

# 2

## VIOLENCE AND TRAUMA

Jeff is beating his wife Karen (Chapter 10), Nicole is being beaten by her father and brothers (Chapter 14), Josephina is physically abusing her infant son (Chapter 18), and Dan doesn't protect himself from the physical abuse of his adult daughter (Chapter 17); there is no safety in their homes. Eric is bullied at school over his sexuality (Chapter 11), Kayla is bullied at school for her Lakota Heritage (Chapter 19), Zechariah is emotionally abused by his roommate at college (Chapter 18); there is no safety in their schools. Sergio is emotionally abused in community stores (Chapter 15), Zechariah witnesses violence in the streets (Chapter 18) as he grows up; there is no safety in their communities.

For all of these clients, violence has impacted their past and current functioning. They all view the world as unsafe. Is it their human right to be safe within their homes, community schools, stores, and work places? How about within the institutions of society, such as child and adult protection agencies, and the legal system (NPEIV, 2017)? What does it mean to be safe? Safety at home includes receiving the provision of developmentally responsive caretaking when needed and the promotion of resilient functioning rather than abuse, neglect, or deterioration of functioning. Safety in the community refers to safety on the streets, in restaurants, parking lots, workspaces, and outside spaces so that individuals can proceed about their business without witnessing or being victimized by violence. Safety in community schools includes the provision of developmentally appropriate education and an environment that promotes resilient functioning and prevents interpersonal violence such as bullying, harassment, sexual assault, and other forms of abuse and neglect. Safety within the institutions of society includes procedures, rules, and laws that are fair and just and the provision of needed services to all citizens regardless of their age, developmental or acquired disabilities, gender, nationality, race/ethnicity, sexual orientation, and socioeconomic status.

Individuals who feel secure that their human rights are respected may also feel safe within themselves. How safe they feel influences their internal world of thoughts, feelings, wishes, dreams, and actions of self-caring. How safe they feel influences their interactions in the outside world, including how people affirming or people destructive and violent they behave in their everyday lives.

Many of the clients in this text are victims, perpetrators, or victim-perpetrators of violence. While they may not indicate that some type of past violence or trauma is behind their current concerns, if you assess carefully, you will frequently find it there continuing to have a negative impact on their lives. Your task in the clinical chapters of this text (Chapters 10–19) is to review the assessment data provided for each client, along with the data from the clinical interviews, and determine what, if any, impact of violence has had on both the issues as well as the strengths the client brings to treatment. Whether or not past violence is directly related to their current presenting concerns, you will need to consider if there are any barriers to their developing an effective treatment relationship with you or any barriers to treatment success embedded within unresolved trauma. The exercises at the end of each clinical chapter will support you in writing treatment goals that build on clients' strengths and help them develop, if necessary, the skills to ensure their own human rights to safety.

Why is this necessary for you to learn? Aren't dealing with victims or perpetrators of violence specialty areas? There are individuals who specialize in the treatment of those impacted by violence. Unfortunately, violence is a very commonplace event in the United States and elsewhere. Thus, all clinicians, not just specialists, need to learn to recognize and respond effectively to violence exposure in their clients' histories. Violence is endemic according to the World Health Organization (WHO, 2002). Interpersonal violence can occur at any time across the life span and has been found to be a common precursor of many of the physical and emotional difficulties that clients bring to treatment.

This chapter provides you with a brief introduction to the impact of violence across the life span. You will also be introduced to trauma-informed care and factors that promote resilience. Substance Abuse and Mental Health Services Administration's (SAMSHA) definition of trauma-informed care, "is a strengths-based service delivery approach that is grounded in an understanding of and responsiveness to the impact of trauma, that emphasizes physical, psychological, and emotional safety for both providers and survivors, and that creates opportunities for survivors to rebuild a sense of control and empowerment" (Hopper, Bassuk, & Olivet, 2010, p. 82). It also involves vigilance in anticipating and avoiding institutional processes and individual practices that are likely to retraumatize individuals who already have histories of trauma, and it upholds the importance of consumer participation in the development, delivery, and evaluation of services" (SAMSHA, 2014, p. xix).

## INTRODUCTION TO THE IMPACT OF VIOLENCE AND TRAUMA

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Research on adult medical populations reveals that exposure to violence and other adverse childhood events (ACEs) are common in the United States. In a sample of 17,000 general medical patients in California, two thirds indicate having at least one adverse event in childhood, and 17% indicate having four or more (Felitti et al., 1998). These statistics are identical within general medical populations in five other states (Ford et al., 2011). Even higher rates of victimization are found in youth samples. Finkelhor, Turner, Shattuck, and Hamby (2013) indicate that 41% of youth reported being physically assaulted, 22.4% witnessed a violence act, 48.4% experienced more than one type of victimization, and 15.1% reported experiencing six or more victimizations over the course of one year.

What is the impact of violence exposure? As the number of ACEs within the family and within community and school settings increase, the likelihood of psychological and physical health problems in adulthood increases (Anda & Felitti, 2011; Cronholm et al., 2015). Exposure to violence in childhood is a substantial predictor of later substance abuse, depression, suicide, and anxiety. It is also strongly related to absenteeism, serious financial problems, and serious job problems. Finally, it is the largest predictor of major health problems such as liver disease, chronic obstructive pulmonary disease, and coronary artery disease; the likelihood of having these problems increasing steadily as ACEs score increases (Felitti & Anda, 2010). Individuals exposed to violence may or may not be traumatized and/or meet the criteria for posttraumatic stress disorder (PTSD). An individual is traumatized when their resources for coping have been overwhelmed and they are not getting the support from significant others that could once again help them cope effectively. These individuals may develop traumatic reactions that can include PTSD and complex trauma. Emotions surrounding trauma may include fear, helplessness, and/or horror. Whether experiencing trauma or not, the impact of exposure to violence, whether in childhood or in later life, can have a long-lasting impact on a person's feeling of safety. When these experiences occur during childhood, they may have a negative impact on the developing brain's ability to regulate feelings, emotions, and behavior. Even when violence exposure occurs later in life, if it is traumatic, it may impact individuals' ability to regulate their own thoughts, emotions, and behavior (Hopper et al., 2010).

Clients do not always realize the relevance experiences with trauma may have on their ability to live day by day or overcome the issues that bring them into treatment with us. They may believe past trauma is irrelevant, or they may believe that if they bring up their past trauma, they will be overwhelmed by it and therefore worse off. Trauma impacts the individual as well as all the family members or other supportive people who try to help the individual; thus, the possibility for secondary trauma needs to be considered by all clinicians (NPEIV, 2017; SAMSHA, 2014).

Research, prevention, and intervention often explore the impact of one type of violence. This is a mistaken approach for many reasons. Research on the long-term impact of violence exposure finds that the number of events, rather than the type of events per se, leads to the greatest impact on later physical and psychological health (Felitti & Anda, 2010). In addition, while there are some individuals who are exposed to only one type of violence on only one occasion (monovictimization), this is infrequent. Co-occurrence, being exposed to more than one type within one incident of violence is more common. Finally, polyvictimization, being impacted by more than one incident of violence over the course of the life span, is significantly more common than monovictimization (Hamby & Grych, 2013). People can be victimized by interpersonal violence without being traumatized. According to the American Psychological Association, “Trauma is an emotional response to a terrible event like an accident, rape or natural disaster. Immediately after the event, shock and denial are typical. Longer term reactions include unpredictable emotions, flashbacks, strained relationships and even physical symptoms like headaches or nausea. While these feelings are normal, some people have difficulty moving on with their lives” (APA, Help Center, 2013).

## VIOLENCE AND MINORS

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Violent behavior is the result of a complex interconnection of many individuals, environments, and priming events in an individual's life. Development does not terminate after adolescence. It starts when circumstances and individuals provide the child with learning experiences where children trust the information as valid and both assimilate and integrate the violent or neglectful information into their view of the world, interpersonal relationships, and their self-understandings (Raeff, 2014). Parents and other caretakers can teach children how to understand and regulate their emotions, thoughts, and behaviors or may neglect to do so and provide maladaptive role modeling (Conduct Problems Prevention Research Group, 2011; Diamond & Lee, 2011). If these positive attachments do not occur, a cascading series of negative events involving broken relationships with adults and peers may follow. The victim of violence can become transformed by repeated trauma, and lack of responsive parenting, into the violent perpetrator (Ryder, 2014).

The mistreatment of minors can take many forms. Each state develops its own specific definitions; most states include neglect, physical abuse, sexual abuse, and psychological abuse within their definitions. However, child abuse and neglect must be, at a minimum, “Any recent act or failure to act on the part of a parent or caretaker which results in death, serious physical or emotional harm, sexual abuse or exploitation; or an act or failure to act, which presents an imminent risk of serious harm” (U.S. Department of Health and Human Services [USDHHS], Administration for Children and Families [ACF], Administration on Children, Youth and Families, Children's Bureau, 2015, p. viii). Exposure to violence can begin as early as the prenatal period if a pregnant woman is assaulted (Centers for Disease Control and Prevention [CDC], 2006). The most serious forms of child maltreatment result in the death of the child. It is the very youngest children, infants and toddlers, who are at greatest risk of severe injury or death; consistently between 1,500 and 3,000 children die from child abuse and neglect every year (Commission to Eliminate Child Abuse and Neglect Fatalities [CECANF], 2016). A comprehensive evaluation of these tragedies makes it clear that the families of these children are struggling with a variety of severe issues that require many different types of professionals to work together to prevent the four to eight children from dying every day.

The Children's Bureau, in their National Child Abuse and Neglect Data System [NCANDS] (U.S. Department of Health and Human Services, Administration for Children and Families, Children's Bureau, 2013) indicates there were 3.5 million referrals in 2013 for possible child maltreatment. This includes approximately 6.4 million children. Screening then occurs with approximately 39% of referred cases not being investigated further. CECANF (2016) suggests that too many cases are screened out. Statistics vary by state, but approximately 28% of 1,000 children are investigated for abusive and/or neglectful parenting with 9% of general population children being considered victims of maltreatment. Within founded cases of maltreatment, neglect is most common (80%), followed by physical abuse (18%), sexual abuse (9%), and other forms of abuse examined together including psychological maltreatment, threatened abuse, drug/alcohol abuse of parent, and relinquishment of newborn (10%). A child may be victimized in more than one way within this data (U.S. Department of Health and Human Services, Administration for Children and Families, Children's Bureau, 2013). Statistics on child maltreatment fatalities indicate that 1,500 to 3,000 children died in 2016 and will die in 2017 if steps aren't taken to be proactive rather than reactive in our response to child maltreatment (CECANF, 2016).

U.S. Department of Health and Human Services. Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau (2015) finds that 91.4% of children are maltreated by one or both of their parents (U.S. Department of Health and Human Services, Administration for Children and Families, Children's Bureau, 2013). Gender differences in perpetration are found when different types of maltreatment are examined. Medical neglect of children is most likely carried out by women (76%) while sexual abuse of children is most likely carried out by men (88%). The perpetrators of physical abuse of children are equally likely to be male or female. Contrary to the common belief that it is the youngest parents who are the most likely to abuse or neglect their children, 83% of perpetrators are in the age range of 18 to 44. The age group most likely to abuse children is within the range of 25 to 34. When a parent is not at least one of the parties abusing/neglecting the child, 13% of the children are abused by people outside the immediate family. The perpetrator is most often a male, either a male relative or male partner of the parent.

## Family Context

Infants are completely dependent on their caregivers for getting all of their needs met. These needs are met within the context of a caretaker-child relationship. Caregivers who are responsive help their infants develop secure attachments that set the stage for building positive relationships later in development. An insecure attachment style is consistently related to an increased likelihood of victimization, perpetration, or both. Trauma exposure influences individuals' learning, behavior, and relationships and thus can have continued impact across the life span even when the victimization or trauma has ended. These damaging experiences can influence how people process their experiences, regulate their emotions, and try to build trusting relationships with others (Cole, Eisner, Gregory, & Ristuccia, 2013). Despite having caretaking that is untrustworthy and violent, poorly attached individuals still try to develop attachments to others but do not have any idea how to do this in an adaptive way. The psychological abuse of rejecting, isolating, and corrupting of them as children is just as damaging to their development as the physical blows and neglect of their basic needs (Garbarino, 2015). When involved in conflict, the insecurely attached individual may be flooded both with negative emotions as well as schemas related to insecure attachment such as, "people will always leave me," "and if I don't do enough for someone they won't love me." In addition, their perceptions of their partner's behavior is likely to be seen through a negative lens (Beck, Pietromonaco, DeVito, Powers, & Boyle, 2014). This can lead anxiously attached individuals to see more withdrawal behavior and see more conflict engagement behavior in their partners. Avoidantly attached individuals may see conflict as their partner's attempt to undermine their independence (Bonache, Gonzalez-Mendez, & Krahé, 2016).

These same insecurely attached people may become parents and not know how to foster a secure attachment. Parents in maltreating households use harsh physical discipline when children make mistakes or misbehave (Consortium for Longitudinal Studies of Child Abuse and Neglect, 2006). The impact of maltreatment is to put children at higher risk for lower cognitive and academic functioning as well as to increase their risk of exhibiting internalizing and externalizing behavior (Bates & Pettit, 2007). Adverse childhood events also predict long-term physical and mental health outcomes including behavioral problems that involve aggression, anxiety, or depression (Brown et al., 2009). Infants and toddlers are at the highest risk for death as a result of child abuse or neglect. A call to a child protective hotline needs to be investigated thoroughly rather than screened out quickly to reduce the risk of later fatality. Having nurses visit the homes of at-risk families has been found to reduce rates of child abuse and neglect (Commission to Eliminate Child Abuse and Neglect Fatalities, 2016). It is critical for parents to teach children and youth how to build respectful relationships. This begins by having parents build healthy parent-child relationships. Parents need to model healthy, respectful relationships that respect personal boundaries. Parents need support in learning how to create positive family relationships, emotionally supportive family environments, and open communication. These could reduce risks for children and youth later engaging in acts of violence such as sexual violence, stalking, and intimate partner violence (Black et al., 2011).

Exposure to violence may occur directly, as in child abuse and neglect, as well as indirectly, through watching adult caretakers engage in violence. There is a 30% to 60% co-occurrence with exposure to intimate partner violence (IPV). Children may see or hear the violent acts of the adults in their lives or witness the sequelae later. These acts may involve physical as well as sexual assaults (Kantor & Little, 2003; Wolak & Finkelhor, 1998). Approximately 8.2% of adolescents indicate they witnessed a family assault, and 6.1% indicate they witnessed one adult caretaker assault the other in the past year. This increased to 20.8% witnessing a family assault and 17.3% witnessing an assault of one adult caretaker on the other over the course of their lifetime (Finkelhor, Turner, Shattuck, Hamby, & Kracke, 2015). In addition to the negative psychological impact of secondhand violence, the assaultive parent may force the child to participate in the assaults, require the child to spy on the victimized parent, and indoctrinate the child with the message that the victim was responsible for the assault (Kantor & Little, 2003). Male batterers may use destructive parenting practices. They may choose favorites among their children and ridicule their children for showing an attachment to their mother (Bancroft & Silverman, 2004/2005). They may unintentionally undermine the mother's authority in parenting children by modeling contempt for her abilities. They may also deliberately overrule her decisions. For example, if she forbids an activity, the batterer may help the child engage in it. He may also reward his children for defying their mother.

Diverse forms of child maltreatment, as well as indirect exposure to violence, may cause similar disruptions to the brains of developing children (National Scientific Council on the Developing Child, 2005). Mammals develop two systems that respond to stress (Gunnar & Quevedo, 2007). One is the sympathetic-adrenomedullary system. This is the system that is designed for the immediate "fight/flight" response when the individual is confronted with something psychologically or physically threatening. There is a concomitant suppression of bodily systems that aren't needed to respond to this immediate emergency. The fight/flight response is caused by a release of epinephrine from the medulla and the adrenal gland; epinephrine does not cross the blood-brain barrier. The second stress system is the hypothalamic-pituitary-adrenocortical system or limbic-hypothalamic-pituitary-adrenocortical axis (LHPA). This system produces glucocorticoids such as cortisol, which is a steroid hormone. Cortisol can cross the blood brain barrier and while slower to develop, continues to impact humans for a greater length of time than epinephrine because of this.

Stress can lead to positive effects when it is short and the child is receiving enough adult support and nurturing to deal effectively with it. In this situation, the child produces a "tolerable stress response." However, a "toxic stress response" can occur when the stressor is long-standing or chronic and the child

does not receive the adult support and nurturing necessary to understand how to cope (National Scientific Council on the Developing Child, 2014, p. 9). Chronic stress prevents the body from returning from its acute stress state back to its homeostatic/resting state. This results in cascading, negative biological impacts from the longer term impact of cortisol on the body and the brain (McCormick & Matthews, 2007; Gunnar & Quevedo, 2007). Emergent adults, who are maltreated as children and show decreases in cortisol during stress tests, have been found to show externalizing behavior. Those who show increases in cortisol during stress tests are found to show internalizing behavior (Hagan, Roubinov, Kraft Mistler, & Luecken, 2014).

The negative cascade starts with child maltreatment and other adverse childhood events that put the LHPA in a state of constant stimulation impacting the neural substrates for emotion, motivation, emotional learning, and emotional and behavioral regulation (De Bellis, Woolley, & Hooper 2013; Gunnar & Quevedo, 2007; Lupien, McEwen, Gunnar, & Heim, 2009). Over time, overstimulation of the LHPA disrupts development of the brain to the second level of the cascade: the dysregulation of the stress system. This dysregulation will then impact the prefrontal cortex and the limbic system leading to hindered neurocognitive, affective, and psychosocial outcomes (De Bellis et al., 2013). These cascading negative impacts can lead children to be either under (hypo) or over (hyper) responsive to signs of potential threat in the environment. Children who are hypo-aroused may not take steps to protect themselves in potentially dangerous situations. Children who are hyper-aroused may find neutral situations to be threatening and respond with flight or aggression. They may have more difficulty learning how to control their thoughts and emotions leading to impulsive behavior. Numbing of emotional responses may also occur. Allwood, Bell, and Horan (2011) find that different emotions are more likely to show numbing based on type of violence exposure. Numbing of fear responses to interpersonal violence may be the strongest form of emotional numbing and can occur due to in-home traumatic violence, indirect violence, physical and verbal abuse, as well as community violence. Numbing of fear also occurs from engaging in all types of delinquent acts. This type of numbing can lead a youth to not be afraid in dangerous situations or in threatening situations. Numbing of sadness occurs only within the context of interpersonal relationships, such as when someone important dies, not when a situation is sad. This type of numbing is related to engaging in aggressive behaviors and delinquent behavior (Allwood et al., 2011).

Cognitive changes can also occur in response to violence exposure. Boys and girls exposed to prolonged domestic violence may take on beliefs that men are superior to women, that the use of violence against women is justifiable, and that violence is an appropriate problem-solving tool (Bancroft & Silverman, 2004/2005). Physical abuse is more likely to lead a young boy, rather than a young girl, to later commit acts of violence. Male victims are more likely to engage in dating violence as well as both violent and nonviolent acts of crime than age-mates who are not abused (Lansford et al., 2007), in addition, they are more likely to engage in IPV once they are adults (Milaniak & Widom, 2014). Children and youth who are exposed to more than one type of violence, and exposed repeatedly, may not experience safety in any aspects of their life and have increased vulnerability. Forty-eight percent of children indicate they had been exposed to more than one type of victimization over the course of a year, and 15% indicated they were exposed to six or more types of victimization; thus, these polyvictimized children represent a significant portion of maltreated children (Finkelhor et al., 2015).

