that this limited the study's generalizability to women who are still being abused by a partner, for whom interventions may need to focus more on increasing safety and accessing resources. They also note that for women who develop chronic PTSD, the symptoms, if untreated can persist for many years, even after they are safe.

In addition, several small studies have examined innovative strategies to reduce mental health symptoms and improve well-being among survivors of IPV. Koopman and colleagues conducted a small randomized controlled study assessing the impact of expressive writing (writing about traumatic experiences) compared to writing about a neutral topic on depression, pain, and PTSD (159). They found a reduction in symptoms of depression, although overall effects were not significant. In another study with a quasi-experimental design, music therapy plus progressive relaxation reduced anxiety and improved self-reported sleep quality (160).

In sum, only a handful of PTSD treatment studies are specific to survivors of IPV. The only randomized controlled trial was designed for women who were no longer in an abusive relationship. Cognitive trauma therapy for battered women however, was effective in treating IPV-related PTSD, reducing IPV-associated feelings of guilt, and addressing several key post-abuse issues. In addition, this model was developed and delivered in conjunction with advocates and survivors and did not require previous clinical training to administer. It demonstrates the potential for developing replicable treatment models that combine evidence-based techniques with interventions designed to address specific concerns of IPV survivors. Determining which, if any, elements of this approach would be helpful to survivors still involved with an abusive partner and/or survivors who have experienced abuse in childhood as well, would be useful next step.

EFFICACY OF CBT FOR SURVIVORS OF CHRONIC INTERPERSONAL TRAUMA: ISSUES AND CONTROVERSIES

Although CBT models appear to be effective in treating PTSD among selected survivors of adult-onset trauma, the use of prolonged exposure techniques has raised a number of concerns that are potentially relevant to survivors of IPV, including reports of negative effects (161,162) and lack of tolerability (163,164) among a subset of survivors, particularly those who have experienced childhood abuse. In addition, studies indicate that exposure therapy appears to be more appropriate for women who are physically safe, who do not have dissociative symptoms, and who are not primarily depressed (161,165). In one study, participants exhibited a poorer response if they felt defeated during a traumatic experience, alienated following the event, and had developed a sense that their lives would never be the same (166). For survivors of chronic childhood abuse who have not developed the internal capacity to modulate affect and arousal, symptoms may be exacerbated by exposure. The distress associated with confronting traumatic memories may make these modalities unacceptable to many survivors, particularly if they are still living in fear or, as Levitt and Cloitre note, if they have difficulty managing feelings of anger or anxiety or establishing a therapeutic relationship (166). In addition, research indicates that people with childhood exposure to interpersonal violence who experience symptoms of PTSD plus other conditions (such as bipolar disorder, suicidality, substance abuse, dissociation, or depression) often do not respond to conventional treatment for these conditions but are generally screened out of trials for PTSD treatment (162). As mentioned previously, randomized controlled studies assessing treatment for women who have been abused by an intimate partner, experienced the lasting effects of childhood abuse, and/or who have comorbid conditions, are still limited (58,82,92).

These issues have generated considerable controversy within the trauma field (164). In response to these concerns, Foa and colleagues investigated the impact of exposure on survivors with chronic PTSD (167). In this study, imaginal exposure did not exacerbate symptoms in the majority of participants and did not lead to treatment dropout. In addition, the minority whose symptoms were exacerbated by exposure still benefited from treatment. However, only 10% of the sample had histories of abuse in childhood, and women experiencing substance abuse, bipolar disorder or schizophrenia, or exposure to ongoing IPV were excluded. Assessment for complex trauma/DESNOS was not reported.

Another study that compared cognitive processing therapy (CPT) and PE therapies for victims of sexual assault did note that within the sample of rape survivors, 85% had experienced at least one other major crime victimization (140). Forty-eight percent had also experienced sexual abuse as a child. In this study, both CPT and PE were found to be successful in treating PTSD, but the authors report a slight advantage in effect sizes and functioning for CPT. Cognitive processing therapy was also better at addressing issues of guilt. In addition, CPT

incorporated cognitive processing designed to modify trauma-related beliefs and employed a less intensive version of trauma recall. The large majority of participants in the two treatment groups were no longer diagnosed with PTSD at the end of treatment, and their improvement was maintained at a 9-month follow-up. Although CPT had been generally conducted in the context of group therapy, this study demonstrated its efficacy in the context of individual therapy, as well.

Russell and Davis, after reviewing over 40 studies of PTSD treatment for rape survivors, claim that none of the criticisms of PE are supported by research data (145). These studies, however, still leave questions about which therapies are most effective for and amenable to survivors of other types of trauma. For example, the persistent danger and coercive control associated with current IPV also makes it difficult to engage in this type of treatment for obvious reasons: the inability to participate safely and consistently, the lack of emotional safety to access feelings while still under siege, and the challenges of treating PTSD via exposure modalities when the trauma is ongoing. Cognitive behavioral therapy appears to be effective in treating PTSD in survivors of various types of abuse, but is not applicable to all survivors, particularly those experiencing greater affect dysregulation or significant comorbidity, or who are still in danger.

Modifications to CBT to Address Controversies: Affect Dysregulation and Complex Trauma

Several researchers have attempted to address these concerns by modifying their treatment approach to include affect regulation and interpersonal skills training prior to introducing exposure techniques. Cloitre and colleagues investigated the efficacy of a modified CBT for PTSD related to child abuse (physical or sexual) (6). Their model, Skills Training in Affect and Interpersonal Regulation with Modified Prolonged Exposure (STAIR-MPE) consists of two eight-session phases: the first involves teaching skills to improve regulation of mood and emotions and the ability to tolerate distress; the second involves the attenuated exposure regimen. Participants showed significant improvement in three specifically targeted domains, including affect regulation, interpersonal skills, and PTSD symptoms. Gains were maintained, and some were enhanced, at the 3- and 9-month follow-up. The authors found that the development of a positive therapeutic alliance and the improvement in negative mood regulation were significant predictors of PTSD reduction.

In another study, McDonagh-Coyle and co-workers adapted an exposure-oriented CBT model originally developed for rape survivors to survivors of child sexual abuse (136). The treatment was more effective than the control condition and present-centered therapy in improving PTSD symptoms and self-dysregulation; gains were maintained at 6- and 12-month follow-ups. However, many participants dropped out of treatment (43%), and treatment outcomes for these participants were not assessed. In sum, these adaptations generally involve strategies that enhance a survivor's capacity to manage the level of arousal induced by imaginal exposure (i.e., cognitive information about trauma and PTSD, cognitive reframing of trauma-related beliefs, and interpersonal and affect regulation skills) followed by less intensive exposure. Both of these models were framed by the authors as treating chronic PTSD among survivors of interpersonal abuse (and in some instances, substance abuse, as well), rather than as treating complex trauma, per se.

In a review of treatment for complex trauma (complex posttraumatic dysregulation), Ford and associates view the hybrid models just described as part of a broader category of interpersonal self-regulation and affect regulation therapy models (IAT) (58). They suggest that, unlike CBT, these models teach specific skills for social problem-solving and affect regulation; may use current stressor experiences and more recent memories as vehicles for examining and dealing with interpersonal difficulties and problematic emotions; and emphasize therapeutic attachment as a vehicle for enhancing survivors' capacities for self-regulation.

As Ford and associates describe, many of protocol-based treatments for PTSD plus chronic affect dysregulation utilize a partial phase-oriented approach—one that focuses on skill development and the establishment of a positive therapeutic relationship as precursor to traumatic memory work, although they point out that little empirical guidance exists on how to determine when a survivor has developed sufficient self-regulatory capacity to move safely from phase I to II. They note that with careful preparation, these modalities can be both effective and safe for some survivors and provide empirical support for the consensus-based phase-oriented approach described next. They also note that some evidence indicates

that trauma recovery work may not be necessary to this process (168,169). Rather, these particular models focus more on helping survivors to understand the relationship between current distress and adaptations needed to survive previous trauma, develop new skills and capacities, and achieve a new sense of purpose and meaning.

Although research has not specifically addressed the efficacy of these approaches for survivors of IPV who have experienced other lifetime abuse, a number of studies have demonstrated promising results for a range of violence survivors experiencing complex trauma. Although some survivors respond to short-term interventions to reduce or eliminate symptoms, for others it may take a number of years and a variety of resources to recover from the traumatic effects of longstanding abuse. From an IAT perspective, safety includes stabilizing suicidality, impulsive, risky behavior, affect lability, dissociation, substance use, and dangerous relationships. It is unclear whether dangerous relationships are viewed as a symptom to be addressed rather than a situation over which a survivor may have little control. However, incorporating an understanding of the dynamics of IPV and attention to IPV safety concerns could extend the usefulness of these modalities for survivors of IPV.

OVERVIEW OF COMPLEX TRAUMA TREATMENT

As clinicians, researchers, and survivors came to recognize the distinct and often pervasive developmental impact of chronic abuse, more complex treatment models evolved. Although it appears that the majority of people who develop complex traumatic stress experienced chronic abuse or neglect in childhood, it is not clear what percentage of people who have experienced childhood abuse go on to develop its more serious sequelae (e.g., DESNOS/complex posttraumatic self-dysregulation/DID). Exposure to abuse in childhood does not necessarily lead to the development of complex trauma disorders. However, a complex trauma framework may be more useful in addressing the multiple domains affected by current and past abuse of various sorts.

