

# *The Most Important Things Learned About Violence and Trauma in the Past 20 Years*

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*In the past 2 decades, important insights have been gained regarding violence and trauma. Complications occur in how violence and trauma, their causes, and their effects on victims should be defined. Violence and abuse to women—physical, sexual, and emotional—are not rare events and are most often perpetrated by partners or acquaintances rather than strangers and occur in nonmarital as well as marital relationships, including same-sex relationships. A promising methodological innovation in the study of violence and trauma is the use of longitudinal designs. Innovations in treatments for victims such as evidence-based interventions have been slow to emerge; they include eye movement desensitization and reprocessing (EMDR) and the Seeking Safety group intervention for drug-abusing women with trauma histories. Future research should address increased understanding of variation in individual responses to violence and trauma, matching of treatment to different types of male offenders, better understanding of how culture affects violence perpetration and victimization, and evaluation of domestic violence interventions.*

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*The study of interpersonal violence and trauma* does not have a long history. For example, the first studies of intimate violence were conducted during the 1970s and concluded that the causes of such violence inhered in marriage itself rather than intimate relationships per se (Straus, Gelles, & Steinmetz, 1980). Many were surprised to learn that such violence and abuse also occurred in nonmarital adult relationships, such as cohabiting relationships and within gay and lesbian relationships as well as heterosexual relationships (see, e.g., Magdol, Moffitt, Caspi, & Silva, 1998; Renzetti, 1988). The latter occurrence challenged the prevailing idea that the main, or a main, cause of intimate violence is patriarchy—the lengthy history of men having superior power in heterosexual relationships (Merrill, 1996). Even more surprising for some has been the existence of abuse and violence in adolescent

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relationships (e.g., Foshee et al., 1996) at a time when many have thought that equality and rights for women were increasing.

The field of sexual assault has yielded equally surprising and important insights during the past 20 years, for example regarding the relationship between victims and offenders. Originally it was assumed that rape was perpetrated on women by strangers and was relatively rare. We now know that rape and other sexual assaults are most often perpetrated not only by those known to the victim but also, in most cases, by someone who has a very close relationship with the victim, such as a father, husband, or boyfriend (e.g., Russell, 1986; Tjaden & Thoennes, 1998).

These observations illustrate the lesson that violence and trauma are extremely complex in terms of how they can be defined, their causes or risk factors, and the effects they have on victims. There continues to be debate in the field about how violence and abuse should be defined; for example, should physical violence be considered by itself or should we adopt more comprehensive definitions that include acts of emotional or sexual abuse? Agreement about definitions has been challenging to obtain and is essential to measuring the true extent of trauma and abuse, which were initially assumed to be relative rare occurrences. Twenty years of research (e.g., Breslau, Davis, Andreski, Federman, & Anthony, 1998; Tjaden & Thoennes, 2000) has challenged this assumption and taught us that intimate violence, abuse, and trauma are more prevalent than once thought, although there continues to be debate about their real prevalence. We have learned that neither physical nor sexual assault experiences for women are rare. For example, the 1995-1996 National Violence Against Women telephone survey found a lifetime prevalence for rape and/or attempted rape of 18% and a lifetime prevalence of physical assault of 52% (Tjaden & Thoennes, 1998). Moreover, people who lack direct experience with violence, abuse, or trauma often have indirect or secondhand experiences via those close to them. In a public opinion survey of 1,200 New York State adults regarding domestic violence, 62% knew someone who had been the victim of partner violence, and 45% had overheard a domestic violence incident. Even more surprising, perhaps, is that 31% knew someone who had received counseling because of victimization, and 45% knew of someone who received an order of protection (Carlson & Worden, 2004).