Some children who are aggressive at early ages show a decrease in their aggression as they progress through school. Children who learn how to effectively regulate their emotions are likely to reduce their aggressive behavior particularly in relation to dealing with feelings of anger (Davey, Day, & Howells, 2005; Masten, 2014). The most aggressive boys and girls in kindergarten are the most likely to maintain their levels of aggressive behavior across the life span. This is likely due to negative family influences (Watson, Andreas, Fischer, & Smith, 2005).

Thus, maltreatment can result in emotional difficulties (restricted affect, numbing, overarousal), cognitive difficulties (hypervigilance, hypovigilance), and physiological responses (arousal in ambiguous or

nonthreatening situations) leading to externalizing or internalizing behavior and, in some, PTSD (Cicchetti & Valentino, 2006; Cromer & Villodas, 2017; Teague, 2013). Risk factors for violence in adulthood include destructive conflict resolution strategies and factors stemming from childhood. Research finds a relationship between destructive resolution strategies and adults with insecure attachment styles (Fowler & Dillow, 2011; Mikulincer & Shaver, 2012). Anxiously attached adults try to maintain closeness to their romantic partner. They become involved in conflicts out of a desire to get attention, care, or support from their partner. When they fear rejection by their partner, they may withdraw. On the other hand, adults with avoidant attachments tend to avoid communication with their partners and avoid disagreements. They do their best to withdraw from conflictual situations. If arguments escalate, avoidantly attached adults may engage in the conflict in order to achieve more distance from their partner (Bonache, Ramírez-Santana, & Gonzalez-Mendez, 2016; Fowler & Dillow, 2011; Mikulincer & Shaver, 2012). All communication patterns in which one partner makes demands and the other one withdraws are related to interpersonal problems and are consistently related to violence in adults (Fournier, Brassard, & Shaver, 2011). Unequal hierarchies of power between men and women entrenched within the institutions of society fuel many abuse dynamics of many forms (Liu, 2005).

### Peer Context

Peers become increasingly influential in development as children enter the early elementary years. Youth are highly sensitive to their status in relation to other peers at a time when their ability to stop and think, versus engage in impulsive actions, can lead to poor decisions (Steinberg, 2008). Peer rejection and lack of social acceptance, particularly when there is a history of being either the victim or perpetrator of violence, makes it five times more likely that a weapon will be carried on the streets or at school in comparison to students who are not involved in bullying (Bradshaw, Waasdorp, Goldweber, & Johnson, 2013; van Geel, Vedder, & Tanilon, 2014). Peers and siblings are common sources of violence exposure during development (Finkelhor et al., 2013). The most common young perpetrator of violence in early childhood is a sibling (28%), while for preteens it is a peer. A prospective study finds that adolescents who are abused during their first five years of life are twice as likely to be arrested as nonabused individuals for all three types of crime contained in juvenile justice records. Male adolescents who are abused are more likely to be arrested for both violent and nonviolent offenses and engage in more violence in dating relationships than females. While all adolescents abused within their first five years of life are at greater risk for nonviolent events including dropping out of high school, being fired from employment, and becoming a teen parent, the rate is higher among females (Lansford et al., 2007).

Children and adolescents spend five days a week in school. It provides a context where harassment and bullying are common occurrences. Harassment is a broader type of violence perpetrated by peers, where there may or may not be a power differential between the perpetrator and the victim (Finkelhor, Turner, & Hamby, 2012). Research indicates 34% of school-age youth report peer harassment. Harassment can take one or more forms. In-person harassment is most common, occurring 54% of the time. However, approximately one third of all harassment includes both technology and in-person aggression. Technology-only harassment occurs 15% of the time. Not all harassment leads to equivalent effects. Mixed harassment involving both in-person and technological harassment is associated with the greatest harm. Technology-only harassment is associated with the least harm. In this form of harassment, victims are more likely to believe they can stop the harassment or move more quickly past it than in-person attacks. The victim-perpetrator pattern is found to occur in 53% of all cases of harassment (Mitchell, Jones, Turner, Shattuck, & Wolak, 2016).

In Grades 7 through 10, 26.3% of students report peer victimization over the last year, with 11% indicating they experienced four or more victimizations. In terms of engaging in perpetration, 64.8% admit to at least one act of aggression, with male adolescents indicating more acts of aggression than females (Duggins, Kuperminc, Henrich, Smalls-Glover, & Perilla, 2016). Over the course of two years, victims of

peer aggression show higher levels of aggression than nonvictims, however, levels of aggression decrease with age for both groups. Higher levels of family connectedness predict lower levels of aggression in the victims of bullying as well as faster decreases in aggressive behavior over time (Duggins et al., 2016). In seventh through twelfth grade, sexual harassment is commonplace with 56% of girls and 40% of boys reporting harassment within a one-year period (Hill & Kearl, 2011).

Bullying is a narrower term than harassment. It is defined by the Centers for Disease Control and Prevention (CDC) as, “an act of intentionally inflicting injury or discomfort upon another person (through physical contact, through words or in other ways) repeatedly and over time for the purpose of intimidation and/or control” (Centers for Disease Control and Prevention, National Center for Injury Prevention and Control, Division of Violence Prevention, Applying Science Advancing Practice, 2012, p.2). Bullying requires the acts of harassment to involve power imbalances (Finkelhor et al., 2012). A power imbalance refers to “an attempt by the aggressor(s) to use observed or perceived personal or situational characteristics to exert control over the target or limit his/her ability to respond or stop the aggression” (Gladden, Vivolo-Kantor, Hamburger, & Lumpkin, 2014, p.4). When they go to school, maltreated children are at increased risk of being bullied by other children. During a typical year, 20% to 28% of youth are bullied (Gladden et al., 2014), with bullying being at the highest levels in middle school and declining in high school (Finkelhor, Turner, Ormrod, & Hamby, 2009; Wang, Iannotti, & Luk, 2012). In a national study in 2015, 22% of third graders report being bullied, after which there is a continuous decline in victimization rate until there are only 7% who report being bullied in twelfth grade. However, looking at this same pattern for those who bully, the rate remains at 4% to 6% from third through twelfth grade (Limber, Olweus, & Luxenberg, 2013; Luxenberg, Limber, & Olweus, 2015).

Children and adolescents can be bullied both while at school and later through electronic means. Relational bullying is the most common type and uses verbal and social means of aggression. Almost 40% of children report having been a victim of relational bullying during the past year (Finkelhor et al., 2015). Relational bullying is used by 29.3% of boys and 29.4% of girls. There is a small group of students who use all forms of bullying. There are 10.5% of boys and 4% of girls who use physical, verbal, and cyber aggression against peers. This group is at most risk for alcohol and drug use and use of weapons (Wang et al., 2012). Adolescent bullies who use cyber bullying in addition to other forms of bullying are the most aggressive adolescents (Wang et al., 2012). During a typical year, 20% to 28% of youth indicate they are bullied on school property, and 15% indicate being bullied electronically in the last year. In addition, 8% of high school students indicate being bullied on a weekly basis (Centers for Disease Control and Prevention, 2013), with bullying being at the highest levels in middle school and declining in high school (Wang et al., 2012). When looking at students bullied two to three times/month or more in Grades 5 through 10, in order from most to least prevalent are verbal mistreatment, lies spread, sexual jokes, being left out, racial slurs, physical mistreatment, computer-originated bullying, and cell phone-originated bullying (Health Behavior in School-Aged Children, 2014). While bullying is a serious problem, it should not be forgotten that 66.6% of girls and 60.2% of boys do not bully others (Finkelhor et al., 2015).

Bullies and victims report psychological difficulties. Holt, Finkelhor, and Kantor (2007) find that anyone who is involved in bullying within the schools reports greater internalizing behavior than those not involved in bullying in any role. However, the causes of the internalizing behavior differ. Bullies develop this behavior due to being victimized themselves within conventional forms of crime. Individuals, who are victimized by bullies develop internalizing behavior directly. In addition, bullies and bully-victims show higher rates of exposure to indirect forms of victimization such as witnessing domestic violence. Victims and bully-victims show higher rates of internalizing psychiatric disorders in childhood and family hardship. Even after controlling for these, victims and bully-victims continue to show anxiety-related psychiatric problems in young adulthood, and bullies show antisocial personality disorders (Copeland, Wolke, Angold, & Costello, 2013).

Victims and bully-victims show similarities in being victimized both at school and through their sibling or other peer relationships. Bully-victims report higher rates of victimization by conventional crime than either bullies or victims. Most strikingly, bully-victims report a rate of 32.1% for sexual victimization in the last year in comparison to 3.1% for those who are not involved in school bullying, and the children with the highest rates of internalizing symptoms are those with the highest rates of child maltreatment and victimization by conventional crime. Twenty-four percent of children are victims of crimes such as vandalism and theft over the course of a year (Finkelhor et al., 2015).

Bullying can have both immediate and long-term consequences. The likelihood of being depressed as an adult is 74% higher for individuals who are bullied in school than for those who are not (Ttofi, Farrington, Lösel, & Loeber, 2011a). On the other hand, these victims can become aggressive over time in certain circumstances or within certain family contexts (Watson et al., 2005). Meta-analyses indicate that being victimized increases a person's chance of becoming aggressive toward others by approximately one third (Ttofi, Farrington, & Lösel, 2012).

Some important risk factors for becoming a bully include harsh parenting, externalizing problems, and attitudes that accept violence as a solution. Risk factors for being victimized include seeming different in any way from peers, having no strong relationships with other children, and low self-esteem (Centers for Disease Control and Prevention, 2013). While victimization may continue to be the pattern for these children, some of them may become victim-perpetrators where in some situations they become the aggressor themselves. Patterns of polyvictimization and polyperpetration are more likely rather than monovictimization or monopertetration (Hamby & Grych, 2013). Research indicates that there is a subgroup of aggressive youth who show a decrease in aggression as they make the transition from middle school to high school, while there is another subgroup of aggressive youth who show increases of aggression during this transition. The difference between the two groups appears to be their understanding of what makes up a peer relationship. Individuals whose understanding of friendship includes trust, closeness, and conflict resolution are more likely to decrease in aggression while those who do not trust, even those they consider friends, are most likely to show increases in aggression (Malti, McDonald, Rubin, Rose-Krasner, & Booth-Laforce, 2015); an increase in understanding of positive qualities associated with friendship has also been found linked to reduced aggression in elementary aged students (Malti, Averdijk, Ribeaud, Rotenberg, & Eisner, 2013).

Bullying and homophobic teasing in middle school can escalate in the adolescent years to include sexual harassment. Called the Bully-Sexual Violence Pathway, it examines how name calling and rumor spreading, associated with homophobic teasing, can lead to a negative climate within the school system where anyone is made fun of who does not express behaviors that are consistent with gender role stereotypes. Boys are more likely to make sexual comments and engage in homophobic teasing than girls; however, girls were slightly more likely to spread sexual rumors (CDC, National Center for Injury Prevention & Control, Division of Violence Prevention, Applying Science Advancing Practice, 2012). Hate speech involving sexual orientation is more prevalent than sexual harassment, with 33.7% of students admitting to using homophobic name calling in comparison to 7.6% admitting to sexual harassment. Similarly, 31.3% report being victimized by homophobic comments, while 14.8% report being victims of at least one form of sexual harassment (Rinehart & Espelage, 2016). Sexual harassment is most likely to include a social power imbalance (69%) between the perpetrator and victim, and 54% of the time there is a physical size power imbalance (Mitchell et al., 2016). LGBTQ youth and youth with disabilities are at higher risk for victimization. They can experience disapproving comments, sexual harassment, and even hate crimes. These types of persecution can lead to poor self-esteem, self-hatred, poorer academic achievement, and physical injury (Kosciw, Palmer, Kull, & Greytak, 2013; Nosek, Hughes, Taylor, & Taylor, 2006; Stein, Mennemeier, Russ, & Taylor, 2012).

Gender is also a major risk factor for committing acts of violence, especially during the teen and early adult years (Kimmel, 2008). Starting in kindergarten, boys show greater levels of aggression than girls

at all levels of aggressiveness (Watson et al., 2005), and young men are 10 times more likely to commit murder than young women (Garbarino, 1999). An adolescent male who is sexually assaulted in childhood, then physically abused in childhood or a witness of domestic violence, is twice as likely to commit a sexual assault as a teenager. Someone who is sexually victimized is at higher risk for revictimization later in life than someone who is not sexually assaulted, with two of three individuals who are sexually assaulted being harmed again. Childhood physical and sexual abuses are predictive of later sexual victimization. Multiple traumas, and how recent the sexual trauma, are also associated with higher risk. Female adolescents who are sexually assaulted are at risk for further assault in adulthood (Classen, Palesh, & Aggarwal, 2005).

Luxenberg and colleagues (2015) surveyed students across the United States using the Olweus Bullying Survey. Girls show a stable rate of bullying others of approximately 4% to 5% in elementary school and decreasing to 3% from tenth to twelfth grades. Boys show only slightly higher rates than girls in elementary school. Boys start bullying others at a stable rate of 6% to 7%, and this remains stable through twelfth grade. Victims also show an impact by gender, with girls being victimized at higher rates than boys, although the difference is marginal by Grade 12. Of those boys who are victimized, 25% report bullying others (bully-victim). This represents 14% in Grades 3 to 5, 16% in Grades 6 to 8, and rises further to be 23% in Grade 12. For girls, the prevalence is fairly stable, remaining at 10% in Grades 3 to 5 and Grades 6 to 8, and then rising to 12% in Grade 12. Bullies of boys are usually boys, while bullies of girls were sometimes boys and sometimes girls. The vast majority of students (83%) are not involved in bullying. The most frequent forms of bullying are parallel for boys and girls. The most common form of victimization is verbal. It occurs for 16% of girls and 15% of boys. The second most common is spreading rumors at 15% of girls and 11% of boys. The third is exclusion at 14% of girls and 11% of boys. Cyber bullying, while getting attention from schools and parents, is actually much less common at 6% of girls and 4% of boys. Students are bullied in more than one way. Students are most likely to indicate they experienced three types of bullying; only 16% experience only one form of bullying. Bullying can be transitory or can last an extended period of time. Forty-one percent were bullied a month or less, 26% six months to one year, and 25% were bullied for several years. Many victims will never tell anyone that they need help. Both boys and girls are less and less likely to confide to friends, family, or teachers as they go from the early primary grades through high school. Up to 38% of boys and 34% of girls tell no one. When they do confide in someone, it is most likely a siblings or a friend. More than 90% of girls and more than 80% of boys feel empathy for the victim but do little to stop the bullying (Luxenberg et al., 2015).

Longitudinal studies of children who are bullies indicate they are more likely to engage in sexual harassment in their later school years (Espelage, Basile, & Hamburger, 2012). They are more likely to use alcohol and drugs, vandalize property, and drop out of school (Olweus, 2011). They also show higher rates of criminal victimization. Comparisons between bullies and nonbullies show that bullies are four times as likely to have frequent criminal convictions (Olweus, 1993). Meta-analyses find bullying related to both later criminal behavior and antisocial behavior (Ttofi, Farrington, Lösel, & Loeber, 2011b). In addition to having an impact on the bully and the victim, witnesses have been found to be impacted. They show reactions such as anxiety and insecurity (Polanin, Espelage, & Pigott, 2012). They may also show signs of helplessness including potential suicidal ideation (Rivers & Noret, 2013). On the positive side, bystanders may show signs of interpersonal sensitivity (Rivers & Noret, 2013).

## Dating Violence

According to the Centers for Disease Control and Prevention (2013), 10% of high school students indicate they are being hit, slapped, or physically injured by a dating partner over the course of the year. Teen dating violence is associated with externalizing behavior such as sexual risk taking and substance use (Florsheim & Moore, 2008; Hipwell et al., 2013) as well as internalizing behavior such as depression and academic failure (Howard & Wang, 2003). Adolescents are highly influenced by their peers and by the school

environment and their dating relationships. Adolescents struggle more with discriminating between what is healthy and unhealthy dating behavior when they are considering someone else's relationship rather than their own. Teenagers perceive healthy relationships to involve positive communication, connection, and signs of commitment, while unhealthy relationships indicate high levels of insecurity, intense focus on the relationship, high levels of dependency, as well as abusive behavior (Goldman, Mulford, Blachman-Demner, 2016). Examples of positive communication include spending time together, talking about what goes on during their day, and smiling and laughing. Examples of unhealthy relationships include high levels of insecurity, such as thinking that their partner isn't contacting them enough, acting impulsively, and doing things because other couples are thought to be doing them. Examples of behavior considered warning signs of more serious problems include having trust issues, rushing into things, and becoming obsessed with knowing what the other person is doing. Finally, examples of abusing behavior may include being put down by partner, justifying abusive behavior, as well as physical attacks on partner (Goldman et al., 2016, p. 502).

Dating violence is moderated by the acceptability of violence for both males and females. Rates of dating violence for girls ranged from 1.9% for violence that results in injury to 6.3% for any level of physical or sexual coercion. For boys, the rates are lower with 1.0% for injurious violence and 8.6% for any level of physical or sexual coercion. Rates for females are also found to be higher when level of fear is included in the definition (Hamby & Turner, 2013). The rates of dating violence in college have ranged from 20% to 50% (Cogan & Fennell, 2007; Forke, Myers, Catalozzi, & Schwarz, 2008; Straus, 2004). The impact of these assaults varies from physical problems such as complaining of somatic symptoms and health problems (Amar & Gennaro, 2005) to having psychological problems such as depression and anxiety (Clements, Ogle, Sabourin, 2005; Kaura & Lohman, 2007). Investigations of moment-to-moment interactions within stressful circumstances suggest that negative emotions and decreasing self-control may be instigating triggers prior to aggressive interactions. Intimate partners can recognize negative emotions in each other; and when this is combined with a decrease in inhibitory factors, this tends to lead to more aggressive responding in conflict situations (Watkins, DiLillo, Hoffman, & Templin, 2015). Risk for teen dating violence increases when adolescents perceive their peers to be involved in violent dating relationships, when peers are engaging in aggressive or antisocial behavior, and when an adolescent is already victimized by peers in another way (Garthe, Sullivan, & McDonald, 2017). This association between other forms of violence or victimization and teen dating violence is not surprising considering the growing research on polyvictimization as a common form of exposure to violence (Hamby & Grych, 2013).