These approaches combine emerging data on the neurobiology of trauma with developmental relational perspectives, CBT for managing overwhelming affect states, skill-building strategies to address developmental disruptions, and in some cases, a feminist emphasis on empowerment and social context. Some incorporate non–cognitively based modalities (e.g., meditation, dance, music, or body-centered therapies), as well. Some involve traumatic memory recovery work after preparation; others do not. All address safety as a priority, recognize that symptoms may be coping strategies, and stress the importance of the survivor–therapist relationship to the process of healing, particularly its role supporting personal and relational experiences that facilitate the reinstatement of disrupted developmental processes, including trust (27,170).

A key difference in approaches to complex trauma versus PTSD treatment is the emphasis on rebuilding, reinstating, and repairing aspects of development that were disrupted by early trauma and subsequent life trajectories, coming to terms with the impact of those experiences, and creating new meaning and purpose as one moves forward in life. Complex trauma models incorporate symptom-focused PTSD treatment as part of a larger array of interventions that help restore a survivor's sense of self, connections to others, and feelings about the world. They tend to view symptom management as a necessary precursor to deeper intra- and interpersonal work. Although designed specifically for survivors of childhood abuse and neglect, many of these domains can also be affected by severe chronic traumatization as an adult, such as torture and IPV (84).

Complex Trauma: Phase-Based Treatment Approach

The primary consensus-based approach to complex trauma treatment incorporates many of the aspects described above into a flexible three-phased model (safety and stability, trauma processing and recovery, reintegration and rebuilding) (26,58,171,172). This model again draws from a combination of evidence-based treatments targeted toward PTSD symptoms, attention to issues of ongoing safety, skill-building training to address capacities that have been derailed by early trauma, and emotional and cognitive reprocessing of feelings and thoughts associated with or stemming from traumatic experiences. This reprocessing includes nonverbal techniques to access experiences that were not verbally stored, all of which are embedded within a relational framework designed to heal the interpersonal bonds disrupted by abuse and

betrayal by a trusted caregiver (and/or person or system that should have been trustworthy). Part of the healing process involves fostering survivors' sense of mastery and control through the development of skills to regulate affect and manage symptoms. And, like the hybrid IAT models, the emphasis is on establishing safety and stability, building a collaborative therapeutic relationship and other supports, and developing a sense of self-efficacy before proceeding (in some versions) to trauma-focused work.

In more developed complex trauma models, however, building a working alliance when trustworthy relationships were never part of a survivor's experience may be critical focus of the initial work, and stabilization may be a longer process. Phase II work involves developing a more integrated and "emotionally modulated" autobiographical narrative and gradual reorientation to the present and future that is no longer dominated by the past (173). Phase III, not addressed in the IAT models, involves integrating new skills, capacities, and traumatic memories (being able to separate past from present) and rebuilding a meaningful, engaging life (no longer defined by trauma and its effects). Other shared components include psychoeducation to help survivors accurately label the abuse and reduce self-blame (i.e., to counter abusers' distortions about blame and responsibility) and destigmatize responses to trauma by recognizing symptoms as adaptations to psychically overwhelming situations.

These models are strength-based, viewing individuals as survivors rather than as victims and promote empowerment, therapeutic collaboration, and choice. They are also attentive to survivors' cultural and spiritual values. They are designed to support survivors' ability to function (i.e., do not promote regression) and to master rather than avoid the effects and/or actual memories of previous trauma (58). Final stages of treatment involve the integration of memories into a coherent narrative, the development of new capacities, reconnecting to others, developing a new sense of meaning and purpose, and rebuilding (14,174). This process is not linear but rather one in which work proceeds and is then revisited from more recent vantage points.

In sum, trauma is complex, individual responses are unique and social context makes a difference. Therefore, treatment needs to be flexible, multimodal, and individually tailored, as well as evidence-informed and, where possible, evidence-based.

Complex Trauma: Research-Based Treatment Models and Approaches

Given these caveats, the limited number of randomized controlled trials on treatment for complex trauma is not surprising. Establishing an evidence base for addressing trauma in the context of ongoing IPV raises a number of additional challenges. For example, a tension exists between the on-the-ground need for flexible, multidimensional survivor-driven models in addition to the fixed, manualized treatments that are easier to evaluate in randomized controlled trials. And, because the harm of interpersonal trauma occurs in the context of relationships, healing often takes place in the context of relationships, as well, which again is more difficult to quantify (e.g., restoring trust in oneself and others through the experience of a nonjudgmental, accepting therapeutic relationship or peer support). In addition, treatment in the context of IPV needs to address realities that often are not under survivor's control. Finally, addressing parenting and attachment issues adds further layers of complexity to incorporate into research designs. Thus, while numerous evidence-based "techniques" are available for treating PTSD, they are generally geared toward addressing specific sets of symptoms, rather than healing from the interpersonal and developmental effects of abuse and violence—a process that, as noted earlier, may require the safety, consistency, caring, and respect of ongoing healing relationships; the development of internal capacities and external supports, including restoring a sense of community; and, in the context of ongoing IPV, access to safety and resources (26,58). The models discussed next, however, are beginning to demonstrate efficacy in combining these core elements in a variety of different configurations.

For example, given the efficacy of evidence-based treatments for acute and chronic PTSD, clinicians have begun to combine pertinent elements into more individually tailored treatment regimes. Many of the techniques utilized in treatment for PTSD have also been incorporated into multidimensional treatment programs designed specifically for women with severe trauma histories and complex PTSD, serious mental illness, and/or substance abuse (8–10,85,169,170,175–181). Several also involve a deeper level work in integrating trauma memories, grieving losses, and establishing a new sense of self and/or meaning (26,27,182). Some are now evidence-based, some have proven

efficacy in open trials, and others are more general approaches to this work.

Several of these models, when combined with IPV-specific interventions, may be particularly applicable to survivors of IPV who have experienced multiple forms of trauma beginning in childhood. For example, the trauma recovery empowerment model (TREM) is a 33-week psycho-educational outpatient group intervention designed to assist women in recovering from long-term effects of childhood abuse. It addresses many of the domains that can be affected by early trauma, including intrapersonal skills (e.g., self-knowledge, self-soothing, self-esteem, self-trust) and interpersonal skills (e.g., self-expression, social perception and accurate labeling, self-protection, self-assertion, relational mutuality), as well as more global skills (e.g., identity formation, initiative taking, problem solving). In addition to skill development, it also focuses on countering feelings of powerlessness and rebuilding connections to oneself and others that were lost in the face of trauma. It also helps women develop the sense of self, skills, and supports needed to prevent future victimization. The TREM was evaluated as part of the SAMHSA Women, Violence and Co-Occurring Disorders Study (quasi-experimental design), which involved integrated mental health, trauma, and substance abuse treatment within a comprehensive array of trauma-informed services (including individual therapy, case management, psychiatric care, supported housing, and peer support). It was one of several treatment modalities that demonstrated modest efficacy compared to controls. Although not specifically reported, for many of the women in this study, although not exposed at the time, IPV was one aspect of the long continuum of trauma they had experienced over the course of their lives.

Trauma recovery and skill-building interventions are also successful for women diagnosed with more severe mental illness, but require increased supports and slower pacing. Again, for a survivor of IPV who is also experiencing a psychiatric disability, these treatments could be adapted to address both safety and trauma symptoms. Mueser and Rosenberg developed a PTSD treatment model designed specifically for survivors experiencing a serious mental illness (183). Their initial model involved brief cognitive-behavioral intervention (psychoeducation followed by modified exposure) designed for people diagnosed with schizophrenia. It focused more narrowly on treating symptoms of PTSD. More recently, they report on a 21-week mixed-group intervention model for addressing PTSD among people with severe mental illness that was piloted at a community mental health center with promising results (137). The Trauma Recovery Group is a CBT intervention comprised of breath retraining, psychoeducation about PTSD, cognitive restructuring, learning to cope with symptoms, and making a recovery plan. In their pre-/post design, participants who completed the program (59% retention rate) had significant improvement in PTSD symptoms, depression, and trauma-related cognitions compared to people who dropped out. Their rationale for using cognitive restructuring rather than PE was based, in part, on the body of positive experience using CBT to treat other symptoms among people who have mental illness, which is not the case for PE. In addition, people who have a mental illness appear to have greater sensitivity to stress, which PE treatment can increase. Again, the authors note that this type of treatment is best embedded within a more comprehensive array of treatment and supports (e.g., meds, case management, and other supports). For example, a survivor may have many other concerns and needs (comorbid symptoms, substance use, issues of managing daily living, medication-related concerns, and the need for skill development in a variety of domains). For survivors of IPV, safety concerns and abusers' use of mental health issues as tactics of control also become priorities. What this and other research point to is the need to recognize both the strengths of evidence-based PTSD treatment models, particularly symptom reduction and prevention of PTSD, as well as their limitations, for someone experiencing affect dysregulation and/or other disruptive mental health symptoms.