Another important finding about the complexity of intimate violence and trauma concern their effects. Early assumptions about what was harmful about abuse—and what kinds of abuse are more and less harmful—have also undergone revision. Ample evidence exists that severe physical violence and sexual assault are major contributors to physical and mental health problems in women (e.g., Campbell, Sullivan, & Davidson, 1995; Kilpatrick,

Edmunds, & Seymour, 1992; McCauley, Kern, Kolodner, Derogatis, & Bass, 1998). However, we now realize that emotional abuse by itself, even in the absence of physical or sexual violence, can contribute to mental health problems such as posttraumatic symptoms (e.g., Follingstad, Brennan, Hause, Polek, & Rutledge, 1991) and that even nonsevere acts of physical violence are associated with health problems (McCauley et al., 1998). These findings may challenge the standard clinical definition of trauma as an experience that is inherently life threatening (“actual or threatened death or serious injury, or a threat to the physical integrity of self or others” (American Psychiatric Association, 2000, p. 467).

The consequences of violence and abuse are not always straightforward and direct. They often involve a range of mediating and moderating variables that must be taken into account to fully understand exposure to trauma and its effects. Longitudinal designs and studies with broad measurement space have been important in better understanding the processes and short- and long-term consequences of abuse. For example, an important study by Sutherland and colleagues discovered that “abuse showed no direct relationship with change in physical health symptoms, but increased levels of symptoms were associated with abuse *through the intervening effect of changes in depression and anxiety* [emphasis added]” (Sutherland, Bybee, & Sullivan, 1998, p. 58).

There are also important factors that moderate the effects of violence and traumatic exposure, exacerbating or buffering their effects. For example, domestic violence advocates have long observed the remarkable resilience of women severely abused for years who continue to function and parent despite chronically stressful lives, so we know that protective factors such as social support and a healthy relationship can sometimes offset the potentially harmful effects of abuse and trauma. On the other hand, trauma and violence can have extremely long-lasting effects on a subgroup of victims even when they are no longer exposed to violence or trauma (e.g., Russell, 1986; Sutherland et al., 1998). This may be attributable to the presence of other risk factors such as childhood exposure to trauma, which can magnify the effects of adult abuse or trauma (e.g., Plichta & Abraham, 1996).

#### **PROMISING METHODOLOGICAL INNOVATIONS IN THE STUDY AND TREATMENT OF TRAUMA AND VIOLENCE**

An important research innovation in the study of interpersonal violence and trauma is the use of longitudinal designs to follow samples of perpetrators and victims over time, ideally starting when they are still young and

tracking them through adulthood. Several large-scale studies that were not necessarily designed with the intention of studying trauma or violence and abuse (e.g., the Rochester Youth Development Study [Terence Thornberry, principal investigator]; the Dunedin Multidisciplinary Health and Development Study of New Zealand youth [Terrie Moffitt, primary investigator in partner violence area]; and the longitudinal study conducted by the University of Oregon Social Learning Laboratory [Deborah Capaldi, primary investigator] included measures of partner violence). Methodological strengths of these investigations include representative samples of youth, multiple waves of data collection beginning during adolescence, and very broad measurement space (see, e.g., Capaldi & Gorman-Smith, 2003; Magdol et al., 1998).

An extremely promising intervention is the 24-session, manualized Seeking Safety group intervention developed with support from the National Institute of Drug Abuse (Najavits, Weiss, Shaw, & Muenz, 1998) for women with substance abuse and comorbid post-traumatic stress disorder (PTSD). Most women in substance abuse treatment have extensive trauma histories and are perceived as difficult to treat (Najavits et al., 1998). The model uses a cognitive-behavioral approach that is present focused, targets symptoms of PTSD, and is designed to improve coping skills and help manage difficult emotions (Najavits, 2002). Similar approaches could be used to develop evidence-based interventions for women who are not abusing substances with histories of interpersonal violence and trauma, such as those seen in domestic violence and rape crisis programs.

Another promising treatment innovation is eye movement desensitization and reprocessing (EMDR), introduced by Shapiro (1989). Combining elements of cognitive-behavioral, psychodynamic, and other approaches (Shapiro & Maxfield, 2002), EMDR is a short-term method that has accumulated a small body of empirical research supporting its effectiveness with PTSD sufferers such as "victims of rape, physical violence, childhood abuse . . . and other traumas" (Shapiro & Maxfield, 2002, p. 934). Viewed by some as a type of exposure therapy, the approach is structured and can be effective in a few sessions or within a matter of months, fitting well into the managed care model of delivery of mental health services. Although not a panacea or without its critics, the approach offers promise, especially for clients who are not willing or able to spend long periods of time extensively processing traumatic events in detail.