Learning how to negotiate romantic relationships is a new task for adolescents. While in the early childhood years, parents and other adults serve as primary attachment figures, no romantic partners can take on this role (Exner-Cortnes, 2014). Anxious attachment style is related to increased risk of both psychological and physical victimization in adolescents within romantic relationships; both victims and perpetrators are more likely to show anxious attachment styles in comparison to those who are securely attached (Bonache, Bonache et al., 2016; Miga, Hare, Allen, & Manning, 2010). There is more than one way in which an insecure attachment can result in problems within romantic relationships. Adolescents who are highly insecurely attached may show a strong need for intimacy and a fear of being rejected (high anxious attachment), or they may have become emotionally detached and show a strong need for independence from others (high avoidant attachment). Anxiously attached individuals will be hypersensitive to any separation from their romantic partner and use many proximity-seeking behaviors; they show high levels of negative affect. Avoidantly attached adolescents will do their best to avoid experiencing negative emotions (Maas, Laan, & Vingerhoets, 2011). College students are at increased risk for intimate partner violence when they are anxious and insecurely attached but not when they are avoidant and insecurely attached (Sandberg, Valdez, Engle, & Menghrajani, 2016).

In addition, insecurely attached adolescents are more likely to become involved with alcohol and drug abuse (Letcher & Slesnick, 2014), which can similarly lead to more violent behavior (Mahalik et al., 2013). At-risk behaviors together with the newness of negotiating problems within a romantic attachment figure may be behind the peak of dating violence that occurs during adolescence (Brooks-Russell, Foshee, & Ennett, 2013). Gendered effects are found with anxious and avoidantly attached males becoming involved in violent behavior as they try to withdraw from conflict as their anxiously attached partner tries to actively engage them (Bonache, Gonzalez-Mendez, & Krahé, 2017).

Research on disadvantaged urban teens finds them at increased risk of dating violence. Goncy, Sullivan, Farrell, Mehari, and Garthe (2017) find that while 54.6% of urban teens from at-risk neighborhoods indicate no involvement in dating violence, 8.3% are victims only, 9.7% are aggressors only, 22% are psychologically aggressive victims, and 5.4% are aggressive victims. Youth who are psychologically aggressive victims or aggressive victims have more trauma-related symptoms than the uninvolved group. The psychologically aggressive victims show even more trauma related to stress than those who are the aggressors in the dating violence. Aggressive youth are more involved in delinquent activities than victimized youth (Goncy et al., 2017).

## Sexual Offenses

The family context of sexual assault in the teen years is most likely to show parental physical abuse, followed by witnessing domestic violence, and then childhood sexual abuse (White & Smith, 2004). Researchers find perpetration of sexual assault in college related to childhood victimization only through the pathway of teen sexual assault. Those men who are victimized in childhood, but are not engaged in sexual assault in adolescence, do not victimize women in college. In following male college students across four years of college, most are not perpetrators of sexual assault. However, for that subset that is engaged in sexually coercive behavior, including rape, the number of assaults of the perpetrator tends to increase with each of the four years of college (White & Smith, 2004). Promoting a community environment in which beliefs, attitudes, and messages include the importance of treating romantic partners, peers, family members, and strangers with respect as well as countering messages that include acceptability for sexual violence, stalking, and physical violence is important in ending victimization of both males and females. Media often reinforces societal and community norms that portray victimizing and perpetrating behavior as normal and find stereotypes of masculinity acceptable that objectify and degrade women (Black et al., 2011).

Sexual offenses involving children are broken down into child sexual abuse (victimization is at the hands of a family member or other adult in a caretaking role), sexual victimization (includes sexual harassment), and sexual assault (attempted and completed rape, contact offenses by adults and peers). Approximately 6% of adolescents admit to being sexually victimized in the past year. Fewer, 2.2%, admit experiencing a sexual assault in the past year. Adolescents aged 14 to 17 indicate that 17% of girls and 4% of boys experience a sexual assault. The rates go down for completed rape to 3.6% for girls and 0.4% for boys. While the thought of unknown adults assaulting their children is frightening to parents, only 6% of girls and 0.3% of boys indicate being sexually assaulted by an adult, and this drops to 3.8% for girls and 0.1% of boys if the adult is unknown to them (Finkelhor et al., 2015). Prison studies indicate that those who sexually offend against children are less likely to reoffend after a longer time in prison than those who are convicted for sexual offenses against adults. However, the greater the number of sexual offenses committed against children prior to being in prison, the greater the likelihood of re-offenses after release from prison (Budd & Desmond, 2014).

Sexual victimization can lead to later sexual perpetration (Finkelhor, Ormrod, & Chaffin, 2009; Schwartz, Cavanagh, Prentky, & Pimental, 2006). Preteen children who sexually offend are likely to be victims of child sexual abuse. These young sex offenders may be as young as nine (5%) and younger than 12 (16%). There are more sexual offenders who are over the age of 12, with youth ages 12 to 14 (38%) and youth 15 to 17 (46%). Males represent 93% of minors who commit sexual offenses.

There is a greater diversity of correlates to sexual perpetration in the adolescent years. Adolescence is a developmental period in which sexual curiosity is typical, and this can be the motivation for some sexual offenses. Some adolescent offenders show a long prior history of violating the human rights of others, with sexual offenses just part of this pattern. Others have serious mental health problems that play a role in their sexual offending. In addition, for some, their sexual offenses are compulsive or reflect impulsive behavior and poor judgment (Chaffin, 2005; Finkelhor, Ormrod, & Chaffin, 2009; Przybylski, 2015). Most juvenile sex offenders (85%–95%) do not go on to be arrested for sex offenses as adults. Caldwell (2010) found only a 7% recidivism rate for sexual perpetration in adolescent offenders. When they reoffend, it is often due to family problems and cognitive difficulties; these are the same factors that are most likely to lead to reoffending in nonsexual offenses. However, other studies found higher rates of reoffending. Reitzel and Carbonell (2007) find a reoffending rate of 12.53% in comparison to 24.73% for violent offending and 28.51% for nonsexual and nonviolent offending. Treatment can reduce recidivism; when sexual offenders receive treatment, their reoffending rate drops to 7%. When compared to adult sexual reoffending rates, adolescent offenders are somewhat less likely to reoffend (Reitzel & Carbonell, 2007). Learning to take responsibility for their own behavior and having parents set appropriate rules about sexual behavior are important aspects of helpful treatment (McGrath, Cumming, Burchard, Zeoli, & Ellerby, 2010).

Research outside of the United States also finds a relationship between being sexually coerced in youth and engaging in sexually coercive behavior toward others. In a comparison of two surveys of male students, 18% admit to being sexually coerced (sexual touching, masturbation, or intercourse) at some time in their lives. These male youth are three times as likely to later sexually coerce others (Seto & Lalumiere, 2010; Seto et al., 2010). In order to reduce the likelihood of perpetration, adolescents who are sexually victimized may need education targeted at how to deal with sexual arousal, sexual harassment, control of sexual impulses, and respect for the personal boundaries of others (Finkelhor, 2008, p. 178). The ability to regulate all emotions, not just those associated with anger, is key to effective change. Reaching prosocial goals requires awareness of an emotion, the ability to inhibit an impulsive reaction to the emotion, and then to think through what action might be appropriate (Robertson, Daffern, & Bucks, 2015).

Many differences are found between juveniles who commit sexual offenses and adults. Juveniles are more likely (24%) than adults (14%) to engage in perpetration as part of a group. They are less likely (24%) to commit rape than adults (31%) and are almost twice as likely to commit acts of sodomy (13% vs 7%). This may be related to the fact that they are almost twice as likely to have male victims (25% vs 13%). Adult sexual offenders commit their offenses at home at a rate of 80% in comparison to juveniles whose rate is 69%. Juvenile offenders are much more likely to offend at school (12% vs 2%). While both juveniles and adults can offend against a wide age range of victims, 59% of juvenile sex offenders pick victims age 12 and younger; adults are more likely to pick victims age 13 and older. When juvenile sex offenders target boys, they are usually much younger and sexually immature boys. When girls are the target, they tend to be more sexually mature females (Finkelhor et al., 2009). Female juvenile sex offenders represent 7% of juvenile offenders. They tend to be younger than male offenders with 31% younger than 12 in comparison to 14% of males being this young. They are also more likely than males to offend with others (36% vs. 23%), more likely to offend along with an adult (13% vs. 5%). They may be victims themselves during the same timeframe in which they are offending against others. More than a quarter of sex crimes overall and more than a third of sex crimes against minors are committed by juveniles (Finkelhor et al., 2009).

### **Campus Sexual Assault**

Campus sexual assault can include physically forced rape, incapacitated rape, alcohol- and drug-facilitated rape, attempted sexual assault, and unwanted sexual contact; and it can include samples of male, female, or

both male and female students. Many studies have been conducted on sexual assault using different types of campuses and using different definitions of what a sexual assault consists of. This can make comparisons across studies difficult. Krebs, Lindquist, Warner, Fisher, and Martin (2007) and associates find a rate of 12.6% for attempted sexual assault and 13.7% for completed sexual assault when surveying women at two public universities. When the same survey instrument is used across universities, sexual assault at historically Black colleges and universities finds a rate of 8% of attempted sexual assault and 9.6% of completed sexual assault of university women (Krebs, Lindquist, & Barrick, 2011). In a study using nine colleges and universities, 10.3% of women and 3.1% of men report experiencing completed sexual assault. Completed rape occurs for 4.1% of women and 0.8% of men (Krebs et al., 2016).

Many different forms of sexual assault are being investigated. Fedina and colleagues, in examining all prevalence research from 2000 to 2015, find that many different types of sexual assault are examined (Fedina, Holmes, & Backes, 2016). In studies looking at completed rape in women, a prevalence ranging from 0.5% to 8.4% of college women is found. Attempted rape ranges in prevalence from 1.1% to 3.8% of college women. Sexual coercion shows prevalence ranging from 1.7% to 32% in women. Both males and females report unwanted sexual contact occurring at college. Across studies, 1.8% to 34% of women report experiencing unwanted sexual contact. In men, from 4.8% to 31% report experiencing unwanted sexual contact. Studies of incapacitated rape find rates from 1.8% to 14.2% in women and 1.9% in men. Overall, the most common form of sexual assault for both men and women across studies is unwanted sexual contact (Fedina et al., 2016).

Men and women on college campuses are more at risk for sexual assault than their noncollege peers. The perpetrator is usually someone they know, an acquaintance or someone they are in a romantic relationship with (Dills, Fowler, & Payne, 2016). One half of women report at least one experience with physical or sexual assault during adolescence. Once women are in their fourth year of university education, 80% indicate experiencing physical or sexual aggression (Smith, White, & Holland, 2003). In a longitudinal study of males, 6.3% of university men indicate raping or attempting to rape a woman in high school, and 22% admit to physical assault. By the end of their fourth year of college, 34.5% of men in this study admit to at least one act of sexual assault by the end of their college careers, with 13.8% of these assaults being attempted or completed rapes (White & Smith, 2004). In a longitudinal study of physical and sexual perpetration among college men, history of child abuse is related to continued perpetration in college through the first year. Almost half of college men indicate engaging in at least one act of physical or sexual dating violence over the course of their college career. Almost 11% reported engaging in at least one act of physical aggression as well as one act of sexual aggression over the course of their university career. There is a decrease in aggressive behavior from high school through the college years overall. However, there are two peaks for violent behavior: one in adolescence and one in the second year of college. The peak in the second year of college may be due to the men now being in committed relationships. College men who either witness violence between their parents or are a victim of physical abuse are more likely to engage in physical aggression against their partners in the second year of college. Men who both physically and sexually assault women in college are more likely to have a history of childhood victimization (White & Smith, 2009). After that, the best predictor of perpetration in the second year is whether there was perpetration in the first year. Dating violence is most common among men indicating they are in a committed relationship (White & Smith, 2009).

Studies of perpetrators are less frequent than those of victims of college sexual assault. When male perpetrators self-report, 75% say they used alcohol prior to the most recent time they assaulted someone. Binge drinking prior to assault is associated with those who perpetrate when under influence of alcohol, and impulsivity, rape myth attitudes, and hostility toward women are associated with assault when not under the influence of alcohol (Kingree & Thompson, 2015).

## Community and Situational Contexts

Community factors are also related to the likelihood of violence exposure and violent behavior. Children and youth are at increased risk for engaging in violence when they live in a dangerous neighborhood, are exposed to street violence, and receive less than adequate parenting (Cronholm et al., 2015). Close to 17% of children and youth are exposed to hearing gunshots or seeing someone shot over the course of the year, and close to 59% say they've been exposed to one of these experiences over the course of their life (Finkelhor et al., 2015). Experiences with bullying and harassment in school environments are also highly potent risk factors. Adolescents exposed to community violence are found to have more psychological symptoms, to be less connected to school, and to have poorer educational performance over the long run (Borofsky, Kellerman, Baucom, Oliver, & Margolin, 2013). Neighborhoods of concentrated poverty are more likely to expose children and youth violence as they may have less effective policing. This can lead to more gang violence and lower levels of social trust between residents and each other and residents and the police force (Sampson, 2012).

Situational factors such as access to violent media, weapons, and the use of alcohol and drugs can all increase the likelihood that violence will occur (Diamond & Lee, 2011; Kellam et al., 2011). Research on the impact of violent media provides strong evidence that it influences both short-term and long-term increases in aggressive affect, aggressive cognitions, and aggressive behavior. It also reduces empathy and prosocial behavior both in the United States and Japan (Anderson et al., 2010). Cultural comparisons with Japan are particularly telling as the society at large strongly emphasizes peace and nonviolent problem solving. In addition, it is difficult to gain access to firearms in Japan. Thus, the social and political context in which violent media is embedded is highly divergent in Japan in comparison to the United States, yet they both show the same effects of violent media (Anderson et al., 2010). Bandura's (1977) social-cognitive model for aggression provides help in understanding how aggressive behavior occurs within the complexity of human experience. Some elements of the environment facilitate an aggressive response in the immediacy of a situation. These facilitating factors can be cues to violent responses such as presence of weapons, violent media. They can also be part of unpleasant situational contexts that tend to put people in unpleasant or angry moods such as hot temperatures, unpleasant smells, and loud noises. They can also be interpersonally unpleasant such as intentionally provocative or frustrating behavior on the part of others. There are also inhibiting factors that make it less likely someone will engage in an aggressive act such as strong internalized sanctions against aggression, and fear of engaging in aggression due to possible negative consequences. Violent media physiologically arouses the player and primes the individual to engage in aggression, and this priming occurs within the first few minutes of the game. In addition, situational factors that put individuals in a positive mood make it less likely they will engage in aggression. Violent media are found to desensitize the individual emotionally to expressions of pain and signs of injury and make it less likely that an individual will offer help to someone who has been hurt. Violent media engage the person physically and psychologically in the game and substantially impact thinking, feeling, and acting; individuals are found to become more aggressive (Anderson et al., 2010).

The frequency of drinking is reciprocally related to victimization. Those who are victimized drink more, supporting the idea that alcohol is playing a role in their coping responses. In addition, those who drink more frequently put themselves in environments and situations that make them more vulnerable to revictimization (Bryan et al., 2016). There is also evidence that while perpetrators bear sole responsibility for assaults, helping victims learn how to directly assert their sexual desires within their interpersonal relationships can help sometimes (Kelley, Orchowski, & Gidycz, 2016).

Families that are dysfunctional due to severe and frequent conflict, substance abuse, changing caretakers, or abusive or neglectful caretakers, all place children at increased risk of revictimization. Each additional trauma in a child's life increases the risk for further victimization (Classen et al., 2005). Cold and hostile parenting

practices promote violence (Piquero, Jennings, & Farrington, 2010; Welsh et al., 2012). As the number of adverse childhood events such as emotional abuse, child maltreatment, and bullying in the schools, increases, the likelihood of suffering severe illness as an adult and likelihood of early death increases (Brown et al., 2009), whatever the particular types of violence experienced.

## Polyvictimization

The National Survey of Children's Exposure to Violence [NatSCEV II] examines the occurrence of 54 forms of offenses over the course of both the year as well as over the life span (Finkelhor et al., 2013). This data is collected using a randomly selected phone survey. Results indicate that 58% of children are exposed to at least one form of violence in the past year. Children are victimized by assault (41%), sexual victimization (6%), property crimes (24%), child maltreatment (14%), witnessing violence (22%), and witnessing violence within the family (8%). While some children experience only one exposure to violence, 48% experience multiple exposures, and 15% are exposed to six or more acts of violence; finally, 5% experience 10 or more exposures. Odds ratios indicate that each additional exposure to violence greatly increases the likelihood of another. As an example, experiencing an assault in the past year makes it three times as likely that there will also be child maltreatment during the same year. In looking at life span data, exposures to violence increase with age, with 26% victimized within their families and 40% witnessing violence. Gender and developmental differences are also found; late adolescent girls (17%) indicate significantly more sexual victimization than boys (4%).

## Impact of Victimization on Children and Youth

Traumatic experiences are complicated, and it is to be expected that children and youth and their families will show heterogeneous responses to victimization. Victims can show internalizing behavior such as ruminating over thoughts of what happened, show specific or generalized anxiety, or be sad, depressed, or suicidal (Copeland et al., 2013; Faris & Felmlee, 2014; Reijntjes, Kamphuis, Prinzie, & Telch, 2010; Ttofi et al., 2011a). They may experience psychosomatic problems, including having difficulty sleeping, decreased appetite, complaints about stomach pain, and headaches (Gini & Pozzoli, 2013). They may develop externalizing behavior such as an increase in aggressiveness, controlling behaviors, or develop a dislike and/or fear of school (Luxenberg et al., 2015). Victimization can also lead to PTSD (National Child Traumatic Stress Network, n.d.). In addition to needing to deal with the event(s) itself, traumatic events can trigger further problems for children, youth, and their families. For example, if the abuse results in the child being removed and placed in foster care, the child may experience grief and loss as well as potential bullying at school for being a "foster kid." There may be situational cues in the environment that remind the child of the victimization, and this can trigger renewed or heightened fear and distress. For example, a child who is sexually abused in the bathtub may have an anxiety attack if the foster family tries to get the child to take a bath. The National Child Traumatic Stress Network (n.d.) calls these secondary adversities, trauma reminders, and loss reminders that can impede emotional and behavioral functioning. Negative consequences can occur far in time from the initial victimizing event. For example, the impact of victimizing events on adults across 10 states and the district of Columbia indicates that those who experience adverse childhood events are more likely not to complete high school, to be unemployed, and to be living in poverty (Metzler, Merrick, Klevens, Ports, & Ford, 2017).

Maltreated children with uninhibited temperaments are more likely to act aggressively. They develop maladaptive cognitive schemas for processing social information and attribute hostile intentions to others, who are often engaging in neutral behavior. These children respond impulsively and get angry quickly. They are learning a repertoire of aggressive retaliatory behavior at home, they view aggression as morally acceptable, and their parents are tolerant of their aggressive behavior toward peers (Dodge, Pettit, Bates, &

Valente, 1995; Watson et al., 2005). Longitudinal studies show that both boys and girls who are significantly more aggressive than their peers at age 5 often continue to be aggressive throughout the elementary years, and the boys may continue to be highly aggressive even into adolescence. In contrast, children who are behaviorally inhibited may be more likely to respond with internalizing symptoms to victimization whether at home or school (Broidy et al., 2003; Watson et al., 2005). The severest forms of internalizing difficulties involve suicidal thoughts and behaviors. Girls have been found to be at most risk for suicide attempts and completed acts of suicide (Klomek et al., 2009). Boys are at increased risk if they are bully-victims (Copeland et al., 2013). According to the National Violent Death Reporting System, when someone dies from suicide between the ages of 10 and 17, 12% of the time it's related to bullying, and 51% of the time it's related to problems within intimate partner relationships (Karch, Logan, McDaniel, Floyd, & Vagi, 2013). In examining different types of bullies and victims, bully-victims showed the highest rate of suicidal ideation (60%), followed by physically aggressive bullies (43%), and relational bullies and victims (32–38%). This is in comparison to only 12% of uninvolved youth reporting suicidal ideation. There were fewer youth who took steps to harm themselves than experienced suicidal ideation. However, the same pattern of prevalence was demonstrated with bully-victims showing the highest rate (44%), followed by physically aggressive bullies (35%), and then relational bullies (24–28%). Only 8% of uninvolved youth took steps to harm themselves (Espelage & Holt, 2012).