Other complex trauma treatment models and approaches that could be adapted for working with survivors of IPV include Trauma Adaptive Recovery Group Education and Therapy (TARGET), the Sanctuary model, and risking connection, among others (27,176,182). TARGET is also designed to address complex trauma among people with serious mental illness; it is a strengths-based model, teaching a set of practical skills to enable participants to gain control of PTSD symptoms. The Sanctuary model, a residential trauma treatment model for creating healing environments, is designed to address the long-term sequelae of chronic abuse (182). It was initially developed for use on inpatient psychiatric units but has been applied in DV shelters and residential treatment programs

for children and adolescents. It is a four-stage model (SAGE) addressing *S*afety, developing *A*ffect regulation skills, processing *G*rief, and supporting *E*mancipation (freedom from the effects of trauma, developing new capacities and meaningful connections, and reinvesting in life). The Risking Connection curriculum is an individual complex trauma treatment approach developed for use in the public mental health systems in Maine and New York; it addresses both provider and survivor issues, particularly transference, countertransference, and vicarious trauma. It too emphasizes the importance of a collaborative therapeutic relationship that provides information; fosters respect, connection, and hope; and supports the development of new self-capacities. Several of these models have been tested through the SAMHSA Women, Violence and Co-Occurring Disorders Study (TREM, Seeking Safety) and have demonstrated efficacy as part of a broader array of trauma-informed mental health and substance abuse services (10,34,184,185). None of these models specifically address IPV. More research is needed to determine if and how they can best be used in conjunction with IPV-specific interventions when safety and coercion are still a concern.

There are several additional studies of promising and/or evidence-based group treatment modalities for survivors of childhood abuse (91,186–190), as well as evidence-based interventions designed specifically for managing the symptoms and self-harming behavior of women with complex trauma who have been diagnosed with borderline personality disorder, a high percentage of whom have experienced abuse in childhood (7,191). Although many initial reports were descriptive in nature, featured nonstandardized approaches to care, and/or demonstrated relatively modest positive results, recent studies (e.g., trauma-focused group therapy) have been more rigorously designed but need to be specifically evaluated to assess their applicability for survivors of IPV who have also experienced childhood abuse (188,192).

Complex Trauma Treatment in the Context of Intimate Partner Violence

Thus, despite the emergence of the models for treating complex traumatic stress, little research has addressed complex trauma in the context of ongoing IPV, where legal, safety, and custody issues abound. And, although each of these models has moved forward our understanding of what is and is not helpful in healing the long-term effects of childhood trauma, none attend to the social context in which IPV takes place, nor do they address the social conditions in which violence and inequality are condoned and supported (18,193). They do, however, provide a treatment framework that could be adapted for survivors of ongoing IPV. And, because complex trauma treatment models stem from work with survivors of gender-based violence (childhood sexual abuse, sexual assault, IPV), they can be offered in ways that incorporate feminist and advocacy perspectives. For example, feminist approaches explicitly address the role of power dynamics, both within a woman's life and within therapeutic encounters, that has been a concern of advocates and survivors. Mental health peer support recovery models promote collaboration and power sharing between consumers and providers, as well (22). In addition, DV advocacy models attend to the social reality of ongoing danger and entrapment and the impact of social institutions, culture, and communities on a survivor's ability to change her or his life. Again, although flexible survivor-centered treatment approaches are more difficult to study than shorter-term protocol-based models, they nonetheless reflect current consensus in this area.

Although the issues that are unique to IPV were described earlier, many survivors have experienced multiple forms of abuse and are dealing with both past and current trauma—trauma that may affect their ability to deal with the ongoing abuse in their lives. In addition, many of the aspects of interpersonal trauma that survivors of IPV report are better addressed by complex trauma models (e.g., betrayal of trust; feelings about oneself, other people, and the world; feelings of shame, guilt, grief, loss, fear, hurt, anger, sadness, emptiness, despair, confusion, etc.).

Regardless of type of trauma, the first priority of treatment is establishing safety, no matter where the threat originates. In the context of ongoing IPV, this means attending to safety from an abusive partner. If a survivor is also experiencing trauma- or mental health-related symptoms, those also need to be addressed, both in terms of how they affect a survivor's ability to be safe from an abusive partner and how they affect a survivor's ability to be safe from potentially dangerous coping strategies and/or symptoms.

Treatment also involves establishing a collaborative working alliance. If a woman is a survivor of childhood abuse and has had no safe, nurturing attachment relationships in her life, then establishing trust can be much more challenging for her and becomes a

central aspect of early work. This phase of treatment may also focus on supporting a survivor in dealing with the many practical issues that arise in establishing safety and economic stability and parenting children who have also been affected by IPV, legal, and custody issues, as well as the myriad of other concerns she is facing, including immigration and potential loss of her community. It also involves providing information and access to resources, creating a safe place for survivors to think clearly and evaluate their situations and options.

At the same time, therapy may include working to decrease fear and isolation, assisting with symptom management and skill acquisition, helping survivors to assess and reformulate any abuse-related perceptions of themselves while making and trusting their own decisions, identifying and building on strengths, establishing networks of support, and working in collaboration with community DV programs. Later phases may involve the processing of traumatic memories and abuse-related feelings and integrating them into the next stage of a survivor's life. Expert clinicians note a number of issues that may emerge during this time, including feelings of anger, fear, betrayal, sadness, and loss, as well as concerns about safety, intimacy, and trust (14,17). Although phase-based models for complex trauma view trauma memory processing as part of phase II with reintegration and rebuilding as the third phase, for survivors of IPV, establishing a safe, secure life may need to occur before it is possible to process the full impact and meaning of their experiences. For others, some of this work may be an important precursor to other steps they will take to create lives that are both safe from abuse and no longer haunted previous trauma.

In summary, the mental health effects of IPV vary widely. Some resolve with safety and support; others require longer-term treatment. A range of modalities may be applicable to victims of IPV. Evidence-based PTSD treatment for single-event trauma includes CBT and medication. Hybrid treatments for chronic PTSD and/or adult survivors of child abuse incorporate affect and interpersonal skill-building techniques prior to trauma memory processing. Complex trauma treatments are comprehensive and phase-based models that incorporate evidence-based affect regulation, skill-building techniques, and traumatic memory work into individualized treatment approaches. Treatment for survivors of IPV includes IPV-specific care, care of acute symptoms, and longer-term trauma recovery. Treatment must also attend to a range of psychological sequelae related to IPV, as well as to ongoing stressors due to stalking, harassment, or prolonged legal battles. Working with community DV advocacy programs to provide concrete and emotional support is vital. From a phase-based perspective, clinical work with survivors who remain in danger should focus on issues of safety, stability, and support, saving trauma recovery work for when it is safe to do so. Research is needed to determine which modalities are most appropriate to individual survivors and which are most helpful to survivors who are experiencing ongoing abuse and violence.

PHARMACOLOGICAL TREATMENT

In their initial work on the healthcare system response to IPV, Stark, Flitcraft, and Frazier found that battered women were more likely to be prescribed psychotropic medication than nonbattered women, even when the abuse went unrecognized (194). Intimate partner violence survivors have also voiced concerns about medications not being paired with attention to abuse-specific issues, including the emotional effects of abuse, abusers' use of medication to undermine and control their partners, safety concerns, and access to resources (116). Although research in this area is limited, a number of issues must be considered when prescribing psychotropic medication in the context of ongoing IPV. They involve (a) the ways in which an abuser is likely to respond to the partner's use of medication, and, more specifically, the potential for an abuser to use medication to control or undermine the partner; (b) the direct effects of an abuser's behavior on the development and exacerbation of symptoms (e.g., being kept from sleeping or maintaining adequate hydration, etc.); (c) the importance of enhancing a survivor's sense of options and choice; (d) the interaction between the effects of current abuse with previous trauma and other mental health symptoms; and (e) the likelihood that a given medication will improve symptoms and enhance safety.

For example, medication should be offered in ways that enhance a survivor's sense of control over her life, ideally in the context of treatment that attends to both IPV and trauma-specific concerns. This can be done by discussing the pros, cons, and possible impact of taking medication and making certain survivors know that deciding whether or not to take psychotropic medication is a choice. It is also

important to work with survivors to try to ensure that they will not be defined or controlled by their use of medication. For example, an abuser may use his partner's prescription for psychotropic medication as evidence that she is "crazy" and/or incapable of caring for their children. Discussing these issues directly can help a woman counter those perceptions and reduce an abusive partner's ability to define her reality. A batterer may also control her partner's access to medication (e.g., withholding medication), or coerce her partner to overdose or to ingest food or medication that is contraindicated. These issues should be addressed as part of safety planning and also factored into medication choice as it pertains to potential toxicity.

In addition, care should be taken so that medication does not lower the vigilance that may be important to a survivor's safety. Sedation, cognitive impairment, and reduced alertness can all impinge on previously honed mechanisms a survivor has used to keep herself safe in the past. Again, these issues need to be taken into account when making medication decisions, in conjunction with considerations about drug interactions and side effects. If a survivor is not able to make decisions for herself at a given point in time, then having discussed these issues in advance (whether or not there is a formal advance directive or other type of plan in place) will help inform clinical decisions and increase the likelihood that they will be consistent with her wishes and not controlled by her partner. At the same time, reducing symptoms while minimizing risks can clearly be of help to a survivor in his efforts to access safety and regain control over his life.