Men who victimize women are not a homogenous group. Thus, there is no reason to assume that a single intervention will work effectively with all types of offenders, even within the domestic violence and sexual assault domains. Greater experimentation is needed to determine which types of intervention programs can be matched to which type of offenders, such as

that offered by Saunders (1996) who compared two models of group treatment (feminist-cognitive-behavioral and process-psychodynamic) with different types of men who are abusive.

#### **THE MOST IMPORTANT THINGS WE NEED TO LEARN IN THE NEXT 10 YEARS**

Although we have made great strides in the past 20 years toward better understanding the complex biopsychosocial processes through which violence and trauma exert their effects, especially why people exposed to the same violent or traumatic events respond differently, we need to redouble our efforts to understand the processes involved in perpetration of physical, emotional, and sexual abuse. Such understanding is essential to developing and refining intervention programs that are effective in helping abusers change their behaviors. A recent review concluded that more rigorous, experimental, and quasi-experimental evaluation designs are needed to assess the impact of programs that treat men who abuse their partners (Saunders & Hamill, 2003). Special attention needs to be paid to offenders with alcohol and drug problems, who are often screened out of batterer intervention programs until their substance abuse problems have been addressed. Because of the high co-occurrence of these problems, an intervention approach that could simultaneously and effectively address substance abuse and domestic violence would be extremely useful to practitioners (Barnett & Fagan, 1993; Bennett & Lawson, 1994). Effective prevention programs also depend on a better understanding of the risk factors and processes involved in development of offending behavior so that interventive efforts can begin earlier. The longitudinal studies mentioned earlier may be helpful in this regard.

Cultural factors in violence, abuse, and trauma need to be better researched. We have known for some time that culture matters when trauma is concerned; however, we need to fine-tune our knowledge of how culture matters in the definition of what is experienced as traumatic or abusive as well as the processes through which traumatic events are experienced and either accommodated or not (see, e.g., Marsella, Friedman, & Spain, 1996). Culture can be expected to moderate the effects of traumatic exposure and may influence the process of healing from the effects of trauma, violence, and abuse. Cultural factors are equally important as they affect the perpetration of violence, abuse, and trauma (Gondolf, 1997). For example, Allen (1996) observed that the "politics of deprivation have created traumatogenic life circumstances in which disproportionate numbers of African Americans act out against each other, *especially in male-to-female violence* [emphasis

added] and youth violence” (p. 227). As a result, culturally competent interventions targeted to men from ethnic minority groups, who have special needs and often are not well served or retained in mainstream programs, are also needed (Gondolf, 1997; Saunders & Hamill, 2003).

Also sorely needed are intervention approaches for victims who have not been responsive to current treatment methods such as those with other comorbid disorders and those who have multiple types of trauma or chronic exposure to trauma. Although standard approaches that offer short-term help such as education, advocacy, and support may be sufficient for many—even most—victims of intimate partner violence, these limited approaches are often not effective for women whose history of exposure has been severe and long-standing. These women may suffer from problems such as PTSD, depression, and substance abuse requiring the help of highly trained mental health professionals who are skilled in using evidence-based approaches.

Finally, domestic violence programs need to be evaluated and their programs refined so that women who need such assistance get the most effective services possible in the most cost-effective manner. The groundbreaking longitudinal study of Cris Sullivan and colleagues is an excellent first step; this project evaluated a comprehensive, postshelter intervention that ultimately was found to be effective in helping women to achieve safety (e.g., Sullivan & Bybee, 1999) and additionally enhanced our understanding of the complex nature of achieving a violence-free life. These same careful methods should also be applied to services offered to women while they are in shelter. This will require attention to the issue of desired outcomes for abused women seen in shelters, which may be controversial in that women who seek shelter do so for a variety of reasons that may or may not include ending the relationship with the abuser.

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