Children and adolescents may or may not be traumatized by the adverse experiences they have. Research on resilience indicates that when children and adolescents experience victimization while living within a functional environment they are less likely to show social or emotional malfunctioning in the long run (Masten, 2014). It is polyvictimization that is shown to have the strongest relationship to long-term social and emotional malfunctioning (Lätsch, Nett, & Hümbel, 2017). When children and adolescents have been victimized repeatedly, it influences their emotional responsivity, their ability to think before they act, their ability to form trusting relationships, and their ability to learn from their experiences at school and in other environments (Cole et al., 2013). Frequent psychological maltreatment, both singly and in addition to frequent or occasional physical maltreatment, is related to children showing higher levels of psychological distress upon reaching adulthood. If these child victims later experience a positive sense of community as adults, they show lower levels of distress than those child victims who do not have this positive connection as adults (Greenfield & Marks, 2010b). Adolescents who are victimized in early childhood (ages 0–6) and show externalizing problems during middle childhood (age 8) are very likely to show externalizing problems in late childhood (age 10). Similarly, those who respond to violence victimization in early childhood and respond with internalizing problems in middle childhood (age 8) continue to show internalizing problems in late childhood. The relationship between victimization and internalizing and externalizing behavior is a direct effect. However, there is also an indirect effect of victimization increasing the likelihood of posttraumatic stress disorder in early childhood, which then increases the likelihood of internalizing or externalizing problems in middle childhood (Cromer & Villodas, 2017). Children who are both psychologically and physically mistreated by their parents are also shown to have greater levels of negative affect when they reach adulthood. All forms of violence from fathers are associated with lower levels of well-being when children reach adulthood. Frequent psychological maltreatment from the mother, even in the absence of other forms of violence, is associated with negative affect when the children reach adulthood but not reduced levels of well-being (Greenfield & Marks, 2010a). Adolescent girls who are victimized by their peers and indicate being emotionally connected to their friends show lower rates of internalizing behavior than girls who reported lower rates of connection to friends; this finding does not hold up for boys. Adolescent boys who are victimized by peers but are emotionally connected to their parents show lower rates of internalizing behavior than those reporting lower connections to their parents; this is not found true for girls (Morin, Bradshaw, & Berg, 2015).

## Protective Factors

Research seeks to understand the factors related to children being exposed to violence in the home or school yet not becoming violent themselves. One important factor is a caregiver who provides social and emotional support to the child. In addition to emotional support, practical guidance in how to cope with the violence is critical to this process of reducing risk for further violence (Consortium for Longitudinal Studies of Child Abuse and Neglect, 2006). Other protective factors include a positive attachment to adults who do not tolerate violent or deviant behavior and parental commitment to their children's school success (Surgeon General, 2001). Family environments that promote open communication, respect for personal boundaries, and emotional support reduce the risk that children and youth will engage in acts of stalking, sexual harassment, and rape (Black et al., 2011). School systems that are trauma sensitive and respond proactively to maltreated or traumatized children can provide the support for healthy learning experiences and reduce the impact of maltreatment and trauma (Cole et al., 2013).

Wright, Masten, and Narayan (2013) indicated that the strongest factors in protecting children from the negative impact of trauma included family characteristics such as positive and responsive caretaking from a family member or surrogate family member and a stable and safe home environment. Child characteristics that are protective features include having learned to regulate emotions and to view self as worthy and valued; having an average or above average intelligence and adaptive problem-solving abilities; and having a positive outlook on life (Masten, 2014).

Finally, community characteristics have been found that are protective factors in dealing with trauma including things such as a safe neighborhood, low levels of community violence, affordable housing, access to recreational centers, effective schools, and employment opportunities. Finally, there were cultural or societal characteristics that served as protective factors such as laws that protected the welfare of children at home, school, and in the labor force; that supported health care; and that did not tolerate physical violence (Wright et al., 2013). Positive connections with parents can decrease the negative impact of victimization at school (Duggins et al., 2016). An important factor that supports resilience is success in school and cognitive competence. Programs that support families from disadvantaged communities in strengthening their children's school readiness skills have been found to reduce problems with the criminal justice system by 75% (Heckman, 2013). The most cost-effective way of reducing violence might be to target those children and youth who have the greatest rate of victimization. In the NatSCEV II sample, 11% had been exposed to six or more types of victimizations. These polyvictims are the most vulnerable populations in need of intervention (Finkelhor et al., 2013). As violence exposure occurs in a variety of settings (home, community, school) and from perpetrators across the life span, ending violence will most likely result when professionals from many different disciplines with expertise in many different forms of violence work together—recognizing that their target populations are often the same, despite the differences in referral issue (Finkelhor et al., 2013).

## VIOLENCE AND ADULTS

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Violence between adults occurs within a context of individuals, stimuli, and physical settings—not as isolated events (Office of Violent Crimes, Department of Justice [OVC], 2010). It may include physical violence, stalking, psychological abuse, sexual violence, threats of physical violence or sexual violence, control of reproductive or sexual health, and psychological aggression (Centers for Disease Control and Prevention, 2015). The National Intimate Partner and Sexual Violence Survey provides important definitions of abusive behavior. Physical violence is defined as “includes a range of behaviors from slapping, pushing or shoving to severe acts such as being beaten, burned, or choked.” Stalking is defined as “victimization [that] involves a pattern of harassing or threatening tactics used by a perpetrator that is both unwanted and causes fear or

safety concerns in the victim.” Sexual violence “includes rape, being made to penetrate someone else, sexual coercion, unwanted sexual contact, and noncontact unwanted sexual experiences.” Psychological aggression includes “expressive aggression (such as name-calling, insulting or humiliating in intimate partner) and coercive control, which includes behaviors that are intended to monitor and control or threaten an intimate partner.” Finally, control of reproductive or sexual health includes behavior such as “the refusal by an intimate partner to use a condom. For women, it also includes times when a partner tried to get her pregnant when she did not want to become pregnant. For men, it also includes times when a partner tried to get pregnant by him when he did not want her to become pregnant” (Black et al., 2011, p. 37).

Co-occurrence of types of violence and polyvictimization is considered normative in intimate partner violence (Hamby & Grych, 2013). Men and women may both experience physical and emotional abuse by an intimate partner, however women are more likely to be stalked, and men are more likely to engage in victimization of both their partners and their children. Men are three times more likely than women to assault both their partners and their children (U.S. Department of Health and Human Services, Administration for Children and Families, 2006).

### Physical Violence

Assaults between partners can range from temporary injuries due to slaps and scratches to fatal injury as a result of repeated punching, kicking, use of weapons, and so forth. Nonlethal injury can result in acute medical conditions and chronic consequences. Legal statutes label all partner abuse as “battery,” despite men’s attacks often showing a higher level of lethality than those initiated by women (Samuelson & Campbell, 2005; Stuart, 2005) as indicated by a ratio of 1:3 female partners being killed in comparison to 1:20 male partners being killed (Reckdenwald & Parker, 2010). Violence may begin with one partner, but this often serves to elicit violence from the other either for self-defense or for revenge (Archer, 2002; Graham-Kevan & Archer, 2005).

Physical abuse does not occur in isolation from other forms of violence (Hamby & Grych, 2013). Finkelhor et al. (2015) found that 22% of children indicated they saw violence between their parents or adult caretakers over the course of the past year (Finkelhor et al., 2015). Violence by an intimate partner occurs for 35.6% of women and 28.5% of men in the United States in their lifetimes. These acts include physical violence, rape, and/or stalking. Intimate partner physical violence and sexual violence often occur within the same relationships. One in three women who are physically assaulted by their partners will experience many forms of sexual assault including rape and stalking. Most male victims who are physically assaulted by their partners do not experience sexual assault; however, 6.3% experience stalking as well as physical violence (Black et al., 2011). Women involved in dating relationships do not show decreases in their satisfaction with their relationship after an episode of violence if they consider violence from a male partner to be acceptable; relationship satisfaction does decrease if they consider violence from a male partner to be unacceptable. Men involved in relationships do not show decreases in satisfaction after a violent incident initiated by their female partner if they consider violence from female partners to be acceptable; if they consider female partner violence unacceptable, then they show decreases in relationship satisfaction as well as increases in mental health problems (Kaura & Lohman, 2007).

Research on IPV is often divided into investigations of victims or perpetrators despite evidence showing that there is often not a clear line between who is a victim and who is a perpetrator (Hamby, 2016; Hamby & Grych, 2013). Straus (2015) considers violence within the relationship as classifiable into three dyadic concordance types including those in which only the male is violent, only the female is violent, or both partners engage in violence. Within this research, more than half of the couples are of the “both violent” type. Similar patterns are found whether the reports on dyadic interactions came from male or female reporters. Additionally, these patterns hold up whether the abuse is physical, psychological, or sexual (Straus & Michel-Smith, 2014a, 2014b, 2015). This pattern also predicts important impacts of IPV on children. In a longitudinal study by Fehringer and Hindin (2009), the greatest risk for the child witnessing violence, to engage later in

violence, is having a family in which both the father and the mother engage in violent acts. In comparing rates of depression in violent couples, levels of depression are greatest in couples where they are both violent (Straus & Winstok, 2013). Thus, from this perspective, the impact of male and female violence is similar. In dating violence this parity is the result of the criterion used for defining dating violence that doesn't include severity. However, when the definition does, then females are victimized more frequently. Women in shelters admit to engaging in mutual violence (93%), however, they rarely report that the aggression is not mutual (5.3%). These data also suggest that women are victimized much more frequently than they respond with violence in return (Holmes et al., 2016).

There are other gendered effects. Women are the victims of IPV at rates from two to four times higher than males on measures of violence that are based on surveillance methodologies (arrest rates, homicide data) (Hamby, 2009). Crime surveillance systems, such as the National Crime Victimization Survey (NCVS), the National Incident-Based Reporting System (Snyder & McCurley, 2008), the National Survey of Children's Exposure to Violence (NatSCEV) (Finkelhor, Turner et al., 2009), and the National Intimate Partner and Sexual Violence Survey, United States (CDC, 2014a) all indicate that men are more likely to victimize a female partner than the reverse. In addition, research indicates that the violence of men is more severe, causes more injuries, and is more likely to result in death (Reckdenwald & Parker, 2010). Most men (85%) who are victimized report having "no fear" of their partner, while the reverse is true for women with 70% reporting "being very frightened" of their violent male partners (Phelan, 2005; Phelan et al., 2005). This greater level of fear that women experience is mirrored by injury rates. Severe injuries occurred for 22.3% of women in comparison to 14% of men (CDC, 2014a). Fear of a male partner fuels his position of control and authority over the women. It is this power differential, per se, that fuels physical and sexual violence in gay and lesbian couples (Eaton et al., 2008; Messinger, 2011). There may also be differences in the types of violence used between males and females. College males who admit to committing acts of violence are found to threaten more violence than college women, while the women are found to admit to use of more emotional abuse than males (Cascardi & Muzyczyn, 2016).

Males are involved in violence outside the home at much greater rates than females, and their serious injuries are most likely to come from these incidents rather than their fights within the home (Hamby, Finkelhor, & Turner, 2013); while these differences are important, they are at the level of the individual. Dyadic interactions indicate that effective intervention and treatment might be different in the three different categories of IPV (Straus, 2016).

Victims of different forms of IPV experience many immediate and later reactions. For example, three in 10 women and one in 10 men report being fearful and concerned for their safety. They may also report more serious impacts such as the development of PTSD, injuries, and the need for health care (Black et al., 2011). Prevention of these forms of violence begins with teaching children how to develop positive family and peer relationships. Parents need to create emotionally supportive environments that will serve as the foundation for developing trustful and positive relationships. In addition, perpetrators of violence need to be held accountable by law enforcement and criminal justice (Black et al., 2011). In addition, there needs to be recognition that many perpetrators were in fact victimized themselves and are in need of support to reduce the impact of their past trauma on their current behavior (Hamby & Grych, 2013).

## Perpetrators of IPV

Violent individuals represent a heterogeneous group. The severity of the violence can differentiate some perpetrators from others. For example, approximately 30% of women and 25.7% of men in the United States admit to experiencing the less severe forms of violence in their lifetime, such as slapping, pushing, or shoving by an intimate partner. On the other hand, approximately 24% of women 13.8% of men admit to experiencing severe physical assault in their lifetime. Partners severely assaulted report being slammed against something

(17.2%), being hit with a fist or something hard (14.2%), and being beaten (11.2%). In the past year, 2.7% of women admit to severe physical assault as compared to 2.3 % of men (Black et al., 2011).

A variety of typologies exist that try to provide insight into differences between perpetrators of violence against intimate partners. Stuart's (2005) typology classifies individuals as predatory abusers, affectively motivated abusers, and instrumental abusers. He considers predatory abusers to be least motivated to change and most dangerous to their victims. They engage in frequent and recurrent violence that is instigated for their own idiosyncratic purposes unrelated to their partner's behavior. Prior to the assault, they may be calm, and they find the violent episode arousing. They severely injure their victims both physically and emotionally, yet after the incident show a lack of empathy or regret for what they have done to the victim.

The instrumental abuser engages in violence in order to gain something from the partner, and incidences of violence are rare. These individuals are calm before the assault and mildly aroused upon gaining whatever it is they want from the partner. They are limited in motivation to change because their desire for personal gain is more important to them than their concern for the victim. The injuries inflicted are incidental to the perpetrator trying to get what he or she wants from the victim.

Stuart considers the affectively motivated assailant to be most amenable to treatment. This individual is actually provoked by the victim or at least interprets the behavior of the victim as provoking. Violent behavior occurs only occasionally. The perpetrator is highly aroused before the assault and calms down afterward. The violent acts occur impulsively, may involve relatively less severe actions, and may result in only mild consequences to the victim in comparison to the acts of other abusers. The acts may have the greatest impact on the victim's self-esteem, and the perpetrator may show empathy for the victim's injuries and regret for having caused them.

Johnson and colleagues (Johnson, 2006; Johnson, Giordano, Manning, & Longmore, 2015; Johnson & Leone, 2005) describe a typology in which perpetrators of intimate violence can be seen as either involved in situational couple violence or intimate terrorism; all together he posits four forms of intimate partner violence. Intimate terrorism is the form of assault in which the goal is a systematic establishing of dominance and control. In this type of violence, the perpetrator uses coercive control as the style of relating throughout the relationship. The perpetrators of this form of violence are predominately male. There are three forms of intimate terrorism. In the first form, simply called intimate terrorism, one partner uses a variety of control measures, some violent and some not, with the intent of gaining absolute control over the other partner. The second form, intimate resistance, is when the partner who is the recipient of the coercive control responds violently but is not trying to exert control over the other partner. The violent response is considered self-protection or revenge.

The third form of violence is labeled mutual violent resistance. In this form, both partners are using violence and trying to control each other. Estimates are that roughly two million women are victimized in this way per year. These are the victims who end up in emergency rooms, at domestic violence shelters, and become involved in law enforcement. The Duluth Model Power was developed in Duluth, Minnesota, and founded by Ellen Pence and Michael Paymar (Domestic Abuse Intervention Programs [DAIP], <https://www.theduluthmodel.org>). This model is designed around intimate terrorism. Examples of a perpetrator of this type of violence would be someone who controls all financial resources, all opportunities to socialize, all opportunities to organize daily tasks in addition to emotionally and physically abusing the partner—the partner is terrorized by a range of tactics.

In contrast, situational couple violence is a more common form of violence and occurs when a stressful situation gets out of control and in which one or both parties responds violently. The intent of the violence is to deal with the immediate situation, and neither partner is trying to exert general control over the other. There may be one or more times when conflicts do become violent. There may be one incident of the mild violence where someone is pushed or slapped but not injured. Immediate remorse and regret follow the violence, and it is not repeated. However, it could be that there is chronic mild or severe violence that can be

life threatening. A particular incident might look like intimate terrorism in terms of the extent and severity of the incident. However, it is situational violence when the power and control dynamics are not present. The violence is embedded in the immediate situation that escalated for the couple. There can be many motivations for the violence including things such as the desire to preserve self-image, jealousy, frustration, or rage. When overall estimates of intimate partner violence include situational couple violence, the number of female victims increases to six million.

It may be that the perpetrator of affectively motivated violence or common couple violence or intimate terrorism is most open to change (Frieze, 2005; Stuart, 2005). Motivation for change may come from dynamics such as regret over harming the partner, the wish to be a good parent, the desire to protect children from harm, or a future orientation (CDC, 2006). Violence, however, may continue throughout 50 years of an intimate relationship or marriage (OVC, 2010). Women over 50 are more likely than men over 50 to be victims of physical and sexual violence. Homicide-suicides are most likely to occur with the husband first killing his wife and then killing himself (OVC, 2010). However, men are also victimized in this way, and some data indicate that exploitation or neglect may have relatively the greatest number of male victims (Pritchard, 2002).

## Stalking

Stalking can involve being physically followed as well as receiving repeated and unwanted phone calls or text messages. These experiences cause fear in the person being stalked and concerns that they or someone close to them will be harmed or killed. In examining lifetime occurrence, 16.2% of women and 5.2% of men experience stalking. When women are stalked, more than two thirds of the perpetrators are current or former intimate partners. For men, it is an intimate partner (41.4%) or acquaintance (40%) who is the stalker. Both men (75.9%) and women (78.8%) indicate that their stalker used unwanted telephone calls, messages, tracking using GPS, and text messages to make them feel fearful. The most common tactic among female victims is unwanted phone calls (78.8%) followed by being approached or having the perpetrator just show up (57.6%) followed by 38.6% being watched or followed. The rest of the unwanted contact occurs through unwanted gifts; unwanted e-mails or messages; or strange items left for them to find or placed into their home or car. For male victims, the most common type of stalking occurs using the phone (75.9%), 43.5% of the time the perpetrator just approaches them or shows up, and 31% of the time they are being watched or followed. For lifetime reports of stalking, it is most likely someone the victim knows who stalked both male and female victims (Black et al., 2011).