Although initial research on the mental health effects of IPV focused on depression and anxiety, more recent studies have focused on PTSD and/or commonly accompanying comorbidities, most notably depression and anxiety disorders and, to a lesser extent, suicidality and substance abuse. Survivors of IPV may experience a range of mental health symptoms consequent to the abuse. In addition to the issues noted earlier, attention to trauma-related symptoms and concerns may provide the most useful overall approach to psychopharmacologic treatment in the context of IPV. Since virtually no research specifically addresses the use of psychotropic medication in the context of ongoing IPV or for treating complex trauma, this section will draw from research on pharmacotherapy for PTSD and for depression plus PTSD and/or childhood abuse.

Pharmacological Treatment for Posttraumatic Stress Disorder: Conceptual Issues

A number of studies have found significant comorbidity between depression and PTSD, in general and among survivors of IPV (195,196). Trauma exposure appears to be a risk factor for major depression as well as for PTSD (197,198). Each may constitute a risk for the other or, alternatively, may reflect a shared vulnerability (195,199). More significantly, several studies have found differential responses to treatment for depression among women experiencing comorbid PTSD (195) and/or childhood abuse (85,88), causing researchers to speculate that early life stress (childhood trauma) may set processes in motion (e.g., alterations in the hypothalamic-pituitary-adrenal [HPA] axis) that lead to a neurobiologically different subtype of depression—one for which psychotherapy may be more effective than medication (88).

In contrast, the study by Green and colleagues found that women with depression plus comorbid PTSD are more likely to have experienced assaults in childhood and/or as adults (including IPV), and to be more symptomatic at the outset and end of treatment than women without PTSD. Both groups, however, had a significantly better response to treatment (medication [paroxetine] or CBT) than did controls (195). These findings, albeit in different ways, are consistent with research supporting the construct of complex trauma/DESNOS as a "better fit" diagnosis than the notion of PTSD plus comorbidities. Green and colleagues hypothesized that the comparable response to CBT among women with depression plus PTSD was due, in part, to the fact that their depression-focused CBT had an additional trauma component. In other words the "comorbidities" that develop in the context of interpersonal trauma appear to be part of a larger constellation of trauma symptoms that may be neurobiologically distinct from their nontrauma-associated counterparts. They also appear to respond differently to treatment (i.e., are more challenging to treat and do not respond as well when trauma is not specifically addressed). Although work in this area is still preliminary, it does begin to provide both a theoretical and research basis for examining how trauma affects the development and treatment of a range of psychiatric conditions.

Research has yet to tease out the respective impact of early life stress versus chronic interpersonal trauma

that occurs later in life on neural circuitry and subsequent mood and anxiety disorders, nor has it delineated what the implications might be for pharmacological (or other) treatment. Developing an evidence-base in this area has been challenging because people experiencing ongoing trauma (such as IPV), as well as individuals with comorbid conditions, are often excluded from clinical trials (92,162,172). And, trauma is not often factored into treatment studies for other co-occurring conditions. This raises questions about the efficacy of pharmacological (and other) treatment for people experiencing complex trauma. Spinnazola suggests the need for broadening inclusion criteria to ensure representation of people experiencing diverse types of trauma and multiple comorbidities, as well as providing detailed reporting on exclusion criteria, study declension, and attrition. Studies on treatment efficacy for individuals who are still in danger from an abusive partner, although critical, will be more difficult to devise and will have to factor in (i.e., assess for and report) abuser-related factors noted earlier, as well.

Although no psychopharmacology is specific to survivors of abuse, medication targeted toward symptoms of PTSD has demonstrated some efficacy in the reduction of core PTSD symptoms of intrusiveness, avoidance, psychic numbing, and hyperarousal; reduction of associated disability and vulnerability to stress; treatment of comorbid symptoms (e.g., depression, anxiety, panic, etc.); reduction of psychotic or dissociative symptoms; improved impulse control; and reduction of self-harming behaviors (200). The treatment recommendations that follow, however, are based on a limited number of randomized clinical trials for PTSD conducted with combat veterans and/or a variety of civilian samples, as well as promising open-label trials for drugs that have not yet moved to the randomized clinical trial stage. Medication studies for the most part have not specifically targeted complex trauma/DESNOS, and only one (pharmaceutical industry-sponsored study) has focused explicitly on survivors of IPV (201). Despite the dearth of controlled trial research, clinicians have been able to draw on the treatment literature for associated disorders (depression, anxiety, panic, bipolar disorder, psychotic disorders) and the ongoing treatment experience of national trauma centers. Few studies have examined response differences for victims of single versus multiple traumas, acute versus chronic PTSD (202), or childhood versus adult-onset trauma, and few specifically examine gender differences in treatment response (203).

Current options for treatment include antidepressants, mood stabilizers, atypical antipsychotics, α-adrenergic inhibitors and, to a lesser extent, anxiolytics. Early PTSD studies mainly focused on the use of tricyclic antidepressants (TCAs) and monoamine oxidase inhibitors (MAOIs) (204,205). Data emerging from double-blind, placebo-controlled clinical trials, however, support the use of selective serotonin reuptake inhibitor (SSRI) antidepressants (paroxetine, sertraline, fluoxetine) as first-line treatment for PTSD. In many, but not all studies, SSRIs have demonstrated greater efficacy for women exposed to civilian trauma than for predominantly male combat veterans (206,207). In some studies, both TCAs and SSRIs were found to be useful for patients with depression plus PTSD, but SSRIs were associated with better outcomes than agents primarily affecting norepinephrine reuptake (208). However, some TCAs (imipramine, amitriptyline), MAOIs (phenelzine, moclobemide), and novel agents (mirtazapine) have demonstrated efficacy in reducing PTSD symptoms (209).

In a meta-analytic review of randomized controlled medication trials for PTSD, antipsychotic medications (olanzapine, risperidone), the anticonvulsant lamotrigine, and the MAOI brofamine did not show demonstrable treatment efficacy, nor did alprazolam, inositol, desipramine, and phenelzine, although they did in open label studies. These results may be due to small sample sizes and short durations of treatment, or, in the case of desipramine, noradrenergic stimulation (210). Although heightened anxiety is characteristic of PTSD, benzodiazepines have not proven useful in controlled trials, and may be associated with rebound anxiety when discontinued. Use of benzodiazepines in the immediate aftermath of trauma is still controversial. In one small placebo-controlled study, subjects given a benzodiazepine (clonazepam or alprazolam) 1 week post-trauma were more likely to develop PTSD than those who had received placebo (211). However, they have received cautious recommendation in some consensus reviews (150,210,212).

In addition, several recent studies have examined the hypothesis that β-blockers and corticosteroids may be useful in preventing the consolidation of traumatic memories if administered shortly after the trauma occurs (PTSD prophylaxis) (213–215), although these findings have not been consistently replicated (210). Despite advances over the past 10 years, less than 60%

of people with chronic PTSD respond to medications, although women who have experienced interpersonal trauma appear to be more medication-responsive than male combat veterans. This points to the need for combining pharmacotherapy with psychotherapy, as well as the need for longitudinal, larger scale, and more nuanced research. The next section describes the more robust research in this area.

Antidepressants: A Focus on Selective Serotonin Reuptake Inhibitors

Antidepressants have been the most well-studied medications for PTSD and have the greatest empirical support, with SSRIs making up the majority of large randomized clinical trials. They have demonstrated efficacy in reducing all three PTSD symptom clusters and increasing the number of treatment responders, based on cut-off scores on the Clinician Administered PTSD Scale (CAPS). They are also effective in treating comorbid depression and improving quality of life, as well as treating other commonly co-occurring conditions (e.g., anxiety disorders). Although other antidepressants, such as TCAs, MAOIs, and novel agents like mirtazapine have also showed some efficacy, those findings appear to be less robust, and TCAs have been mainly studied among veterans with chronic, severe PTSD, whereas SSRI trials have included civilians as well (210,216,217).

Posttraumatic stress disorder affects a number of neuroendocrine and neurotransmitter systems, including serotonin pathways, which appear to have a modulating effect on the processing of external stimuli and on noradrenergic activity through their connections to the locus ceruleus (216,218). The SSRIs have been effective in reducing PTSD symptoms in open-label and double-blind randomized controlled trials (219–224). Many of these studies have included women with longstanding PTSD secondary to childhood abuse, rape, or physical assault (225). One randomized double-blind, placebo-controlled study comparing fluoxetine, EMDR, and placebo found EMDR to be superior to fluoxetine in reducing symptoms of PTSD and depression at 6 months, but more so for people who had experienced trauma as adults (75% remission) versus as children (33% remission). Overall, neither treatment led to complete symptom remission for survivors of childhood trauma (226).

Sertraline and paroxetine have shown efficacy in both open and randomized controlled trials, as well (219,220,223,224,227). In one small (n = 5), open, 12-week clinical trial, Rothbaum and co-workers found that sertraline significantly reduced PTSD among women who had been raped (228). Two randomized placebo-controlled trials have confirmed these results (219,220). In both studies, over 70% of the participants were women, medication was well-tolerated, and treatment response was significantly better for the sertraline group than for controls. In the first study, sertraline was more effective at reducing symptoms of increased arousal and avoidance/numbing than intrusive reexperiencing. A reanalysis of data from these two studies found sertraline to be more effective than placebo for people who had experienced child abuse or interpersonal (versus non-interpersonal) trauma (207). Effect sizes, although significant, were also modest (216). One randomized controlled double-blinded study of a predominantly male population with combat-related PTSD conducted at an outpatient VA clinic did not find sertraline to be more effective than placebo in treating PTSD (229). Two randomized controlled trials of paroxetine (12-week, fixed-dose studies with predominantly female participants) also found significant reductions in all three symptom clusters for those taking the drug versus placebo (223,227). In these studies, results did not differ by gender (230).

In the Stein and colleagues' meta-analytic review, 12 SSRI randomized clinical trials demonstrated significant reductions in symptom severity on all three subscales of the CAPS for both paroxetine and (to a slightly lesser extent), sertraline (210). The authors postulated that the lack of demonstrable treatment effects for venlafaxine, fluoxetine, and citalopram was due to small sample size and insufficient power in their analysis. In their numbers needed to treat (NNT) analysis, compared to placebo, the likelihood of becoming a treatment responder was 23%, 22%, and 16.5%, respectively, for paroxetine, sertraline, and fluoxetine. A randomized controlled study of extended-release venlafaxine found it superior to placebo in reducing reexperiencing and avoidance/numbing, but not hyperarousal cluster scores on the CAPS (231). It was also superior to placebo on measures of depression, quality of life, functioning, and global illness severity.

The SSRIs, unlike other drugs that have been studied for this disorder, seem to address both the psychic numbing associated with PTSD and comorbid depression (232,233). They may also provide additional efficacy for reducing alcohol consumption, as well as

a range of possible serotonergically mediated symptoms associated with PTSD such as rage, impulsivity, suicidal intent, depression, panic, and obsessional thinking (232,234). On the other hand, SSRIs have been less effective than MAOIs and TCAs in treating comorbid anxiety (210).

Longer-term Selective Serotonin Reuptake Inhibitor Treatment Studies

Although initial randomized controlled trials were designed to assess short-term treatment responses (12 weeks), several additional studies have examined longer-term treatment effects examining two primary questions: (a) Do response rates improve with longer-term treatment, and (b) does longer term treatment prevent relapse? Two open-label 24-week extensions to 12-week randomized clinical studies found continued improvement in CAPS scores for paroxetine and sertraline, as well as ongoing improvement in depression and quality of life for sertraline during the extension phase (220,235,236). In addition, two double-blind placebo-controlled extension studies found increased relapse rates for subjects who were switched to placebo from fluoxetine and sertraline (220,237). The majority of subjects in the sertraline study were women who had experienced physical or sexual assault. Subjects in the paroxetine study (urban adults, the majority of whom were Latinas who had experienced a range of interpersonal trauma) also had significant reductions in dissociative symptoms and self-reported interpersonal problems. In another 9-month open-label paroxetine study, in which the predominant type of trauma was childhood sexual abuse (9 men and 14 women), in addition to improvement in CAPS scores, subjects also demonstrated improvement in verbal declarative memory and increases in hippocampal volume, although these findings did not correlate with PTSD symptomatology or with each other. They do lend support to the hypothesis that SSRIs may increase neurogenesis in the hippocampus (238).

These findings highlight several important points. First, many survivors, particularly those with more severe symptoms, may take longer to respond than the time allotted for standard short-term (12 weeks) treatment trials or the 3–4 weeks generally thought of as the time needed for SSRIs to work. Second, in these studies, the majority of participants who did not respond during the acute treatment phase did become treatment responders during the 24-week extension, and approximately a third of the treatment response occurred during this period. It was not entirely clear what portion of this response was due to natural course or other benefits that accrue from participation in a clinical trial. In addition, one study reported drop-out rates of close to 40% (239). The role of IPV (i.e., abuser control) in study declension or attrition, to our knowledge, has not been specifically addressed. Nonetheless, these findings highlight the importance of a therapeutic relationship in helping to sustain treatment when responses are delayed and is consistent with research demonstrating superior results with nonpharmacological and/or combined pharmacological and nonpharmacological treatment modalities. Because none of these studies specifically addressed issues of ongoing violence, there is no way to know what role an abuser's behavior and or safety interventions may have played in a survivor's response to treatment.

Other Psychopharmacological Treatments for Posttraumatic Stress Disorder: A Theory-Driven Approach

A number of theory-driven approaches to psychopharmacological treatment of PTSD have yet to demonstrate efficacy in randomized controlled trials (e.g., anticonvulsants, adrenergic-inhibiting agents benzodiazepines, antipsychotics, and cortisol). However, a brief discussion of current thinking in this area may be helpful in guiding treatment choices when initial modalities are not successful, as well as illuminating future research.

Kindling and Anticonvulsants

Kindling (lowering of the excitability threshold after repeated electrical stimulation, leading to oversensitization of the limbic system, manifesting in physiologic hyperarousal) has been posited as one theoretical model for the development of PTSD. Kindling and sensitization have also been viewed as a possible mechanism for the repeated activation of fear memories leading to flashbacks and intrusive reexperiencing and therefore may be useful in preventing the development of sensitization of these pathways in the aftermath of trauma (216). This has led to several trials of anticonvulsants, which have demonstrated some beneficial effects in people with chronic PTSD, although their efficacy is yet to be fully demonstrated in randomized controlled trials (240,241).

Dysregulation and Adrenergic Inhibition

Dysregulation of adrenergic and noradrenergic systems and their mediating effects on cortisol production is thought to be a core component of PTSD and has been implicated in the over-consolidation of traumatic memories, and subsequent intrusive reexperiencing and hyperarousal. Theoretically, α_2-blockade of presynaptic norepinephrine release or β-blockade of postsynaptic norepinephrine receptors would reduce cortisol-enhanced memory consolidation and fear conditioning and could potentially prevent or reduce these effects, although results from clinical trials have been mixed (242).

γ-Aminobutyric Acid/Glutamine Dysregulation and Benzodiazepines

Because benzodiazepines potentiate the inhibitory effects of γ-aminobutyric acid (GABA) receptors that are found throughout the brain and appear to counter excitatory glutaminergic transmission and modulate the increased arousal associated with PTSD, theoretically they should be useful treatment modalities for PTSD. However, recommendations for the use of benzodiazepines for acute and chronic PTSD remain unclear, and studies have yielded mixed results, as well. Benzodiazepines appear to reduce anxiety, arousal, irritability, and insomnia in people with PTSD and in a small number of those with dissociative identity disorder. They have not been found to be effective for intrusive symptoms or for avoidance and numbing.

Endogenous Opioid Dysregulation and Narcotic Antagonists

The use of narcotic antagonists, studied because they should theoretically reduce endogenous opioid-induced numbing, has also met with mixed results, showing improvement in some studies and worsening in others (243).

Dopaminergic, Serotonergic and α-Adrenergic Pathways, and Antipsychotics

The rationale for using antipsychotic medication was the similarity between flashbacks and the visual and auditory hallucinations seen in schizophrenia, as well as their potential action on dopaminergic, serotonergic, and α-adrenergic pathways (239,244). Current thinking is that these agents may be of benefit for people who have chronic PTSD that is more treatment-resistant and/or for treating concomitant psychotic symptoms, but larger randomized clinical trial research is needed to determine their efficacy (216,245,246). The potential for developing metabolic syndrome also makes these medications a less desirable option unless psychotic symptoms are part of the clinical picture.

Hypothalamic-Pituitary-Adrenal Axis and Cortisol

Several preliminary studies report theory-driven efforts to prevent the development of PTSD through medications that might prevent the consolidation of fear-based memories and chronic hyperarousal. One set of studies is based on the role of cortisol in the retrieval and consolidation of traumatic memories (elevated cortisol inhibits memory retrieval in animals and healthy humans). These were conducted with small samples of patients who had chronic PTSD, were experiencing septic shock, and/or were undergoing cardiac surgery (213,215,245,247–249). Results in the prevention of the consolidation of traumatic memories were mixed. Although these preliminary findings are of interest, more research is needed before this strategy can be recommended.