## Psychological Violence

Psychological abuse includes acts such as name calling, deliberate public embarrassment of the victim, isolating the victim from family and friends, controlling finances, and use of coercive control tactics (CDC, 2006). Over the course of the lifetime, approximately 50% of both men and women report having experienced emotional abuse/psychological aggression by an intimate partner (Black et al., 2011). Partner abuse is often a family secret. Many reasons for this are posited, including beliefs that the victimization is one's own fault, that victimization is a universal family experience, or that it would be dangerous to the self or family to reveal its existence (Stuart, 2005). Victims of partner violence are heterogeneous and come from all socioeconomic levels, ethnic or racial groups, educational backgrounds, and sexual orientations (CDC, 2006). Thirty-three percent of multiracial women report rape in their lifetime, followed by 26.9% of Native American-Indian women, 22% of African-American women, 18.8% of White and non-Hispanic women, and 14.6% of Hispanic women (Black et al., 2011). A commonality among victims is that they view the violent experience as a betrayal of their prior relationship with the perpetrator; even those who are not physically injured experience significant emotional disturbance often losing self-confidence and feeling worthless. Victims may also show fearfulness and become vigilant for signs of danger from the partner (Stuart, 2005).

Coercive control includes behaviors such as keeping partner from seeing family or friends; making decisions for the partner that the partner could make for themselves; forcing partner to give minute by minute accountings of what they do with their time; making threats of physical harm; and hurting someone the partner loves (Black et al., 2011). Many cultural norms give men authority over their partners and families. Thus, males may enter relationships expecting to have power and control in the relationship. Males who adhere to traditional gender roles are more likely to assault an intimate partner when they perceive a potential loss of power in the relationship (Santana, Raj, Decker, Marche, & Silverman, 2006). In addition, male victims are less likely to report their victimization or seek professional help: They put their need to present a front of being strong and independent ahead of their personal safety. However, Caldwell, Swan, and Woodbrown (2012) find that sexual minority couples engage in even greater levels of intimate partner violence than heterosexual couples. They suggest that it is power, and its abuse, rather than gender that are the key dynamics in IPV (Caldwell et al., 2012).

Recognizing the signs of coercive control (Dutton & Goodman, 2005; Stark, 2009) is key to recognizing the difference between the major types of interpersonal violence. Coercive control contains the element of intimidation to make the vulnerable partner do something against his or her will. This can be threats to the partner's body, but it can also be threats to harm children or prevent a partner from seeing children. The perpetrator can gain control only by proving to the partner that the threatened harm will follow if compliance doesn't. The violent partner must use constant surveillance of the vulnerable one in order to mete out punishment if compliance doesn't occur. Finally, the perpetrator can reduce the vulnerable person's ability to keep fighting to have any personal control. In a sample of 157 couples involved in situational couple violence, males (55%) and females (45%) perpetrated acts of violence and the modal acts of violence was one (Johnson, 2008, p. 22).

Another manner of conceptualizing IPV proposes three patterns (Dutton, Kaltman, Goodman, Weinfurt, & Vankos, 2005). One characteristic that differentiates all three patterns is the likelihood of sexual violence that is most common when the perpetrator engages in physical abuse, psychological, sexual abuse, and stalking. This pattern is the one most likely to lead to PTSD and depression in the female partner. How severe the violence is also differentiates the patterns. With one pattern being a perpetrator who while engaged in multiple forms of violence, most often physical, psychological abuse and stalking, uses more moderate levels of violence. The second pattern uses high levels of all forms of violence except sexual abuse.

Studies of male perpetrators of IPV find that a higher exposure to trauma, and a variety of types of victimization, is most related to engaging in IPV. Of the types of adverse experiences, 77% report trauma exposure, 62% report multiple trauma exposures, and 11% screen positive for a possible diagnosis of PTSD. Only one in five participants reports exposure to childhood abuse, which indicates that many forms of trauma are related to IPV not just prior exposure to abuse as a child. While alcohol problems, drug use, and depression are related to relationship difficulties, different symptoms of PTSD symptoms show unique relationships to IPV. Hyperarousal is related only to forms of emotional abuse. However, reexperiencing symptoms from past trauma is related to relationship problems, denigration of partner, and sexual coercion. It may be that reexperiencing traumatic memories is an important motivation behind abusive behavior. Traumatic memories involving themes of betrayal, mistrust, and a desire for control may be particularly relevant to engaging in IPV. The posttraumatic symptoms of avoidance/numbing predict dominance/intimidation in the relationship and injurious violence (Semiatin, Torres, LaMotte, Portnoy, & Murphy, 2017).

## Sexual Violence

The National Intimate Partner and Sexual Violence Survey finds that both men and women can be victims of sexual assault from intimate partners. Sexual violence is committed against women (18.3%) more than men (1.4%). While both men and women may be abused within a relationship, women are more

likely to develop depression, PTSD, and negative health consequences than men (Caldwell et al., 2012). The increased negative consequences to women may be consequences of the severity of the assaults. More women (22.3%) than men (14%) are severely injured, and women are more likely to be afraid of their male partner than the reverse (Walton et al., 2009). Males may have different motivations for aggression against intimate partners than females (Caldwell et al., 2012), and male aggression is more lethal. One in three women who is murdered was killed by their male partner while only one in 20 males who is murdered was killed by a female partner (Reckdenwald & Parker, 2010). Sex role socialization is posited as playing a role in male-female IPV. Coercive control by one partner over the other has been a common dynamic found in IPV (Black et al., 2011; Stark, 2009).

Sexual violence includes many types of behavior including completed rape, attempted rape, and rape committed under the influence of alcohol/drugs. The most likely perpetrator of sexual violence against women is an intimate partner (51.1%), and the second most is an acquaintance (40.8%). Males are most likely to be raped by an acquaintance (52.4%), and then a stranger (15.1%), and not by an intimate partner. Being a victim of rape for the first time usually occurs in the younger years. For women, 79.6% indicate their first rape occurred before the age of 25, and 42.2% said it happened before they turned 18 years. For males, the first rape occurs at an even earlier age; 27.8% indicate rape at or before the age of 10. In addition, 4.8% of males report being forced to penetrate someone else. Sexually coercive supervision is also experienced by 13% of women and 6% of men during their lifetime. Unwanted sexual contact is experienced by 27.2% of women and 11.7% of men over the course of their lifetime. For women, across all types of sexual offenses, men are reported as the perpetrators. For males the picture is more complex and varied across types of sexual violence (Black et al., 2011). Violence risk is also increased for adults with disabilities and for members of the LGBTQ community (Nosek et al., 2006; Reuter, Newcomb, Whitton, & Mustanski, 2017; Smith, 2008). Within the sexual minority community, females, male-to-female transgender, and Black/African-American young adults are at higher risk compared to those who identified as male, female-to-male transgender, and other races (Reuter et al., 2017).

The National Intimate Partner and Sexual Violence Survey finds one in five women and one in 71 men are raped at some point in their lives. These rapes are usually perpetrated by an intimate partner, followed by an acquaintance, and, least frequently, a stranger. Most female victims indicate their first completed rape prior to the age of 25, and 42% indicate their first completed rape came before they were 18. More than 25% of male victims indicate a completed rape when they were 10 years of age or younger. Both males and females indicate that men are most likely to be the perpetrators of their assaults (Black et al., 2011). Women who are sexually abused as children or sexually assaulted as adults show use of alcohol to reduce their painful associations to sexual victimization as well as to place themselves in situations that may lead to victimization due to their risky use of alcohol (Bryan et al., 2016). In addition to problematic drinking, women who have a history of sexual victimization are at increased risk of other serious negative outcomes. These include both chronic health problems as well as psychological disorders such as PTSD, anxiety disorders, and mood disorders (Santaularia et al., 2014; Zinzow et al., 2012). The consequences of violence, sexual violence, and stalking can cause immediate symptoms as well as long-term health consequences in both men and women. Immediate symptoms include things such as being fearful, concern for safety, injury, and missing at least one day of school or work. Some of the long-term symptoms they report include chronic pain, sleep difficulties, and poor physical and mental health (Black et al., 2011). Adult women who sexually assault children are more likely to abuse their own biological children, while adult males are more likely to sexually assault their stepchildren. Female sex offenders also are more likely in a caretaking role with their own younger children (less than 12 years old) or babysitting for other people's younger children. Male sex offenders are more likely to select older children in the age range of 16 to 17 that they are not taking care of in their homes (Hassett-Walker & Lateano, 2014).

Hipp and colleagues (2017) analyzed anonymous, online reports on REDDIT dealing with sexual assault. A question asked if members of the community ever forced someone to have sex and whether they regretted it. Hipp and colleagues used a qualitative analysis to examine themes within a sample of responses to this prompt. Perpetrators are shown to be a heterogeneous group based on this analysis. Six themes emerged, with some perpetrators indicating more than one theme in their online responses to the prompting question. One theme involves sexual scripts in which men are assumed to be the ones who are to initiate sexual encounters, women are believed to mean yes even when they say no, and having confusion over what indicates real consent in sexual relationships. A second theme involves victim blame. A large number of reasons are given for why the sexual encounter is a result of the victim's behavior despite the victim not giving clear consent. A third theme is hostile sexism where enjoyment in the sexual encounter is entwined with dominating the woman. A fourth theme that applies both with male and female victims is biological essentialism. Within this theme, perpetrators view sexual arousal as a biological imperative and hormones and erections are viewed as legitimate reasons for forcing sexual behavior on others. A fifth theme is sexual objectification. This theme also applies to both male and female victims where "a body existed" to have sex with it. If the perpetrator is aroused and an appropriate sexual object is present, then having sex without consent is appropriate. The last theme is unrestricted sociosexuality. This is the desire to have anonymous sex for personal gratification and a lack of interest in having sex within the context of a relationship (Hipp et al., 2017).

### **Polyvictimization**

Cortisol levels show that women with a history of child abuse and neglect show higher rates of cortisol during conflictual discussions in the laboratory with their husbands. In addition, these women show heightened cortisol levels even when their husbands are engaged in nonhostile discussions with them as well as in hostile discussions. Men with family of origin child abuse and neglect show reduced cortisol production when their wives are engaged in hostile reactions with them. This shows the long-term impact of child abuse and neglect in the emotional responsivity, particularly of women (Arbel, Rodriguez, & Margolin, 2016). Longitudinal research on long-term marriages indicates that the ability to decrease negative emotions is valuable to marital happiness. This impact is greatest for the ability of the wife to decrease her negative emotions and behavior and communicate effectively with her partner about the source of discontent (Bloch, Haase, & Levenson, 2014). There may be gender differences in motivation for engaging in violent behavior. Males may perpetrate so that others view them as "tough" and "in control," particularly as it relates to their sexual partners. Females may respond more in the moment as an expression of anger or jealousy in reaction to something that just happened (Kelley, Edwards, Dardis, & Gidycz, 2015), however, the motivation behind physical aggression is found to vary based on the definitions used in the studies, and both males and females tend to attribute violence more to the character of their partners than to that of themselves (Flynn & Graham, 2010).

## **VIOLENCE AGAINST OLDER ADULTS**

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Violence continues into later life. Current best estimates are that 4.3 million, or one in 10 older adults, is a victim of some form of maltreatment (Dong, 2014; Kaplan & Pillemer, 2015). It is difficult to determine the frequency, causes, and best prevention mechanisms for elder abuse because there is still a lack of agreement upon important definitions of the various forms of abuse (Roberto, 2016). While abuse is harmful at any age, there are vulnerabilities that come with advanced age. Older adults may be increasingly frail due to physical infirmities that are more likely with advanced age. Elder abuse risk appears to increase in older adults who need caregiving (Cooper, Selwood, & Livingston, 2008). Society holds many negative myths of older adults that may make their testimony less respected than that of a younger adult. This may be the result of their loss

of social roles brought on by no longer raising children, being less likely to be employed, and their greater reliance on caregivers such as doctors and nurses as well as family members due to physical infirmities or medical conditions. These may be the only vulnerabilities experienced by an older adult or they may be added to vulnerabilities that are not unique to late life: poverty, poor educational background, prior trauma, and so forth (Hamby, Smith, Mitchell, & Turner, 2016).

The definition of how old an individual needs to be in order to be categorized as an older adult influences the rates of elder abuse. The National Intimate Partner and Sexual Violence Survey examines rates of elder abuse in adults 70 and older. Using this definition, 14%, or one in 10 adults, experiences some form of abuse during the year. The most common form of abuse is psychological abuse (12.1%), and one in nine adults who are 70 or older experience psychological abuse over the course of the past year. The next most common is physical abuse with 1.7% of adults who are 70 or older indicating this had happened to them. Psychological maltreatment is assessed on the survey using items representing expressive aggression and coercive control. Physical abuse includes items indicating physical violence and sexual violence. Potential other corollaries of abuse examined include race/ethnicity, gender, financial status, marital and relationship status, level of physical ability, housing insecurity, food insecurity, health care insecurity, physical health, and mental health. Health care insecurity places an older adult at higher risk of abuse with the odds of experiencing abuse being 4.53 times greater for those with health care insecurity (Rosay & Mulford, 2017).

The National Maltreatment Survey examines abuse incidence for individuals age 60 and older (Acierno et al., 2010). With this definition of who is an older adult, there is an 11% rate of abuse. The most common forms of abuse found are financial (5.2%), neglect (5.1%), emotional (5.1%), physical (4.5%), and sexual abuse (0.6%). While abuse occurs across the life span, there is a relationship between age and type of abuse. As individuals go from age 60 through the end of the age span, the less likely they are to be physically and/or emotionally/psychologically abused. Physical abuse occurs four times as often for participants under the age of 70. Psychological abuse also occurs three times as often for those under the age of 70 in comparison to those who are over 70. Victimization in older adults increases with the level of frailty of the individual. A frail elder may be someone who needs help with the activities of daily living due to physical disabilities or being in poor health. Frailty can also occur due to needing to live with someone else as a result of poor finances, having low social support, and having psychological difficulties due to prior trauma or earlier experiences with abuse (Acierno et al., 2010). There are no overall differences in abuse incidence by race/ethnicity or gender. Intimate partners are the most likely perpetrator of elder abuse followed by adult children (Acierno et al., 2010; National Committee for the Prevention of Elder Abuse [NCPEA], 2017b).

Definitions of elder abuse vary by state including what age demarcates older adulthood. In general, the types of abuse identified include neglect, psychological abuse, physical abuse, sexual abuse, and financial exploitation (Pillemer, Connolly, Breckman, Spreng, & Lachs, 2015). Physical abuse is defined as, "physical force that results in bodily injury, pain, or impairment. It includes assault, battery, and inappropriate restraint." Sexual abuse is defined as, "non-consensual sexual contact of any kind with an older person." Domestic violence is defined as "an escalating pattern of violence by an intimate partner where the violence is used to exercise power and control." Psychological abuse is defined as, "the willful infliction of mental or emotional anguish by threat, humiliation, or other verbal or nonverbal conduct." Financial abuse is defined as "the illegal or improper use of an older person's funds, property, or resources." Neglect is defined as "the failure of a caregiver to fulfill his or her care giving responsibilities." And finally, self-neglect is defined as "failure to provide for one's own essential needs." It is financial exploitation and self-neglect that may represent the greatest difference between older adult victimization and that which occurs at younger ages. Financial exploitation can involve a variety of behaviors at increasing levels of victimization, such as an adult grandchild asking for a financial loan despite knowing that the elder can't afford to give a loan, to threatening or engaging in physical violence to force an elder to provide money. It can involve neighbors or strangers misleading a cognitively impaired

elder and so forth. Neglect can involve behavior such as not providing nutritious food to a physically disabled elder who is dependent on a caregiver for nutrition. It can involve not taking a seriously ill elder to the doctor. In cases of self-neglect, the elder may stop taking necessary medication out of a lack of interest in continued living (NCPEA, 2017d). Self-neglect is most common among elders who are frail, as defined by slower walking speed as a result of decreased muscle tone, perhaps brought on by obesity and lack of exercise in earlier years (Lee, Burnett, & Dyer, 2016).

### Physical Violence

The National Committee for the Prevention of Elder Abuse (NCPEA) describes two patterns of IPV that may exist in later life. One is called “IPV grown old.” This represents the same pattern of IPV occurring between the couple as it did in their younger years. On the other hand, “late onset IPV” may represent new behavior or an exacerbation of a strained relationship. There are many sources of stress that may come from age including increases in physical disabilities, changes in family roles, loss of important sources of validation through retirement, sexual and other physical changes, and financial strain. Finally, some elders may enter into new relationships that involve abusive behavior (NCPEA, 2017b). Overall rates of IPV decrease as women age. However, the adverse physical and mental health outcomes are similar across the life span (Fisher, Zink, & Regan, 2011).

There are times when violence extends to murder. Eldercide, or the murder of an older adult, is most likely carried out by a White male, in contrast to other forms of homicide, which are more likely to be carried out by racial and ethnic minority males (Bridges, 2013). Older adult males are murdered at higher rates than older adult females. At any age, men are three times as likely to be murdered as women (Morgan & Mason, 2014). In the younger years, it is most likely a young male who will commit an act of murder against an acquaintance or stranger, and the violence usually occurs out in the community. Whether it is the victim or the perpetrator, it is most likely to be a male. The perpetrators of the male homicides are unlikely to be an intimate partner. However, the murder of a woman is most likely an act by a current or former intimate partner, and the murder is most likely to occur at home. When femicide occurs, it's most likely that the victims are involved in a relationship of intimate partner terrorism. These women are at greatest risk of being murdered if their intimate partner believes they are going to leave the relationship. When femicide occurs in the older adult years, it will most likely be a murder-suicide where the woman is first killed and then the partner kills himself. It is most likely that this male partner is suicidal and decides to kill his wife before killing himself. While the woman may be aware that the partner is under distress, since it is not directed at herself, she may not be aware that she is in danger (Salari & Sillito, 2016). When an older adult woman is killed by someone who is not an intimate partner, it is most likely another family member (Salari & Maxwell, 2016). Older adult cohorts value privacy at higher rates than younger adults and therefore are even more likely to keep what they perceive to be family business within the family and not reach out to shelters, police officers, or social service workers (Salari, 2015).

### Sexual Violence

Older adults are sexually victimized by family members, caretakers, and other individuals. This victimization can occur within their own home, in community settings, as well as in nursing homes. Studies of cases of sexual abuse that came to the attention of adult protective services or the criminal justice system indicate the majority of victims are female (93.2%), however, males are also victimized (6.8%). The perpetrators of sexual assault range in age from adolescence through the older adult years. When older adults experience significant cognitive issues, they are more likely to show evidence of sexual abuse through their nonverbal behavior than by actual disclosures of abuse. Examples of such nonverbal behavior include the older adult showing intense fear reaction

to the perpetrator or signs of shame. Individuals with dementia are easily confused and verbally manipulated by others. Signs of distress should be seen as warning signs that abuse might be ongoing. The mere presence of an offender can be coercive to an older adult with dementia. Individuals with dementia are more likely to be abused by someone known to them than by a stranger. The victim's home is where the abuse occurs for 70% of the sexual assaults. Twenty-three percent of sexual assaults against older adults occur in nursing homes, and only 4.8% occur in other community settings.

Two types of perpetrators are found to commit acts of sexual abuse against older adults. These are the opportunistic, nonsadistic perpetrators and the sadistic perpetrators (Burgess, 2006). When an elder does not have dementia, if the abuse is reported, he or she is most likely to make a self-report (33.2%), followed by health care provider reporting (20.8%). The opportunistic perpetrator is less likely to use penetration as part of the sexual abuse in comparison to the sadistic perpetrator. This type of offender may provide intrusive personal care rather than penetrative assault, expose victims' genitals, or make sexually explicit comments. Sadistic perpetrators are more likely to show pervasive anger and to be very vindictive. This offender is more likely to have a history of criminal behavior. This type of offender may use threats of physical harm to gain compliance from the victim. In 77.3% of the cases, there are observable signs of the abuse. Restraints are more often used with victims without dementia. The perpetrator is usually male.