Pharmacological Management of Posttraumatic Stress Disorder with Comorbid Conditions

Although a complex trauma framework may be more useful for understanding the psychological effects of chronic interpersonal trauma, medication trials generally focus on single disorders and few have specifically addressed comorbidity in the context of PTSD treatment. Given the high rates of comorbidity associated with PTSD (most notably affective disorders, anxiety disorders, and substance abuse), as well as treatment for PTSD in the context of other psychiatric conditions (e.g., bipolar disorder, schizophrenia), choice of medication needs to be tailored to address co-occurring conditions as well. For example, SSRIs can be used to effectively treat both PTSD and major depression, although responses appear to be less robust when they co-occur (216,223). Sertraline and paroxetine have also demonstrated effectiveness, compared to placebo,

in comorbid anxiety and sleep disturbances (250,251). Associated insomnia can also be treated with low-dose trazodone at bedtime or prazosin for nightmares, and acute or persistent agitation with clonidine or small regular doses of a benzodiazepine such as clonazepam. Mood stabilizers can also be used to treat agitation or co-occurring bipolar disorder, as can atypical antipsychotics, which can also be used to treat psychotic symptoms or disorders. For acute trauma, reduction of autonomic arousal with propranolol or corticosteroids might theoretically prevent the development of chronic PTSD, although replication studies have not yet borne this out. Schoenfeld and colleagues present a useful set of recommendations for pharmacological treatment of comorbid conditions in the presence of PTSD (216). However, expert consensus guidelines recommend a combination of psychotherapy and pharmacotherapy under these circumstances (150).

Gender Differences in Treatment Response

Seedat and colleagues provide a summary of research on gender differences in treatment response to for depression and PTSD (225). Several studies have found SSRIs, MAOIs, and to a lesser extent selective norepinephrine reuptake inhibitors (SNRIs) to be more effective for women than men, while finding the opposite true for TCAs (252–255). Other studies of SSRIs, TCAs, and MAOIs failed to demonstrate any gender effects (256–258). Hamilton and Jensvold were among the first to point out that fluctuations in hormone levels can alter antidepressant pharmacokinetics and pharmacodynamics, potentially necessitating dosage alterations (259). Estrogen may also influence responses of the key neurotransmitter systems involved in PTSD, including serotonin receptors (260). Seedat and colleagues also point out that other gender-related metabolic factors may affect SSRI metabolism through the cytochrome P450 system (256). Although the research is not sufficiently developed to provide clear guidelines in this area, it is important to keep in mind in tailoring medication for individual women. Again, most important for women experiencing ongoing IPV, is to be sure that medication does not undermine the need to remain vigilant when safety is at stake. Even medications that are not overtly sedating (e.g., paroxetine, sertraline, venlafaxine) can cause people to feel like they've "lost their edge." Sometimes this is desirable. Other times it is not.

Summary of Pharmacologic Therapy for Posttraumatic Stress Disorder

In summary, SSRIs appear to be the most effective medications for post-assault or abuse-related PTSD among civilian trauma survivors and have the most favorable side-effect profile. Sertraline and paroxetine are the only two medications approved by the U.S. Food and Drug Administration (FDA) for treatment of PTSD, although fluoxetine has shown some efficacy as well. The SNRIs also show promise in this area but have not been well-studied. Full treatment response may take up to 9 months or longer, and longer-term treatment appears to prevent relapse. Additional medications should be targeted toward specific unresponsive symptom constellations or comorbidities. Potential gender-related drug level alterations need to be taken into account. However, there is a limited evidence-base in this area and further study is needed. Differences in response to medication by type and duration of trauma, gender, race, culture, ethnicity, and age, as well as specific abuser behaviors also need to be taken into account. Attending to safety issues is a critical factor in recommending a course of medication and evaluating drug response.

SUBSTANCE ABUSE AND TRAUMA TREATMENT IN THE CONTEXT OF INTIMATE PARTNER VIOLENCE

Achieving sobriety may be difficult if underlying issues of abuse are not addressed, whether they are related to ongoing coercion and danger, in which a survivor's use of drugs or alcohol and her efforts to stop, may be controlled by an abusive partner, or to feelings associated with current or previous trauma. Understanding the role of trauma and abuse in initiating and sustaining a woman's use of substances, as well as the role substance use plays in a survivor's life, are important to developing a treatment plan that is tailored to her needs. In addition, not all substance abuse is associated with experiences of abuse or other trauma. Initial use may relate more to the availability and social acceptance of drugs or alcohol in one's family, neighborhood, or peer group. Using, however, places women at increased risk for being abused. Many authors view these as two separate but frequently interconnected phenomena that require individualized treatment to address the particular constellation of issues a

survivor is facing (261). While describing how to conduct substance abuse treatment in the context of IPV is beyond the scope of this chapter, a number of models are available for treating substance abuse in the context of previous trauma, some of which have been adapted to work with survivors experiencing ongoing IPV. Evidence that integrated models may be more effective is beginning to emerge. For example, treatment models that address trauma (PTSD) and substance abuse together appear to be more effective for women experiencing both conditions (169,175,181). Trauma-enhanced residential substance abuse programs have higher retention rates for women trauma survivors who experiencing co-occurring disorders (184). The SAMHSA's treatment intervention protocol (TIP) on substance abuse and IPV offers guidance for substance abuse providers working with both victims and perpetrators of IPV (262). Combining IPV advocacy services and substance abuse treatment appears to be effective in improving self-efficacy and reducing use of drugs and alcohol, but may lead to more painful awareness of the effects of abuse (IPV) (261). Research from the SAMHSA-funded Violence Against Women and Co-Occurring Disorders Study, also indicates that an integrated approach (i.e., one that incorporates attention to both trauma and substance use—as well as ongoing safety and other mental health concerns) is likely to be more helpful than any single approach (9,10,34,168,263). Substance abuse recovery among women who have experienced multiple forms of trauma can be challenging and may require a combination of supports and skill development strategies (174).

Integrated treatment plans should address issues of safety, sobriety, and trauma recovery. Models for which there is some evidence base include Trauma Recovery Empowerment Model (TREM) a 33-week psychoeducational group intervention that addresses basic life skills as well as trauma and substance use issues (170); Seeking Safety, a 25-topic cognitive behavioral group intervention that addresses both PTSD and substance abuse (initially designed for women in groups, although it has since been adapted for men and for individual treatment formats as well, and includes 80 coping skills) (179); and the Addiction, Trauma, Recovery Integration Model (264). Two additional models, Helping Women Recover: A Program for Treating Addiction and Beyond Trauma: A Healing Journey for Women, which integrate trauma recovery and substance abuse treatment, again through a combination of empowerment and support, psychoeducation, identification of relapse triggers, and the fostering of new coping skills development, are still being evaluated (265,266). For a more detailed description of these treatment models see the survey by Finkelstein and colleagues (267).

Again, when a woman is contending with ongoing IPV, safety issues need to be attended to along with other IPV-specific concerns. These include issues such as the abuser's role in undermining a survivor's efforts to achieve sobriety; isolating her from sources of support and using her dependence as a way to control her; threats that undermine custody or credibility, or that implicate a survivor in illegal activities that limit her ability to access law enforcement; realistic options for creating a different life, including economic support, and job and financial skills; stigma; and social support, as well as trauma related-feelings that are likely to emerge.

POTENTIALLY HARMFUL INTERVENTIONS FOR INTIMATE PARTNER VIOLENCE SURVIVORS

Because of the ongoing dangers battered women face, it is important to be aware of interventions that can potentially increase their risk of harm, such as confronting a batterer with the intention of getting him to change. In some cases, a batterer's violence may escalate while he (or she) is in treatment or participating in a batterer intervention program. Therefore, it is generally not recommended that programs for batterers without supports for battered women begin until women have access to adequate shelter and advocacy (38). In addition, many agencies offer anger control groups that fail to confront underlying issues of power and control. A batterer may then feel entitled to "lose control" to reprimand or punish his partner. Anger management alone is a potentially problematic intervention unless it also challenges a batterer's need to control his partner and his right to use violence against her (268). Anger management is not considered an appropriate intervention for a variety of reasons. First, it assumes that the individual cannot control his anger, when in fact abusers control their anger very well—their violence is targeted to a very specific victim (their partner). Second, anger management courses ask participants to identify things that "trigger" their anger. In doing so, these programs blame the victim for the violence

perpetrated against her, and suggest that the violence is something the batterer cannot control. Although some controversy exists about these issues, both experienced advocates and batterer intervention practitioners concur that IPV is always a choice—the batterer's choice to use violence and abuse to exert power and control over his partner. Finally, survivors report that having a partner in treatment creates the illusion of safety, which may not turn out to be realistic.

Referral to couples' counseling in situations of ongoing violence, threats, or intimidation is another potentially harmful intervention. Any disclosure of abuse during a counseling session is highly unsafe for the victim and can precipitate violent retaliation. Couples therapy also assumes equal power in the relationship and equal contribution to the couple's problems, and thus can reinforce the victim-blaming that occurs. Again, in considering couples therapy, it is important to remember that IPV, by definition, is about a systematic abuse of power by one partner over another. Partners in these situations do not have equal power, and victims are not responsible for the violence that is committed against them. Because of these concerns, victim advocates have felt strongly for some time that clinicians should never recommend couples therapy when there is ongoing IPV. Assessing for these dynamics is critical before proceeding with any couples work.

Some survivors may request a referral for couples therapy because they feel this is the only way to get help for their partner. At a minimum, couple's counseling is indicated only when violence and coercive tactics have ceased for longer than the longest period the batterer has stopped before, when both parties request this form of treatment, and after the perpetrator has successfully completed a batterer intervention treatment program, the abusive pattern has been successfully altered, and the couple is committed to repairing the damage. Conjoint therapy should not occur when there is ongoing violence, threats and intimidation, stalking, fear expressed by the victim, continued use of alcohol or drugs, or a high level of danger.

To engage in couples counseling, the survivor needs to feel that the therapist is on her side and the perpetrator must be ready to take full responsibility for his actions; refrain from further violence, harassment, and stalking; and understand that maintenance of safety takes priority over the resolution of relationship issues (269). This requires a careful assessment of many factors, including the woman's safety, her understanding of the risks involved, what she wants, what she thinks will happen, when her partner was last violent to her or someone else, threats the abuser has made, and whether she has procured a protective order and whether or not the abuser has violated it. For example, couples counseling would be contraindicated if there has been a recent assault or if the woman has a protection order from a court. Whether or not she has been coerced into seeking couples therapy is also important to assess. Additional requirements for the perpetrator include having stopped all obsessive thoughts about the survivor, having learned skills to manage his need for control, having learned to manage anger and conflict in nonabusive ways, having addressed key family-of-origin issues, having learned new sex-role socialization patterns and, as noted a moment ago, having been violence-free for longer than the time between two past incidents. Stopping the abuser's violence and controlling behavior should not be the focus of couples therapy (14,268). Working to rebuild the relationship and repair the damage will only be helpful if that dynamic has truly changed. Because of the many significant factors that must be in place before engaging in conjoint therapy, it will not often be an optimal choice. In essence, couples work should not be attempted, even when these conditions appear to have been met, without having had very specific training and supervision on these issues. These considerations apply to work with gay and lesbian couples also.

Court mediation is also problematic in cases of DV. It is based on the assumption of equal parties who can negotiate in good faith and solve problems together. Abusers, by definition, manipulate, intimidate, and bully their partners and do not negotiate responsibly. Given this scenario, battered women should be encouraged to seek legal assistance from an attorney who is knowledgeable about DV before discussing divorce, child custody, visitation, and other issues with their partners (268).

LEGAL ISSUES PERTINENT TO MENTAL HEALTH INTERVENTION

Information to Present to Patients about Legal Rights and Remedies

A range of legal issues, both criminal and civil, may emerge in working with patients who are being

abused by a current or former partner. Particular concerns include custody decisions, divorce settlements, immigration issues, enforcement of protection orders, testifying against the abuser, and other ramifications of DV. These issues are very complex, vary by jurisdiction, are continually in flux, and are best addressed by DV programs and/or lawyers knowledgeable about DV. The best way to support patients who are dealing with complicated legal situations is through relationships with local DV programs. Patients involved in DV-related cases can refer their attorneys to national DV organizations for assistance (e.g., National Council on Juvenile and Family Court Judges, Battered Women's Justice Project, National Center on Domestic Violence, Trauma & Mental Health, Legal Momentum).

Although survivors of abuse face a multitude of legal situations, the issues tend to fall into two categories: (a) understanding the laws, the options for utilizing the criminal and civil system to enhance safety, and a victim's rights under such laws; and (b) advocating within the legal system to have the laws enforced, survivors' rights upheld, and their safety needs considered. The latter category represents the unique challenges faced by victims of DV and illustrates the necessity of clinicians to link effectively with advocacy organizations. Knowing the law, calling the police, filing for divorce—such remedies that one might traditionally think of are not necessarily simple solutions. Inconsistent enforcement of laws and the biases of court systems can have devastating effects on the safety and well-being of DV victims and their children. It will often be necessary to consult with DV programs and DV legal specialists to obtain accurate information when these complex issues arise. Information is also available from the National Resource Center on Domestic Violence (1–800–537–2238), State Domestic Violence Coalitions, and websites such as the National Coalition Against Domestic Violence (http://www.ncadv.org), the National Network to End Domestic Violence (http://www. nnedv.org), and the American Bar Association Commission on Domestic Violence (http://www.abanet.org/domviol/).

Supporting Patients Facing Retraumatizing Experiences in the Judicial Process

In addition, going through prolonged legal battles with an abusive partner can be traumatic in itself. The court may minimize the abuse a woman has experienced, and the abuser may not receive appropriate consequences for the abuse, be it jail time or restricted visitation rights. A survivor may be pressured to testify against the abuser, which can put her at increased risk for retaliatory abuse. Batterers are known to use the system to control their partners, often through prolonged court battles. The stress for a woman trying to navigate the legal system to protect herself and her children from further abuse cannot be overestimated. Furthermore, having to repeatedly tell the story of the abuse to strangers and often with the abuser present can be particularly difficult and retraumatizing. It can be an eye-opening experience for mental health providers to learn about the court process in criminal and civil DV cases. For those without prior experience with DV court proceedings, it might be shocking to learn about some of the policies and practices in handling such cases (of course, court systems vary widely in this regard). Societal biases and stereotypes still have a strong influence on the legal process, and victims often find that the court did not effectively mete out justice or offer adequate protection to them and their children. Again, referring a patient to a DV advocacy program may be the most helpful way for her to obtain the resources and expert advice that will be most beneficial. At the same time, working with a survivor to manage these additional stressors can be an important aspect of treatment.

Mandated Reporting: Adult Victims

Because healthcare providers in some states are required by law to report injuries they suspect resulted from a battering incident, it is important to become familiar with state reporting laws. Although these requirements generally refer to patients seen after an acute injury, statutory reporting mandates vary greatly from state to state regarding who is required to report, what kind of injuries need to be reported, penalties for failure to report, and/or immunity from liability.

Liability can also attach to providers who fail to respond appropriately to the DV experiences and injuries of their patients. Clinicians can be held liable for subsequent injuries sustained by a patient who returns to an abusive situation if no inquiries about abuse were made when they were initially seen or treated. Documenting discussions of DV in a patient's record, including any referrals to other services is critical. Remembering that records may be discoverable in

a legal proceeding, it is also important not to include unnecessary information such as the patient's denial of need for services or attributions of self-blame. On the other hand, documenting the specific ways a survivor is taking care of herself and her children can be quite helpful.

Mandated Reporting: Child Victims

State laws require mental health professionals to report known or suspected child abuse to their local child protective services authority, a mandate that is generally quite familiar to clinicians. Although some states classify the witnessing of DV as a form of child *abuse or neglect*, in other states definitions of exposure and risk are less clear, allowing clinicians greater discretion over reporting. The most helpful interventions are those that support the nonabusive parent to keep her and her children safe.

Many child trauma experts question the effectiveness of addressing children's exposure to DV as a form of child abuse (270). Given the wide range of experiences, varying levels of protective factors, and diversity of effects among children who witness DV, standardization of criteria for defining and reporting child witnessing of DV becomes an unwieldy task. Reporting to child protective services under these circumstance can, and often does, have devastating consequences for both the children and the abused parent because it risks the possibility that an abused woman will be viewed as "failing to protect" her children. This may lead to removal of the children from the home, rather than efforts to work with the mother to create a safer environment or steps to ensure the perpetrator is held accountable. Because the nonoffending parent is sometimes the only legal parent, she also becomes an easier target for public sector interventions.

Reporting children as being directly physically abused or at serious risk of harm presents difficult tasks for the clinician as well. Providers must inform the abused parent about the potential consequences of involving child protective services, such as investigation, retaliation by the abuser, losing children to protective custody, and advocating for their needs and safety with the system, while also discussing the hazards of children continuing to live in a home where they are being abused. It is a complicated and often painful challenge to uphold one's legal and ethical obligations and to maintain a working alliance with the nonabusive parent. If an abused woman is also abusing her children, efforts to support the woman and protect the children must be made, difficult as that can be. Working with battered women to understand ways in which their own experiences of current or past abuse have affected their ability to parent and helping them to develop new skills and capacities to address these issues, appears to be helpful to some women.

Whenever the clinician involves the child protection system, the safety of the woman and her children again becomes a critical factor. If a woman feels that reporting will put her in danger from her partner, discuss and help arrange a safe place for her and her children to go. Children's protective services should also be warned of the risk of danger posed by the abuser. Particularly if the children are being abused by someone other than the patient, it may be preferable for her to make the report to children's services herself. It can help her retain a sense of control over the situation and can become a collaborative endeavor between clinician and patient. Making the report herself can also demonstrate to the child protective system that she is taking steps to protect the children and herself from abuse, potentially shielding her from "failure to protect" charges. However, this may not be the best practice for every survivor, or in every community. Mental health providers should consult with local DV experts about the most effective procedures for reporting child abuse/neglect when there is concurrent DV, in order to elicit the most helpful, and least punitive, response from the local children's protective services agency.

Subpoena of Records and Testimony

Mental health records may be subpoenaed by the patient's lawyer, the abuser. or by the court. Without a subpoena, however, records do not have to be released, even if the patient has signed a release. In general, patients do not know what is in their records and the potential ways they could be harmful in court. Providers should discuss with the patient the possible ramifications, and benefits, of releasing records, so that the person is able to make informed decisions. Careful documentation may preclude some of the dangers but, as noted earlier, private information can be always be used by an abuser to further control his partner. The laws of many states protect clients from unnecessary release of mental health records through a formal court process. Receiving a subpoena is the

first step of this process, and records should never be released at this stage. Mental health providers should consult an attorney familiar with the rules of civil procedure before releasing any information. Consulting with DV programs or lawyers who specialize in DV is advisable in these situations (17).