Victims in nursing homes may try to wear many layers of clothing or run away from the nursing home to try to protect themselves from the perpetrators. Some victims are so traumatized that they remain in a fetal position and do not respond to others. Others may become highly agitated. They may show signs of PTSD in more subtle ways, expressed by symptoms such as confused thinking, agitation, withdrawal, disturbed sleep, and fearful behaviors. If the perpetrator is a caregiver, retribution may be feared if the victim comes forward to report. In addition, if the perpetrator is a member of the family, there may be divided loyalty that prevents the victim from reporting.

Research on sexual offenders against the elderly is limited. However, whether "gerontophilia" should be considered a type of paraphilia is noted in the literature. Gerontophilia includes both arousal to an inappropriate person as well as an inability to control the impulse to engage in sexual behavior. There is a loosening of internal and external controls in the presence of a vulnerable person over whom the perpetrator can exert power and control (Burgess, Prentky, & Dowdell, 2000; Prentky & Burgess, 2000).

Resident-on-resident sexual abuse within nursing home facilities does occur. The organization, A Perfect Cause, did an investigation and found registered sex offenders living in nursing homes. These offenders have committed a number of criminal acts, both physical and sexual against both male and female residents (Burgess, 2006). Burgess, Commons, Safarik, Looper, and Ross (2007) discuss four primary motivations of offenders, including opportunistic, pervasive anger, sexual, and vindictive. For each of these primary motivations, they also discuss the level of social competence of the perpetrator. In the opportunistic rape, there is no aggression used in the act unless it is needed to force compliance, and the level of aggression is usually low. These acts are sexualized and compulsive but involve little premeditation. If the individual is low in social competence, then the commission of the crime is likely to be impulsive. For the opportunistic rapist, the intention is to get immediate sexual gratification. When pervasive anger is the motivation, then the person shows a high level of aggression and uses gratuitous violence; both males and females may be victims. While rape occurs, it is just one of many forms of violence used against the victim.

Serial rapists can be of the overtly sadistic or the muted sadistic type. In the sadistic rapist, there is a fusion between aggression and sexual arousal. The victim must endure pain and be humiliated for the perpetrator to be sexually aroused. There is usually a great deal of offense planning and premeditation. For the muted sadistic type, there is a lower level of violence and limited physical injury. The sexual acts are symbolic and noninjurious, and the injuries that are present are limited to these acts. For the sadistic rapist, the perpetrator uses a highly developed fantasy or sexualized ritual. In any of these types

of motivations for rape, the perpetrator may know the victim. Finally, for the vindictive rapists, anger at women is the central motivator behind their behavior. These rapists are truly misogynistic. In their assaults, they want their female victims to feel demeaned and humiliated and will increase the intensity of their assault in order to achieve these goals. The rapists are using sexuality to achieve their goals, rather than because violence is sexually arousing to them. In addition, relative to other rapists, they have fewer difficulties with impulsivity.

### Financial Exploitation

It is estimated that one in 20 older adults may be financially exploited (Lichtenberg, 2016). The MetLife Mature Market Institute (2011) estimated that \$3 billion is stolen annually through financial abuse and exploitation. Older adults who are financially abused have a harder time compensating for their losses as they are often no longer in the workforce and have less time before these resources are needed. Fractured families and severe health care problems may result from the abuse (MetLife, 2011). Adults who are age 75 and older may be more likely to live with a large number of individuals either moving in with a family or in an institution, and this may put them at increased risk for financial exploitation (Peterson et al., 2014). Cognitive decline is the most agreed-upon risk factor for elder abuse (Dong, Simon, Rajan, & Evans, 2011). Studies indicate that cognitive impairment makes individuals less able to judge the trustworthiness of others and therefore more susceptible to undue influence in their decision making (Charles & Carstensen, 2010). The association between greater age and greater risk for abuse may be related to an individual's decrease in functional health and need for increased dependence on others for care. Women, because of their greater longevity, may therefore be at increased risk for family violence. Some research suggests that males might be at equal risk to females but even less likely to report their maltreatment (Kosberg, 2014). In addition, research has indicated that African-American, Latin, the poor, and isolated older adults are more likely to be victimized (Connolly, Brandl, & Breckman, 2014).

Other individuals called in to provide additional support to older adults are also found sometimes to engage in maltreatment. Professionals such as guardians, lawyers, investment counselors, and paid caregivers may intentionally use their charm and attention to take advantage of a trusting older person. Research on these acts of perpetration suggests that some of these individuals believe they are entitled to additional compensation and others find themselves able to access money and assets and unable to resist taking advantage of this (MetLife, 2011).

### Co-occurrence

Just as with children, and younger adults, co-occurrence of victimization is the norm. Emotionally abuse and physical abuse show high rates of co-occurrence; rates for sexual abuse are unknown due to a paucity of research investigating it (Hamby & Grych, 2013; Rosay & Mulford, 2017). Adult protective services professionals indicate that polyvictimization is a common form of abuse on their caseloads ranging from 15% to 25% (Ramsey-Klawnsnik & Heisler, 2014). Older adult victims can suffer from significant trauma and may have PTSD (Ramsey-Klawnsnik, 2004). Evidence suggests that certain elders are more vulnerable to abuse than others; not having many social contacts and having had previous exposure to trauma are most related to vulnerability (Acierno et al., 2010). The most vulnerable also indicate low levels of psychological and social well-being. A question that remains is whether high depression, a marginal social network, and little engagement are the results of elder abuse or increase the risk for being abused (Dong et al., 2011). For example, the psychological risk factors of low self-esteem, poorer cognitive abilities, behavior problems, and mental health problems are associated with higher rates of victimization at all ages (Acierno et al., 2010; Hamby & Grych, 2013). Just as other victims do, older adults can benefit from psychological help addressing the trauma and stress associated with abuse such as their depression and anxiety (Sirey et al., 2015).

## Polyvictimization

Polyvictimization is a common experience among those who are victimized by others. The Polyvictimization in Later Life Project defines polyvictimization in later life as, “when a person aged 60+ is harmed due to multiple co-occurring or sequential types of elder abuse by one or more perpetrators, or when an older adult experiences one type of abuse perpetrated by multiple others with whom the older adult has a personal, professional or care recipient relationship in which there is a societal expectation of trust” (Ramsey-Klawnsnik & Heisler, 2014, p. 4). Jackson and Hafemeister (2012) examine financial exploitation when it occurs alone and when it occurs along with some other type of victimization. They find that when polyvictimization occurs, victims have poor outcomes. The abuse tends to be of longer duration, and the victim tends to be in poor health and to show more fear of the perpetrator who is more likely to be a household member. Neglect is most likely to occur when the perpetrator is living in the same home as the older adult, and financial exploitation is most associated with other forms of maltreatment occurring along with mutual dependency (Jackson & Hafemeister, 2014).

## Impact of Victimization

The National Social Life Health and Aging Project indicates a lasting impact of maltreatment on health that is not moderated by social support. Those who are victimized indicate more anxiety, loneliness, and worse physical and functional health when followed up with five years later. Decreases in both physical and psychological health occur both as a result of psychological maltreatment and financial exploitation. Social support does not moderate the impact of maltreatment. It is possible this is because the older adult is turning to sources of social support that are now victimizing them—older adults may need to expand their social support outside of their immediate social group for this to not occur. Financial abuse may harm physical health because it reduces the ability of the older adult to pay for services that can help compensate for the physical challenges that come with increasing age (Wong & Waite, 2017). Older adults are also at increased risk for financial abuse and exploitation when they have decreases in cognitive capacity. This can occur due to decreases in processing speed or working memory as well as from dementia (Lichtenberg, 2016; Spreng, Karlawish, & Marson, 2016).

Elder abuse and psychological distress are associated with increased mortality, and there is an increased risk when both are present (Dong, Chen, Chang, & Simon, 2013; Lichtenberg, Ficker, & Rahman-Filipiak, 2016). Older adult women who are self-reported polyvictims within the prior year are mostly likely to report verbal abuse (88.7%), both verbal and physical (9.2%), or only physical (2.2%). These women report more negative emotions or ambivalence about expressing emotions. In addition, compared to those who do not experience any form of violence, they are less optimistic, more depressed, and more hostile. Finally, separate from the direct results of violence, women who were physically abused died younger than women who were not abused: 12.8% in comparison to 7.5% per 1,000. Women who are polyvictims are the next most likely to die, followed by women who are only verbally abused: 10.1% to 8.4% per 1,000 (Baker et al., 2009).

Social support is found to mitigate the harm of violence across the life span, including among older adults. Any professionals working with older adults should attend to the quality of their social network and the quality of their relationships with their adult children. As adult children are the most frequent perpetrators of elder abuse, programs that could include anger management, social skills training, stress management, and counseling may all prove of value in reducing elder abuse (Dong et al., 2013). Increasing the connection of older adults to their communities, most particularly when they come from cultural minority groups, may serve as an important protective factor due to even lower reporting of elder abuse in these communities in comparison to the dominant White community (Dong et al., 2013).

## Perpetrators

The National Center on Elder Abuse, Administration on Aging (2015) finds 90% of abusers to be family members. Elder abuse that is a continuation of earlier abuse and late onset interpersonal violence show similar patterns. There is the use of coercion to maintain power and control (National Center on Elder Abuse, 2015). Some medical or mental health conditions may lead to an increase in aggressive behavior or the power and control dynamic may have deepened into violence as a result of increased health problems (OVC, 2010). Abusive individuals find ways to justify their use of actual violence or threats of violence to get what they want from their victim. The most common perpetrator of violence against senior citizens is a member of their family. The victims trust them and have ongoing relationships with them (OVC, 2010). However, elder abuse can occur within new relationships after there's been some type of significant family disruption. While women live longer than men, even adjusting for longevity, older adult women are victimized at higher rates than men (U.S. Department of Health and Human Services, Health Resources and Services Administration, 2013). As in all cases of interpersonal violence, the majority of perpetrators are family members.

The National Intimate Partner and Sexual Violence Survey compares the abuse of older adults by both intimate and nonintimate partners (Rosay & Mulford, 2017). The frequency of different forms of victimization varies by whether the perpetrator is an intimate or nonintimate partner. If an elder is being psychologically victimized, then 57.1% of the time this is occurring only at the hands of a nonintimate partners, and 20.6% of these elders are victimized by both nonintimate and intimate partners. Only 22.2 % of cases of psychological abuse are perpetrated only by intimate partners. The pattern is different for physical abuse. Only 34.8% of physical assaults are by nonintimate partners, followed by 37.8% being assaulted by both intimate and nonintimate partners, and 27.4% being assaulted only by intimate partners. Elder abuse is most likely to occur in elders who are romantically involved, whether they are married to the perpetrator or not. They are also more likely to be victimized if the elder can engage only in limited physical activity and if an elder has health care insecurity; the relationship to health care insecurity is the strongest (Rosay & Mulford, 2017). For individuals age 70 or above, 77% of victims were abused by at least one perpetrator who was not an intimate, and 43.8% had been abused by at least one intimate partner. Being romantically involved increased victimization rates (Rosay & Mulford, 2017).

There is a myth that perpetrators are not in control of their behavior. However, research indicates that perpetrators of many different types of violence are selective both in choosing their victims, the places, and the times where they will engage in violent behavior. Research on rape both on college campuses and those that occur in the community find that a small number of perpetrators are responsible for the majority of rapes (Lisak & Miller, 2002; White & Smith, 2009). Despite these facts, gender bias leads legal institutions to blame the victim and describe rape in terms of victim characteristics rather than perpetrator characteristics. In addition, sexual assaults do not often reach the level of court prosecution (Alderden & Ullman, 2012).

## Role of Cognitive Capacity

Mental capacity is complex and affected by many things. It involves the mental skills that people use to make decisions for the here and now of their lives as well as the future. Mental capacity can decline due to transitory situations such as severe illness, side effects of medication, or inadequate nutrition. However, mental capacity can decline due to more permanent situations such as brain injury from multiple sclerosis, Parkinson's disease, and dementia, for example. Consent is when someone, who has the capacity to understand what he or she is doing, agrees to something proposed by somebody else. Undue influence is when someone, who is more powerful, gets a weaker person to do something against his or her best self-interest. The perpetrator may be more powerful because he or she has a stronger will or because the older person is dependent on the help of the exploitive person. The Constitution of the United States gives individuals the

right to make choices for themselves when they do not harm others. Therefore, an elder who decides to give their home to a grandchild and to move into a smaller and less appropriate apartment has the constitutional right to do this as long as he or she has the cognitive capacity to make an informed decision. Thus, he or she has the right to self-determination and to select this smaller apartment. If the older adult is beginning to lose his or her cognitive capacity, he or she has the right to live in the least restrictive manner possible. Therefore, adult children don't have the right to take over all decision making for their parents due to mild memory difficulties. Helping their parents to remember all their responsibilities would be appropriate support and less restrictive than taking away the parents' right to making decisions with appropriate help; professionals involved in caring for older adults should always seek to maximize the independence and freedom of the individual considering their cognitive capacity (NCPEA, 2017a).

Individuals with disabilities are at particular risk for abuse in older adulthood. They may not know how to set appropriate boundaries with individuals who are providing them with a great deal of care, particularly if they need care for things such as bathing and toileting. They may also fear that their reports will not be believed. For example, what might happen if they report being touched inappropriately and their caretaker indicates this is a fake report or due to the difficulty of providing physical care rather than actual intent to engage in sexually inappropriate touching. Thus, elders may feel emotionally abused by those to whom they make reports (Nosek et al., 2006). In addition, financial exploitation both by strangers and family members increases when there is cognitive impairment or psychological vulnerability due to loneliness or depression (Lichtenberg, 2016; Spreng et al., 2016).

Self-reports are influenced by individuals' cultural understanding as to what is appropriate care of elders and what constitutes abuse (Jervis, Sconzert-Hall, & The Shielding American Indian Elders Project Team, 2017). For example, Native American-Indians consider being treated well as being respected as an elder within the community. Traditionally, it is the elders who are the decision makers of the family and of the community; their accumulated knowledge base is highly respected. Having younger family members listen to their stories and accumulated wisdom is critical to their being treated with respect. In addition, elders are to be the "first in line" (Jervis et al., 2017, p. 49) at social gatherings to symbolize their honored status in the community. Being treated well includes being taken on outings with other family members and being included in social gatherings within the home as a valued family member. Being treated poorly commonly involves behavior that would be classified as financial exploitation and neglect. Financial exploitation could be things such as younger family members moving into the home and treating it as their own rather than as the home of the elder or taking money the elder needs for food and spending it on drugs. An example of neglect is socializing and leaving the elder alone at home socially isolated. This is considered showing lack of respect and psychological abuse. Physical abuse is recounted by Native American-Indians but less often (Jervis et al., 2017).

## Living Arrangements

Caregiving between family members is a regular part of life and can be expected to occur throughout the life span (Nichols, 2017; Roberts & Ishler, 2017). Most adult children provide appropriate care to their parents. However, when they become overwhelmed caregivers, they may engage in maltreatment of their parents (Amstadter et al., 2011). Demographic analysis indicates that adults aged 60 to 69 are the most susceptible to maltreatment (Acierno et al., 2010). However, when specific forms of abuse are examined, adults age 75 and older are particularly vulnerable to financial abuse. Hypotheses to explain reasons why the 60 to 69-year-old group is most vulnerable include that this is a time when an individual may be continuing to live with a violent spouse. In addition, it's the time when adult children with serious personal struggles may be most likely to be living with their parents (Lachs & Pillemer, 2015). When an older adult needs his or her adult child's help, yet is providing the adult child with a place to live, financial

help, or emotional support, this dual dependency may increase the risk for abuse (Jackson & Hafemeister, 2012). Adult children are more likely to be dependent on their parents when they are abusing substances (Jorgst, Daly, Galloway, Zheng, & Xu, 2012), suffering from a mental or emotional illness, or dealing with chronic unemployment (Jackson & Hafemeister, 2012). While some adult children abuse only when overwhelmed, some perpetrating adult children are narcissistic and domineering and feel justified in their behavior (Ramsey-Klawnsnik, 2000).

### Issues in Reporting

The older adult victim may be fully aware of what is happening to him or her and of the consequences that might result from reporting. Concerns for what might happen to family members may lead to victims not reporting abuse even when questioned about it. In addition, concerns about having to live in community housing versus with family may make it preferable to the elder to deny abuse (Robinson, Saisan, & Siegel, 2016). The victim may not want to disrupt the personal relationship he or she has with the perpetrator, may need caregiving from the perpetrator, and fear retaliation if they report (National Center on Elder Abuse, 2015). Victims may be embarrassed by what happened (Kosberg, 2014), accept the perpetrator's behavior (Teaster, Roberto, & Dugar, 2006), believe that the abuse is their fault, or worry that worse harm will result from reporting (Ziminski, Pickering, & Rempusheski, 2014).

Why might a victim accept the perpetrator's behavior? Adherence to traditional gender roles may lead older adult women to believe maintaining their relationships with family members and protecting them from harm is more important than protecting themselves (Kimmel, 2008). Victims of financial exploitation may be least likely to cooperate with authorities (Jackson & Hafemeister, 2012). Financial exploitation can occur for many reasons, including the perpetrator's willingness to abuse a trusting relationship with the victim; a perpetrator's sense of financial entitlement; inequality that leaves the victim open to coercion by the perpetrator; the need of the victim to depend on the perpetrator for managing money; and thefts and scams initiated by acquaintances or strangers (Conrad, Iris, Ridings, Langley, & Wilber, 2010). Mandated reporters need to be on the alert for warning signs of psychological abuse and financial exploitation as these may be the most common forms of elder mistreatment (Sooryanarayana, Choo, & Hairi, 2013).

Physical injuries from abuse are believed to be underreported for many reasons. One is that professionals don't have the training to recognize the difference between signs of physical abuse and injuries that may be due to decreased physical abilities (Bonomi et al., 2007), and they may not know when to report (Mosqueda & Olsen, 2015). It is normal for the skin to become thinner with aging, which can result in bruising more easily. In addition, older adults may be on medications such as blood thinners that also affect bruising. Finally, decreases in health and mobility can lead to an increase in falling (Beach, Carpenter, Rosen, Sharps, & Gelles, 2016). Professionals need to be trained to take these factors into account as well as to look carefully at what part of the elder is injured and whether this is likely to be a result of accidental versus intentional injury. Studying cases of elder abuse indicates that two thirds of all injuries from physical abuse occur to the upper extremities, neck, and the face (Murphy, Waa, Jaffer, Sauter, & Chan, 2013; Rosen et al., 2016).