Good documentation of IPV and its mental health consequences can be of help to clients if a client's mental health becomes an issue in a legal case, particularly in custody battles, divorce settlements, civil damages, or immigration. Clinicians can offer general clinical information to the attorney (e.g., educating about PTSD) that could be very helpful to the case. Clinicians may be asked to testify as to their opinions about their client's mental health, the relationship of symptoms to abuse, and/or their ability to be a good parent. The testimony of a professional can do a great deal to enhance the credibility of a woman who is being battered, and this testimony is viewed by the judge as valuable evidence on relevant issues. Thorough discussion with the client about the proposed testimony is a necessity. When it is determined that the clinician will provide evidence in court, the lawyer should prepare the clinician to testify. If the patient's legal counsel does not provide adequate pretrial coaching, consultation with a lawyer experienced in these issues is advisable.

Custody disputes are common in cases involving DV. Very often, the court orders an evaluation to determine where the child's best interests lie, and the evaluator seeks the release of the battered woman's treatment records for use in the evaluation. Again, good documentation in the treatment file can play a crucial role in a successful litigation outcome for the client, playing much the same role for the evaluator as for the judge. The clinician should confer with the patient, and perhaps the lawyer, to determine if the information contained in the file would be helpful, as well as the possible negative ramifications of the file's release. The clinician can assist the patient in making informed decisions on these issues.

Protecting the patient–therapist relationship will be of concern to the clinician under these circumstances. Keeping the client informed about the clinician's interactions with the evaluator or the lawyer, ensuring the client is involved and giving consent to any communications, and explaining the ramifications of these activities are key. Clear parameters must be drawn between the role of the treating therapist who must maintain his alliance with his client and a nontreating expert witness who interviews the client for the sole purpose of evaluating the issue in question. The clinician must also be careful to maintain clear boundaries with the patient's lawyer, while also collaborating and advising whenever necessary. The therapist's involvement in the court case poses risks to his relationship to the client, particularly if the case does not turn out as hoped. Clinicians must be prepared to discuss these issues with the client in advance of any court proceedings, as well as processing their feelings afterwards.

CONCLUSION

Working collaboratively with other systems to create the kind of society that will stop violence against women and prevent its traumatic sequelae is of vital importance for all clinicians. important. Mental health providers have a significant role to play in voicing concerns about the impact of abuse and violence on the lives of individuals they work with clinically. Working with people who have survived unthinkable trauma teaches us about the complexity and unpredictability of human life; the intersections among individual biology, human development, social and cultural contexts, and larger societal norms; and the importance of caring, respectful human interactions. In working toward social justice, it is also necessary to incorporate an understanding of how the traumatic effects of social *injustice* can play out in both individual and social/institutional/political forms. When we do not address the denial of intolerable feelings at a personal level, we are in danger of recreating them not only in individual relationships, but also on social and political levels as well, and when we do not acknowledge the impact of social forms of abuse of power, they are often internalized and reproduced through individual interactions. Mental health providers can play a critical role in preventing IPV in addition to treating its consequences by beginning to address the social as well as psychological conditions that create and support this kind of violence in the first place.

Offering mental health treatment in the context of IPV also raises a number of practice and policy concerns. First is the need to ensure that any mental health treatment incorporates an understanding of the dynamics of IPV and the range of issues survivors face related

to safety, confidentiality, coercive control, parenting, custody, legal issues, immigration, social support, economic independence, and more, all of which influence how a survivor is affected and what her or his options are. Second is the need to change the way that symptoms and disorders are currently viewed, documented, and reimbursed, and to incorporate recognition of the direct impact of abuser behaviors, as well as the traumatic effects of abuse. Although trauma models focus on the impact of abuse and healing from its traumatic effects, advocacy approaches focus on social context and on changing the conditions that place survivors in jeopardy. Responding to a person who is experiencing the mental health effects of IPV and other trauma clearly requires attention to both of these domains. This, in turn, will necessitate changes in practice, research, and policy.

IMPLICATIONS FOR POLICY, PRACTICE, AND RESEARCH

Policy

- Support cross-sector collaboration among mental health and substance abuse providers, mental health peer support services, DV advocacy and legal organizations, and other community groups to ensure a wider range of options for survivors. This could take a number of different forms, such as: (a) establishing individual relationships with local DV resources for consultation and referral; (b) brokering existing resources through the development community task forces to examine existing services, needs, resources, gaps, barriers, and potential strategies; (c) establishing mechanisms for interagency cross-training, cross-consultation and referral, and providing mental health backup to DV shelters; or (d) creating pro bono or sliding scale mental health services for survivors without adequate insurance coverage.
- An obvious need exists for additional funding to support research, training, and services. Funding cuts to DV services are dire and reflect the loss of a critical element of support for both survivors and practitioners. Advocacy programs work not only to provide safety, justice, and redress for individual survivors but also to eliminate key sources of ongoing trauma, stress, and despair, including unresponsive court systems, retraumatizing custody practices, punitive immigration laws, lack of economic opportunities or social safety nets, and ultimately to develop strategies to reduce IPV. Having a broader base from which to mobilize may also help in the process of garnering the necessary funding to improve existing clinical services, develop new institutional capacities (education, training, supervision, and consultation) and create new resources for survivors (new onsite services, linkages with other health and mental health agencies.)
- Facilitate the development and dissemination of resolutions and practice recommendations from mental health professional associations related to IPV that reflect the perspectives of advocates and survivors, as well as cutting-edge research and practice
- Support efforts to reduce stigma associated with mental illness, promote recovery-oriented practices, and establish mental health parity.
- There is sufficient consensus to warrant integration of training on core principles of working with survivors of IPV and other lifetime trauma into clinical and advocacy training. Integrated training materials need to be created and strategies for incorporation into graduate and postgraduate health and mental health training need to be developed.
- In addition, concepts of vicarious trauma, elements of transference and countertransference, and the likelihood of one's own experiences of trauma being evoked, also need to be carefully attended to, and opportunities for support and processing are essential.

Practice

- Ensure that mental health treatment incorporates an understanding of the dynamics of IPV and the range of issues survivors face.
- Influence the ways psychiatric symptoms and disorders are currently viewed, documented, and reimbursed to incorporate recognition of the direct impact of abuser behaviors, as well as the traumatic effects of abuse.
- Ensure attention to the ways mental health information can be misused by abusers and other systems by developing policies for documentation, confidentiality, and information sharing, and new levels of protection for electronic health information technology systems.

- Support the creation of institutional and practice environments that are IPV, trauma-, and culture-informed. Elements of creating safe, welcoming services for IPV survivors were discussed earlier. Creating trauma-informed practice environments also requires institutional or agency commitment to equalizing power imbalances, ensuring provider trustworthiness, maximizing survivor control and choice, and establishing the necessary hiring practices, training, supervision, policies, and administrative support to change agency culture in this regard. Funding streams are also needed to support this type of agency and institutional work.
- Another important element for integrating complex IPV–trauma treatment into practice is the need for ongoing mentoring, supervision, and peer support. It is notoriously difficult to translate research into practice when practitioners often work under severe time constraints and patients have messy, complicated lives not necessarily under their own control. Institutional or agency commitment to provide regular consultation and/or supervision is also key. This can also be accomplished through distance expert consultation accompanied by local peer support.

Research

- One of the overarching gaps in existing research on mental health, trauma, and IPV is the need to develop a better understanding of the range of ways survivors of IPV are affected, given the vastly different circumstances of their lives and, consequently, what types of treatment modalities and community interventions are likely to be most effective and for whom.
- Research is needed to determine the extent to which a complex trauma framework is useful for understanding the traumatic effects of IPV or only so for some survivors: For example, survivors of childhood abuse; survivors of multiple types of trauma; survivors whose experience of IPV is prolonged, severe, and more akin to torture; survivors who are dealing with a mental illness as well as IPV where stigma, abuser manipulation, and institutionalization bring additional layers of trauma; or survivors who are trapped in prolonged custody battles and visitation experiences who live in constant fear for their children.
- Studies could be designed to inquire about unmet mental health needs; what has and has not been helpful, and what might have been helpful at the time; sources of healing and support; and what survivors would find both compelling and safe—not only after being out of an abusive relationship, but also while they are still under siege.
- Additional steps might include developing comprehensive intervention and treatment models along with strategies to evaluate specific core elements, as well as the flexible delivery of an individually tailored menu of services and treatment modalities with or without an additional set of community-based resources and supports—guided by survivors' experience, goals, and priorities.
- Research is also needed to examine inclusion criteria for study participation (who is excluded and why, what treatment works best for survivors who are excluded) and to assess study attrition (who leaves, why, to what extent does this relate to safety, tolerability, or efficacy). There is also a need for longitudinal studies that can assess changes over time, studies that examine the interactions among a wider range of factors that influence women's experiences and responses, and studies that look at the variations in responses to trauma and to treatment interventions
- Research is needed to examine the applicability of a complex trauma framework for understanding the traumatic effects of IPV.
- It is essential to evaluate combined IPV-, culture-, and trauma-informed treatment and intervention models that can be individually tailored and flexibly applied in a range of practice and community settings.

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