Myths that older adults are not interested in sex may make it less likely that a doctor will ask questions that may evoke a report of sexual victimization. Individuals in good health between the ages of 60 and 80 may still be interested in engaging in sexual activity. Unfortunately, injuries as a result of engaging in sex are more common among older adults. This is because changes that occur in the female reproductive system cause decreases in lubrication of the vagina. This makes it easier for the vagina to sustain injury during intercourse. Without asking questions, a mandated reporter is unlikely to recognize the difference between someone injured during consensual sex and when an unwilling partner is forced into sex by a long-term partner who is cognitively impaired or some other perpetrator (Beach et al., 2016).

Professionals who value an older adult's right to self-determine what will happen in his or her life may hesitate to make a report that is against the older adult's wishes. There may also be confusion as to when, in addition to contacting elder protective services, it is appropriate to contact other family members (Mosqueda & Olsen, 2015). In addition, professionals may be concerned about the consequences of false positives to both the older adult and their family members. Self-reports of mistreatment consistently yield higher rates of elder abuse than data collected from social service agencies (Beach et al., 2017). For example, in the Lifespan of Greater Rochester, Inc., Weill Cornell Medical Center of Cornell University, and New York City Department for the Aging (2011) project, it is estimated that only one in 23 cases of elder abuse gets reported to authorities.

Sometimes concerns about the safety of an older adult come into conflict with what elders want for themselves. Important issues that professionals and family members need to grapple with include the older adult's mental capacity, consent, and undue influence; the elder's rights to autonomy, self-determination, and the least restrictive alternatives (NCPEA, 2017c).

A comprehensive national bill called the Elder Justice Act of 2009 (H.R. 3590) passed in 2010 as an amendment to the Affordable Care Act. The Elder Justice Roadmap (Connolly et al., 2014) establishes five priorities for bringing an end to elder abuse and promoting health, independence, and justice to older adults: increasing public awareness of elder abuse; supporting research on brain health to improve capacity and mental health in both victims and perpetrators; supporting training for those who are paid and unpaid caregivers of older adults; understanding the economics of elder abuse vis-à-vis preventing it; and investing resources to promote better services, education, and research in order to reduce elder abuse. Unfortunately, achieving these priorities is inhibited as the Elder Adult Justice Act was not reauthorized after it expired in 2014.

## VIOLENCE ACROSS THE LIFE SPAN

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Interpersonal violence can occur at any point across the life span. While being a victim of violence can involve a single incidence of monovictimization, research indicates that co-occurrence and polyvictimization are common across physical assault, sexual victimization, maltreatment exposure to violence, and so forth (Finkelhor, Turner, et al., 2009; Hamby & Grych, 2013). For example, how likely is a youth to be sexually victimized? If this youth has been physically assaulted at least once, then the likelihood they will be sexually assaulted is 620% higher than for youth who have never been physically assaulted (Finkelhor, Turner, et al., 2009). While some people involved in violence are only victims or perpetrators, many are both (Hamby & Grych, 2013). There are many links between types of victimization in children, youth, adults, and older adults giving evidence to the intergenerational transmission of violence. However, not all victims become perpetrators, and the interconnections found between some types of violence do not occur for all people (Hamby & Grych, 2013).

Violence is most likely to occur between people who are in caretaking relationships with each other or with a history of such relationships (USDHH, 2015). These caregiving relationships promote development and survival of the dependent individuals (Brown & Brown, 2014). While in childhood, a parent may teach a young child how to tie shoes, in older adulthood, a grandchild might teach a grandparent how to use a smart phone. While isolated acts of violence can occur, research indicates that both co-occurrence (more than one type of violence occurring within an incident of violence) and polyvictimization (more than one incident of violence) are most common when the perpetrator of violence is known to the victim. In addition, there is often not a clear divide between who is a victim of violence and who is a perpetrator of violence. The victim-perpetrator is someone who has been or is a victim of violence and also commits acts of violence against someone else; this pattern may be more common than the solely victimized or solely perpetrating individual (Finkelhor, Turner, et al., 2009; Hamby & Grych, 2013; Ramsey-Klawnsnik & Heisler, 2014).

People may show many types of resilient reactions to single instances of victimization, whatever its form, when it occurs within a developmental context of prior adaptive functioning (Masten, 2014). In these instances, victimization is not related to long-term maladjustment. However, polyvictimization, while living within a dysfunctional context, shows a long-term relationship with maladaptive emotional and social functioning in both children and adolescents. Chronicity of psychological abuse is also related to decreases in psychological functioning (Lätsch et al., 2017). Polyvictimization is more strongly related to maladjustment than chronicity. Research using the Juvenile Victimization Questionnaire defines polyvictimization as five or more victimizations within a year. Polyvictimization has been found to occur within 9.5% of Chinese adolescents, 11% of Canadian adolescents, 20.5% of Spanish adolescents, and 22% of adolescents in the United States (Chan, 2013; Cry et al., 2013; Finkelhor, Ormrod, Turner, & Hamby, 2005; Pereda, Guilera, & Abad, 2014).

### **Perpetrators of Violence Across the Life Span**

A common misconception is that severe mental illness fuels interpersonal violence; however, 96% of violent acts are committed by individuals who do not have severe mental illness (Appelbaum, 2013). When someone with a mental illness does commit an act of violence, the factors that lead up to this act are parallel to those that lead up to violence from an individual without a mental illness (Van Dorn, Volavka, & Johnson, 2012). The most common precursor of perpetration of violence is a past history of exposure to violence. Many individuals who are victimized as children and youth may later engage in acts of perpetration (victim-perpetrator), and this might be the most common type of perpetrator (Hamby & Grych, 2013). While an understanding of who is resilient and who develops mild or severe psychopathology as a result of exposure to violence is most related to polyvictimization versus any particular type of victimization, the research literature to date is still highly focused on specific types of victimization. Therefore, there is more discussion of types of victimization, rather than victimization or perpetration of violence. Research makes it clear diverse outcomes or multifinality can result from what may appear to be similar forms of violence exposure. In addition, similar outcomes can result from diverse exposures to violence (Toth & Cicchetti, 2013).

### **Prison**

Society often deals with perpetrators by sending them to prison. Involvement with the juvenile justice system, in and of itself, is a significant risk factor for the healthy development of adolescents. The earlier adolescents are incarcerated, the higher the likelihood that they will have an extremely poor adjustment to prison. It is likely that their development of executive functions and emotional regulation will be seriously disrupted by the prison environment, leading to an increased likelihood of committing a violent offense after their release; this leads to a return to prison in a cyclic fashion. If they experience violence and trauma in prison, then these negative effects are potentiated. If they are fortunate and receive prosocial and transformative education, then the likelihood of reoffending goes down (Haney, 2001). Adolescent offenders are not just harmed by their freedom being curtailed, it also by their being surrounded by a dysfunctional peer group and a prison system that is dehumanizing and too rigid to respond to the unique needs of individual inmates (Garbarino, 2015).

Longer prison sentences, when they don't result in participation in treatment programs for sexual offenders, tend to result in increases in recidivism rates. Visits from family members have been found to decrease recidivism in adults and to decrease depression and violent incidents and improve grades in adolescents (Shanahan & diZerega, 2016). Prison sentences for sexual offenses of rape and sexual assault indicate a complex picture. Re-offense is most likely for those with the most prior rates of arrest for sexual offenses. However, longer prison length is associated with increased risk of reoffending. This may be due to the fact that some states give offenders considered most dangerous the longer prison sentences (Budd & Desmond, 2014). Across all types of offenders,

those who sexually offend against children have the lowest rate of reoffending. Factors that can decrease recidivism rates include greater levels of supervision after release from prison by the probation department, continued contact with family and social contacts, increased employment, and increased residential stability (Budd & Desmond, 2014).

Minors in prison or institutions, even if they commit extremely heinous crimes, need to be treated as the children and adolescents they are. They need help to process their own experiences with trauma and then helped to develop the skills they need, in order to have a chance for leading an adaptive life upon release. What led to violent and heinous behavior on the part of youths and adults may be a dissociation or disconnection from life due to their violent and traumatic upbringing. These individuals are trying to make sense of the senseless and dangerous way in which they are being raised. This is an upbringing in which no one is teaching them adaptive skills or behaving adaptively. As a result, they develop a stunted sense of morality (Garbarino, 2015).

Women and adolescent girls with no history of healthy attachments still try to attach to peers and sexual partners. However, due to their lack of healthy emotional or behavioral skills, their attachments will be to others who continue their process of traumatization by those they are close to (Ryder, 2014). Trying to find meaning in life, they search for meaning in the clothing, hairstyles, jewelry, physical possessions, and so forth that media say lead to happiness; however, this just leaves them feeling empty and may lead to depression and anxiety. Violent individuals need help building a social and psychological foundation for nonviolence, including learning how to recognize their emotions, their level of arousal, and learning how to regulate them with healthy strategies rather than with violence, alcohol, or drugs; learning how to find meaning in their lives despite their current situation; learning how to be empathetic to their own needs and those of others despite their current feelings of fear, rage, or disappointment with their prior or current attachment figures; learning how to engage effectively with peers to develop attachments that are secure, trustworthy, and safe.

Garbarino (2015) examined the risk and protective factors in the lives of men on death row and what might have been needed to prevent the cascading events that lead them to become murderers. The protective factors they needed included an emotionally available parent and help building emotional intelligence. Minors in prison or institutions, even if they have committed extremely heinous crimes, need to be treated as children and adolescents and helped to process the trauma, and then develop the developmental skills that they need, in order to have a chance for leading an adaptive life on release. What led to violent and heinous behavior on the part of youths and adults was a dissociation or disconnection from life due to their violent and traumatic upbringing. These individuals were trying to make sense of the senseless and dangerous way in which they were raised and had no adaptive skills or adaptive people in their lives to help them for meaningful connections and developed a stunted sense of morality (Garbarino, 2015).

## Prevention of Violence and Trauma

Acts of violence are complexly determined, and not all can be prevented, particularly those perpetrated by strangers (Hamby & Grych, 2013). However, repeat victimization can be prevented through accurate behavioral threat assessment and effective response by those in the legal and treatment communities (American Psychological Association, 2013). The developmental context in which the individual is exposed to violence can provide important information for planning what types of experiences and skills are needed for the individual to live a life free of further violence. Effective treatment planning starts with assessment of individuals' exposure to violence across their life spans; most victims of violence will have experienced multiple forms of victimization and may play different roles in violence across situations or across time, sometimes as the victim, sometimes as the perpetrator of violent acts (Finkelhor, Turner, et al., 2009; Hamby & Grych, 2013). Thus, effective treatment plans need to take each type of exposure violence into account. These assessments need to include whether the individuals are directly involved or indirectly involved as a witness; the frequency of their exposure; the severity of the incidents; and their role in the exposure (witness, victim, perpetrator, victim-perpetrator)

(Hamby & Grych, 2013, p.10). Clinicians need to recognize that the form of violence indicated on the referral sheet is just a starting point to a comprehensive assessment (Hamby & Grych, 2013).

## Resilience or Positive Adaptation to Violence Exposure

Resilience is defined in many ways depending on the research project. It may be defined as the presence of assets in the person's life, the abilities the person has, or just the absence of pathology. According to SAMSHA (2014) it refers to "the ability to bounce back or rise above adversity as an individual, family, community, or provider. Well beyond individual characteristics of hardiness, resilience includes the process of using available resources to negotiate hardship and/or the consequences of adverse events" (p. xviii). Research by the Search Institute on over 5 million children and adolescents now uses a framework of 40 developmental assets to understand how adaptively a child may function. As assets accumulate, the child is most likely to be showing an adaptive response to life. However, as the number of assets decreases, the odds increase that a child or adolescent will engage in dangerous behavior such as premature sexual behavior, use of alcohol, and use of drugs (Search Institute, 1990).

There can be individual, family, and social environmental sources of resilience (Khanlou & Wray, 2014). Factors within the individual can include biological and psychological variables. Factors within the family can be factors such as the relationship skills of the parents and the stability of the parental relationship. A healthy parent-child relationship includes a child being the recipient of positive and effective parenting skills from both the mother and the father. This creates a family environment that is emotionally supportive and includes open communication. Children require many complex skills from their parents, and their needs change as they develop. Parents need to learn new behaviors and develop new skills and resources as their children age and place differing demands on them. Parents are also children's role models for how adults should behave in intimate relationships. Thus, a respectful intimate relationship, free of aggression or violence, provides children with a compelling example of what they should be developing in their own future relationships. Eisenberg, Hofer, Sulik, and Spinrad (2014) find that the use of punishment either had no impact or a modest negative impact on the child's prosocial behavior.

Relationships do not develop through passive interactions. A parent's level of warmth in interacting with a child provides more and less motivation for the child to interact back, to copy the parent's interaction behaviors, and to interact in a way he or she perceives might please the parent. The temperamental style of both individuals in the interaction provides a mutual influence on how positively or negatively it proceeds. Parents who know how to foster warm mutual relationships; to respond in a sensitive way when the child makes an attempt to interact; to take a lead in trying to regulate interactions in a way that eases the way into communication and positive communication; and to structure family routines and rituals in a way that integrates how each party should behave will support more positive relationships and more sophisticated relationship skills in the developing person (Laible, Thompson, & Froimson, 2015).

Some research shows that prosocial interactions can influence the development of a child's brain so that the centers of the brain in the limbic system that deal with emotional reasoning are more highly developed (Brown & Brown, 2014). Neural correlates exist for experiencing both compassionate responses and responses of respect and admiration. While compassionate responses for physical and psychological pain have been found to occur in the same brain areas, compassion for physical pain shows more immediate versus time-delayed reactions in the brain. This suggests that greater cognitive processing of information may need to occur before a compassionate response to emotional pain occurs (Immordino-Yang, McColl, Damasio, & Damasio, 2009).

Some research suggests that we are hardwired for the development of caregiving behaviors given the appropriate environmental stimulation. The level of empathy and altruism individuals show are heritable inclinations (Knafo & Israel, 2010). Children show more thoughtfulness in their behavior and exhibit more empathetic responding toward others and to engage in more prosocial behavior, such as helping spontaneously, providing emotional support, and sharing, when their parents helped them understand the impact of their own

behavior on others as well as supported their autonomy as individuals. On the other hand, parents who use power-assertive strategies to gain compliance from their children and negative forms of discipline have children who show less empathic responses and less prosocial behavior (Eisenberg et al., 2014).

Neural research continues to show the complexity of the environment by genetic interaction in brain development. A gene exists that makes children more likely to be influenced by the behavior of their parents (Knafo & Israel, 2010). The serotonergic and dopaminergic systems may underlie the differences in susceptibility to parental influence that exists between siblings (Belsky & Pluess, 2009). Despite the clear existence of biological influences, environmental influences account for approximately 50% of variance in behavior (Knafo & Israel, 2010).

Family relationships are always in need of change as the individuals involved change. The help that can go in one or both directions between family members promotes positive meaning to family life. Transitions that occur to everyone as they first seek to learn, master, and then move on to new skills put pressure on the family structure to change (Minuchin, 1974). Adolescents can use this example of a good relationship to guide them as they go on to develop relationships with peers and dating partners. Children and teens will come into conflict with others and need to hold beliefs that violence is not acceptable in relationships as well as to have strategies for nonviolent communication and problem-solving strategies. Parents are critical in helping their children and teenagers learn how to negotiate conflict, reduce stress, and manage negative emotions in a safe manner (Black et al., 2011). The importance of family support does not end when children become adults. Emerging adults, adults, and older adults benefit from positive family support. The Pew Research Center (2010) indicates that 80% of people believe they should provide help to older family members. Strengthening human relationships so that they provide a positive narrative and roles for family members is critical to violence prevention. Intervening to reduce predisposing, eliciting, and potentiating factors that support violence as well as other dysfunctional lifestyles can help decrease violence (Finkel, 2007, 2008; Finkel, De Wall, Slotter, Oaten, & Foshee, 2009).

Factors within the social environment that can reduce violence can include increasing the safety of the neighborhood, the quality of the school, and societal policies around law enforcement (Sabina & Banyard, 2015). Studies examining interpersonal violence and resilience at the same time find that school qualities such as how well connected individuals are to their peers, their teachers, and their parents, promoted well-being, but this impact is greater for students who had not been victimized than for those who had (Morin et al., 2015).

## Promoting Resilience

Research indicates that victims of violence are helped more when protective factors occurring across broad domains of resilience are strengthened than when treatment targets only one domain (Lenzi et al., 2015). Masten (2014) recommends building strengths in four areas including ability to develop positive attachments to others and quality of current close relationships; intelligence, ingenuity, and ability to solve life problems at this time; ability to regulate emotions and thoughts and develop personal goals; desire to master skills important in life, ability to take action to help self and others, and the rewards in the environment that support the individual; and the individual's ability to have faith, hope, or a belief that life has meaning.

Garbarino (2015) suggests that the construct of "malleability" may be more useful than the construct of "resiliency" when looking at an individual's ability to respond adaptively to violence/trauma. From this perspective, when individuals are provided with what they need during development, they are able to respond to a risk factor/adversity in the short run and continue to live relatively adaptively in the longer run. However, if the risk factors are too numerous, or the negative effects of an episode of adversity too numerous, the individual's ability to cope becomes overwhelmed. Sameroff and associates, who take an ecological approach, do research on

the influence of adversity on intelligence quotient (IQ). Using verbal IQ scores, their data suggests most children can cope adequately with 1–2 risk factors or episodes of adversity and maintain a verbal IQ within the average range. However, once they accumulate four or more, their verbal IQ's is more likely to be in the borderline to retarded range. This research indicates that it is the accumulation of risk, rather than any particular risk factor, that negatively impacts verbal ability (Sameroff, Seifer, Barocas, Zax, & Greenspan, 1987). This coincides with research on adults using the adverse childhood experience scale. This research finds that experiencing 0 to 3 adversities in childhood is not associated with negative psychological and physical health problems in adulthood. However, four or more lead to a variety of psychological and physical health problems in adulthood (Felitti, 2002; Felitti & Anda, 2010).

Strengthening individual and family skills is important. However, ending violence also requires developing community norms that do not tolerate violence and that provide economic and social support to people in need. Multiracial, racial minority individuals, and sexual minority individuals experience violence and sexual violence at higher rates than Whites (Basile et al., 2016; Breiding, Basile, Smith, Black, & Mahendra, 2015; Walters, Chen, & Breiding, 2013). Schools that can learn to react proactively, rather than punitively, to students with a history of adverse events can support their students socially, emotionally, and behaviorally; these maltreated students can then focus on their academics and learn critical educational skills (Cole et al., 2013). It is not just children who need to feel safe and connected. All the institutions of society need to support human safety as a fundamental human right by taking proactive approaches to reducing violence (NPEIV, 2017).

## TREATMENT OF VICTIMS AND PERPETRATORS

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The National Child Traumatic Stress Network (NCTSN) considers 12 core concepts critical to dealing with cases of trauma brought on by interpersonal violence. These concepts were developed using a grant from the Substance Abuse and Mental Health Services Administration (SAMSHA) and involved trauma professionals from across the nation in two national meetings, one in August of 2007 and another in August of 2011 (NCTSN, n.d.). The first concept, that traumatic experiences are complex, refers to the fact that even if a trauma is highly specific and lasts a brief moment in time, the subjective reaction the child or other vulnerable person has to the trauma will involve physical, emotional, and cognitive components. Moment-to-moment reactions during the actual trauma will not be the end of the reaction as the situation(s) in which the trauma occurs, and the reactions of other people to the trauma, will all interact with the victim's immediate response. In addition, trauma does not occur in isolation. It occurs within a context that involves the individual's personal characteristics, his or her past experiences, and his or her current circumstances. Individuals who experience a traumatic event after otherwise healthy functioning will experience the trauma differently than those experiencing a series of developmental challenges.

NCTSN's third concept is that trauma often leads to cascading additional, or secondary, adversities. For example, a child who is sexually assaulted by a stranger may then have to undergo an extremely difficult, painful, and unexpected examination at the emergency room. While victims can gain from social support, unfortunately, social ostracism sometimes follows as well as other negative responses. The fourth concept, that can be difficult for other people to understand, is that a victim can exhibit a large range of responses to victimization, from withdrawing and crying (which may seem appropriate) to throwing the family cat out the window after it suddenly lands on their heads near an open window (which may seem pathological). Some victims develop full PTSD. Others may keep their pain and sufferings to themselves. Individuals with pre-existing emotional or mental health disturbances are likely to show heightened reactions compared to those without them.

The fifth concept is that traumatized children become very concerned with danger and safety and need reassurance as well as concrete help in increasing their current and future levels of safety; not just reassurance without concrete assistance. Fearful people do not clearly indicate they are afraid, they may just stop showing an interest in exploring the world or allowing those close to them to explore it either. The sixth concept is that as individuals are not islands, their entire family and support group will also be negatively impacted by trauma. Thus, just at a time when a child needs even more social support, everyone they normally receive it from may also be in need of help. A seventh concept is that there are protective and promotive factors in life that can help individuals adjust to any event, even traumatic ones. Some children do not show as great a negative response to victimization as others because they gained help from their own spunky personality, their families and friends, their teachers, and neighborhood.

The eighth concept is that without effective help, trauma and posttraumatic adversities can be expected to have cascading negative impacts on child development. The ninth concept, linked to the previous one, is that developmental neurobiology can be negatively affected by trauma. Brain structures and neuroendocrine systems can be programmed to view the world as a dangerous place and provide less effective filtering of new experiences. The tenth concept is that, like all positive and negative experiences, the culture of the individual influences how he or she will respond and recover from trauma. The eleventh concept is that while no one may speak of it, it is part of the social contract with adults that they will protect children. It is part of the social contract with society that its institutions will keep its citizens safe. Until trauma occurs, no one may think consciously of “expecting” anyone or anything to keep them safe. The final concept is that everyone attempting to help the victim is vulnerable to developing distress themselves. Thus, helpers need to be aware of the possibility of secondary trauma and engage in active self-care activities.

Treatment needs to help clients regain a sense of safety and control in their lives. Thus, it is critical that even very young clients be actively involved in treatment planning. Otherwise, victims of IPV, who experienced coercive control over every aspect of their lives, may react with retraumatization to a cognitive behavioral treatment plan where they are expected to always account for what’s going on in their heads and questioned in detail about their treatment homework. While these are standard techniques that are helpful for many people, for this particular type of client, having a highly directive therapist could be unintentionally retraumatizing. For another client, these same procedures could help the client regain a feeling of safety because treatment takes on a predictable flow each session. As another example, sometimes treatment is provided in small rooms, and many people within the treatment center know highly personal information about the client. It is possible that this can be reminiscent of prior traumatic events where the client had limited privacy and limited personal space, which then might trigger maladaptive behavior or traumatic reactions that seem to come out of nowhere for the clinician. Only through the clinician carefully evaluating the specific features of violence exposure and trauma can these triggers be avoided. Through all phases of treatment, clients need to feel respected and empowered by the clinician to be in charge of their own recovery. While this can seem overwhelming at first, remember that you can ask your client what interpersonal behavior might be associated with their past victimization (SAMSHA, 2014).

Evidence-informed treatment for trauma requires that the NCTSN twelve core concepts be incorporated as appropriate. The Resilience Portfolio Model is one approach for helping the clinician organize the research on both risk and protective factors into treatment. This approach looks at resilience as processes that help the individual deal with adversity as well as signs of positive outcome with increased well-being (Grych, Hamby, & Banyard, 2015). This is an ecological model that examines social support within and outside of the family and positive community factors such as quality schools or health care. Assets are characteristics that are of value in supporting well-being at any time in the life span. Assets can occur in a variety of ways. Regulatory assets are things that exist within the individual, such as level of emotional regulation, coping skills, or the ability to endure

even when things are difficult. Another type of asset is in terms of meaning making. This includes things such as a sense of purpose or of mattering in the universe that may include ideas such as everyone is a unique individual and is valuable; or the ability to engage in meaning-making activities as well as religious-based coping, which can include things like the creation of art or the use of prayer. Interpersonal assets include social skills, level of generosity, and the ability to forgive. This model considers having a variety of assets, poly-strengths, as more important than developing any particular asset or resource. The greater the constellation of these, the better someone's functioning after adversity; this model provides a strength-based method of examining outcome and looks for the presence of well-being rather than just the absence of adverse reactions or problems (Grych et al., 2015; Banyard, Hamby, & Grych, 2017).

A study in the Appalachian region of three southern states with 2,565 participants finds that those experiencing adversity ranging from financial strain to victimization as a child indicate poorer quality of life. However, while this explains 8% (financial strain) and 4% (childhood victimization) and adult quality of life, positive factors carry more predictive power. The factor with the strongest power is increased emotional regulation, which improved odds of well-being by 36%. The next most powerful factors were meaning-making activities that increase well-being by 26%, community support (20%), self-care activities by 19%, support from friends (18%), and finally, practicing forgiveness (15%). These strengths may have an indirect impact on health; individuals with more emotional regulation may be less likely to use alcohol to excess. Or, the impact may be direct in that religious views may help provide a framework for understanding life that supports good immune system functioning.

As of May 2017, there was one manualized trauma treatment listed as having undergone randomly controlled trials (RCTs) in the Substance Abuse and Mental Health Services Administration (SAMHSA) National Registry of Evidence-Based Programs and Practices (NREPP). This is a program for children and their families called Trauma-Focused Cognitive Behavioral Therapy for Children Affected by Sexual Abuse or Trauma, and it is an empirically supported treatment for young victims of abuse, neglect, and trauma (Cohen, Mannarino, & Deblinger, 2006). There are two major components. The first is a series of treatment steps for dealing with the violent or traumatic experiences of the young person. Second, is to deal with the cascading negative impact the person may have developed as a result of the violence/trauma to aid return to an appropriate developmental course. If a child or adolescent is traumatized, you need to ensure the physical and emotional safety of the individual. This will include making tasks clear, maintaining boundaries, behaving in a trustful manner, providing as many choices as possible in order to give the individual choice and control, sharing/collaborating and engaging in mutual relationships with the individual in need of help, and engaging in skill building and empowerment so that the traumatized individual can regain control over his or her own well-being. Trauma can leave the individual with indirect effects, such as maladaptive ways of thinking about and understanding the world, emotional dysregulation, interpersonal problems, and problems raising children (e.g., lack of effective communication skills, parenting skills, and ability to set appropriate boundaries). In addition, victims can have problems directly related to the traumatic experience, such as avoidance of specific places and experiences; people who may trigger memories of trauma; and development of aggressive, sexualized, or other maladaptive behaviors for interacting in the world. Finally, they may be hyper- or hypoaroused and show hypervigilance.

## Summary

Providing trauma-informed care is to become aware and knowledgeable about the impact of trauma on individuals, families, and the community. According to the national epidemiologic survey on alcohol-related conditions, 71.6% indicate witnessing trauma. Injury-related trauma is experienced by 30.7% in the sample, and

psychological trauma is experienced by 17.3% (El-Gabalawy, 2012). There is a bidirectional relationship between psychological disorders and exposure to traumatic experiences. While not every individual with a psychological disorder or problem with alcohol or drugs has been exposed to trauma, there is a higher prevalence among these groups (SAMSHA, 2014). Due to the commonality of violence exposure, clinicians need to proactively assess for the impact of violence exposure across the life span. Strengths/assets can also support well-being, and increasing them may be important foci for intervention so these should also be comprehensively addressed. SAMSHA (2014) recommends a trauma-informed, strength-based approach. Treatment needs to be a safe, collaborative, and compassionate environment (SAMSHA, 2014).

## FINAL WORDS

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There are commonalities across different forms of violence, however, there are also unique forms of trauma that may be specific to different age groups, such as financial exploitation in older adults (Acierno et al., 2010). Additionally, there may be forms of trauma that impact only certain groups such as race-based traumatic stress (Carter et al., 2017; Comas-Díaz, 2012), immigration-status-based violence, sexual orientation-based violence, and so forth. Research finds relationships between psychological health and racial identity status with individuals at more external stages showing a lower level of psychological health (Pillay, 2005).

## RED FLAG GUIDELINES FOR TRAUMA-INFORMED CARE

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1. Assess how safe, secure, and supported clients are within the institutions of society (level of institutional support, level of institutional betrayal).
2. Assess how safe, secure, and supported clients are within the local community (level of community support, level of community betrayal).
3. Assess how safe, secure, and supported clients are; if a minor, within the school system, or if an adult, in the work environment (level of support for success, level of violence exposure or neglect of scaffolding for success).
4. Assess how safe, secure, and supported clients are at home with others (how well are developmental needs being met, how much is violence or neglect the norm).
5. Assess how safe, secure, and supported clients are within self in terms of thoughts, feelings, fantasies, wishes, actions (positive, hopeful, and affirming versus negative, inhibiting, and destructive).
6. Assess how safe clients are overall (assess role in violence, types of violence exposure, frequency of exposure).
7. Assess how secure clients are overall (assess personal employment/caretaker employment, food security, housing security, medical security).
8. Assess how developmentally supported clients are overall (assess emotional, cognitive, and physical development).
9. Consider if ensuring clients' human right to safety might involve change/treatment aimed at more internal and/or family awareness or actions for clients or if it might involve more social and political actions to change policies, procedures, and values of an environment that has institutionally betrayed clients; consider if there could be any specific resources, treatment strategies, or helpers clients would value at this time that might be effectively used within your treatment plan.

## SELF-ANALYSIS GUIDELINES

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Answer the following self-reflection questions in detail, providing specific examples to support your points from your own life. The points beneath each question are there to help you in thinking comprehensively.

1. What is your current knowledge of the impact of violence, neglect, and trauma on individuals, families, communities, and countries?
  - a. Discuss how well you think your educational experiences have prepared you for recognizing the warning signs of violence, neglect, and trauma on individuals and families and strategies for intervention (consider different age groups and the types of violence that affect them).
  - b. Discuss how well you think your professional experiences have prepared you for recognizing the warning signs of violence, neglect, and trauma on individuals and families and strategies for intervention (consider different age groups and the types of violence that affect them).
  - c. Discuss how well you think your personal experiences have prepared you for recognizing the warnings signs of violence, neglect, and trauma on individuals and families and strategies for intervention (consider different age groups and the types of violence that affect them).
  - d. Discuss how well your academic and professional work has prepared you for recognizing and enhancing clients' strengths for overcoming the barriers to adaptive functioning in their lives (be specific and concrete).
  - e. Based on what you have learned in the past, and the information in this chapter, describe your strengths in working with victims of violence, neglect, and trauma and what you might find the most challenging/difficult (consider different age groups and the types of violence that affect them).
2. In what ways have individuals who have been victims of violence, neglect, and trauma been most visible within the current media?
  - a. Describe the stereotypes of victims and perpetrators you have seen portrayed most frequently within television and movies (consider different age groups as well as different types of violence).
  - b. Discuss how myths that “bad people” have been born that way and a belief that violence has been caused by bad people might have operated in these stereotypes (be specific and concrete).
  - c. Describe current events in which individuals who have been involved in violent incidents have been covered within print, magazine, and/or news reporting (be specific and concrete).
  - d. Describe how negative stereotypes and myths about what makes people “bad” might have operated in this coverage (be specific and concrete).
  - e. Describe a recent political issue that has received significant coverage within the news media and what if any myths and misinformation about what causes violence might have played in the issue (be specific and concrete).
3. Considering what you have learned about violence, neglect, and trauma from your past experiences and from reading this chapter, what might currently be your limitations in working effectively with clients impacted by violence, neglect, and trauma?
  - a. Discuss the knowledge base you might need to develop further to be effective with victims, perpetrators, and victim-perpetrators and how it might be of value to you.
  - b. Discuss the skills you might need to develop further to be effective with victims, perpetrators, and victim-perpetrators and how these might be of value to you.

4. What action steps could you take as you progress through the different stages of treatment to increase your effectiveness with clients who have been impacted by violence, neglect, and trauma?
  - a. What might you change in how you interact within the rapport-building phase to develop a more effective working alliance with clients who have been impacted by violence, neglect, and trauma (consider your safety within your family, your safety with your peers, your sense of belonging at work, your sense of belonging in society, your beliefs in your ability to succeed, the lifestyle or skills you needed to develop as you grew older to survive, how your learning history has influenced how truthful you are in communications with authority figures, how easy is it for you to have “basic trust” in authority figures)?
  - b. How might you structure the treatment environment to increase the likelihood of a positive outcome with clients who have been impacted by violence, neglect, and trauma (how frequently clients come in, how long the session is, how important it is for clients to show up on time or cancel appointments they won't attend, how important it is to always have treatment appointments at the same time, how you will communicate your expectations to them and how you will attempt to gain increased communication from them about their expectations)?
  - c. What aspects of a theoretical orientation do you think might be most beneficial or problematic with clients who have been impacted by violence, neglect, and trauma (consider any implicit bias a treatment approach you are familiar with might contain, consider the origins of the treatment, the treatment assumptions related to how clients developed problems, treatment assumptions about what is necessary for change to occur, and the role of the clinician in treatment)?
  - d. What might you change in the treatment-planning phase to increase the likelihood of a positive outcome with clients who have been impacted by violence, neglect, or trauma (what values based on your level of safety as you grew up might be embedded in your expectations for how much trust should clients have that your role is to help them; how much agency clients should show within a treatment session; how much clients should challenge versus accept the ideas of the clinician; how much time clients should spend outside of the treatment session working on treatment goals; how much clients should value time in treatment versus time at work, with their families or with their other social groups)?
  - e. What might you change in the termination phase of treatment to increase the likelihood of a positive outcome with clients who have a history of violence or trauma (consider how much clients should value their own, the clinician's, their family's or their social group's opinions as to what a success treatment outcome would be; consider the impact on clients of you ending a relationship in which they have felt safe; consider the impact on clients of ending a relationship in which they have felt listened to and cared about)?

## RECOMMENDED RESOURCES

### Books

Becker-Blease, K. A., & Kerig, P. K., (2016). *Child maltreatment: A developmental psychopathology approach*. Washington, DC: American Psychological Association.

Bond, M. A., & Serrano-Garcia, I. (2017). *APA handbook of trauma psychology: Vol.1 Foundations in knowledge, Vol. 2. Trauma practice*. Washington, DC: American Psychological Association.

- Cole, S. F., Eisner, A., Gregory, M., & Ristuccia, J. (2013). *Helping traumatized children learn, Volume 2*. Retrieved from <https://traumasensitiveschools.org/tlpi-publications>
- Comas-Díaz, L. (2016). Racial trauma recovery: A race informed therapeutic approach to racial wounds. In A. N. Alvarez, C. T. H. Liang, & H. A. Neville (Eds.), *The cost of racism for people of color* (pp. 249–272). Washington, DC: American Psychological Association. <http://dx.doi.org/10.1037/14852-012>
- Hamby, S., & Grych, J. (2013). *The web of violence: Exploring connections among different forms of interpersonal violence and abuse*. New York, NY: Springer.
- Harris, J. I., & Slattery, J.M. (2017). *Trauma, meaning and spirituality: Translating research into clinical practice*. Washington, DC: American Psychological Association.
- Myers, J. E. B. (2017). *Legal issues in clinical practice with victims of violence*. New York, NY: Guilford Press.
- Taft, C. T., Murphy, C. M., & Creech S. K. (2016). *Trauma-informed treatment and prevention of intimate partner violence. New and bestselling titles of trauma*. Washington, DC: American Psychological Association.
- Toch, H. (2017). *Violent men: An inquiry into the psychology of violence, 25th Anniversary Edition*. Washington, DC: American Psychological Association.

### Websites

**Advanced Trauma Solutions (ATS).** ATS developed the target model that is an evidence-based practice for helping people overcome the effects of chronic and extreme stress.

<http://www.advancedtrauma.com>

**The Centers for Disease Control and Prevention: Division of Violence Prevention.** This website provides detailed information about violence across the life span as well as interactive, free trainings.

<https://vetoviolence.cdc.gov>

**National Center on Elder Abuse Resources.** This website provides free resources to those interested in learning more about the many forms of elder abuse and what to do about it.

<http://elderjusticecoalition.com>

**National Center for Victims of Crime.** This site provides education, training, and evaluation

service through collaboration with partnerships across the country and provides resources for victims of crime.

[victimsofcrime.org](http://victimsofcrime.org)

**The National Domestic Violence Hotline.** This resource provides free phone support as well as live chat in English and Spanish.

[www.thehotline.org](http://www.thehotline.org)

Hotline at 1-800-799-7233 or TTY 1-800-787-3224.

**National Sexual Violence Resource Center (NSVRC).** This center provides resources such as an eLearning campus, a library, publications, an experts database and a store.

<https://www.nsvrc.org/>

**No More Campaign.** This organization is a sister campaign devoted to ending domestic violence and sexual assault.

<http://nomore.org>

**Office of Violence against Women, Department of Justice.** This office focuses on domestic violence, sexual assault, dating violence, and stalking.

<https://www.justice.gov/ovw>

**RAINN.** Provides information about sexual assault and prevention, a live chat line, and a free phone line that provides support 24 hours a day for victims of sexual assault.

National sexual Assault hotline: 800-656-HOPE

<https://www.rainn.org>

**Stalking Resource Center.** Provides information on stalking as well as help for victims.

<http://victimsofcrime.org/our-programs/stalking-resource-center/about-us>

**Stopbullying.gov.** This website provides detailed information about all different forms of bullying as well as strategies for intervening effectively to end bullying.

<https://www.stopbullying.gov/respond/index.html>

## Videos

- Angust, L., & Paivio, S.C. (2015). *Narrative processes in emotion-focused therapy for trauma*. United States: American Psychological Association.
- The Glendon Association. (2011). *The roots of violence: Part one of the voices of violence series*. United States: Glendon Association.
- The Glendon Association. (2011). *Effective treatment of violent criminals: Part two of the voices of violence series*. United States: Glendon Association.
- Monson, C. M. (Featured). (2016). Cognitive behavioral interventions for posttraumatic stress disorder (Video series episode). In *The APA specific treatments for specific populations video series*. Washington, DC: American Psychological Association.
- Paivio, S. C. (Featured). (2014). Emotion-focused therapy for trauma (Video series episode). In *The APA specific treatments for specific populations video series*. Washington, DC: American Psychological Association.
- Taft, C. T. (Featured). (2016). Intimate partner violence (Video series episode). In *The APA specific treatments for specific populations video series*. Washington, DC: American Psychological Association.

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