

Violence Against Women

Outcome Complexity and Implications for Assessment and Treatment

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This article reviews the major forms of violence against women, including sexual assault, intimate-relationship violence, and stalking and outlines the known psychological effects of such victimization. Also discussed are a number of variables that combine to determine the effects of such victimization, including type and characteristics of the assault; victim variables such as demographics, psychological reactions at the time of the trauma, previous victimization history, current or previous psychological difficulties, and general coping style; and sociocultural factors such as poverty, social inequality, and inadequate social support. The implications of this complexity are explored in terms of psychological assessment and the frequent need for multitarget, multimodal treatment approaches.

Keywords: *violence against women; rape; assault; battering; assessment; treatment*

Interpersonal violence against women is virtually endemic in our society. It is estimated, for example, that 14% to 20% of women will experience rape at some point in their lives (Kilpatrick & Resnick, 1993; Koss, 1993; Tjaden & Thoennes, 2000), 25% to 28% will be physically abused in a sexual-romantic relationship (Elliott & Briere, 2003; Strauss & Gelles, 1990), and 8% to 24% will be stalked by someone known or unknown to them (Sheridan, Blaauw, & Davies, 2003; Spitzberg, 2002; Tjaden & Thoennes, 2000). When added to the 25% to 35% likelihood that the average adult woman has been sexually abused as a child (Briere & Elliott, 2003; Finkelhor, Hotelling, Lewis, & Smith, 1990), the epidemiology of interpersonal violence against women is a pressing social issue.

Equally of concern is the association between these various forms of interpersonal victimization and mental health issues in women. As is shown in

this article, violence can have an extremely wide range of effects on its victims—effects that appear to vary as a function of the type of assault and a large number of victim-specific, trauma-related, and sociocultural variables. These variable and complex impacts are of such breadth that a given disorder or symptom cluster (e.g., post-traumatic stress disorder [PTSD], complex PTSD, or rape trauma syndrome) is relatively unlikely to capture the overall symptomatic experience of a given victim of violence.

Despite this complexity, most current empirically validated treatment approaches tend to focus on a relatively small number of impacts (primarily PTSD) associated with an equally small number of assault types (primarily sexual assault). Although in no way disparaging existing treatment models, which have been shown to be helpful for many victims, we suggest in this article that such complexity points to the need for interventions that (a) are customized to the various issues, problems, and sociocultural embeddedness experienced by a given victim, (b) address a larger proportion of the victim's symptomatic experience, and therefore (c) are multimodal in approach—involving, for example, not only cognitive-behavioral and relational methodologies but also interventions and advocacy in the victim's social environment. In support of the need for individualized, flexible intervention strategies, we review in this article the wide variety of psychological effects of violence against women, as moderated by an equally diverse range of victim, assault, and social variables, and then discuss the implications of this complexity for assessment and treatment.

MENTAL HEALTH CORRELATES OF VIOLENCE AGAINST WOMEN

The mental health correlates of violence against women are widely documented. In fact, most of the major nonorganic forms of mental distress and disorder have been associated with at least one form of interpersonal victimization in women. For example, sexual and/or physical assaults, within and outside of domestic relationships, have been associated repeatedly with increased anxiety (Gleason, 1993; Kemp, Green, Hovanitz, & Rawlings, 1995), depression (Campbell, Sullivan, & Davidson, 1995; Gleason, 1993; Orava, McLeod, & Sharpe, 1996; Plichta & Weisman, 1995), cognitive disturbance such as hopelessness and low self-esteem (e.g., Janoff-Bullman, 1992), posttraumatic stress (Astin, Lawrence, & Foy, 1993; Kilpatrick, Acierno, Resnick, Saunders, & Best, 1997; Kilpatrick & Resnick, 1993), dissociation (Briere, Woo, McRae, Foltz, & Sitzman, 1997), somatization (Ullman & Brecklin, 2003), sexual problems (Briere, Elliott, Harris, &

Cotman, 1995), substance abuse (Epstein, Saunders, Kilpatrick, & Resnick, 1998; Kilpatrick, Acierno, Saunders, Resnick, & Best, 2000; Martin, Kilgallen, Dee, Dawson, & Campbell, 1998), and suicidality (Golding, 1999; Thompson, Kaslow, & Kingree, 2002; Ullman & Brecklin, 2002). Similar findings have been reported for victims of stalking (Davis, Coker, & Sanderson, 2002; Pathé & Mullen, 1997; Mechanic, 2002), partner psychological maltreatment (Migeot & Lester, 1996; Vitanza, Vogel, & Marshall, 1995), sex trafficking (e.g., Farley, 2004; Pathé & Mullen, 1997), and in women who have experienced sexual torture (Arcel, 2002). In addition, although less the focus of this article, sexual and physical abuse of girls has been shown to be similarly injurious, producing a wide range of symptoms that can last well into adulthood (Berliner & Elliott, 2002).

The average victim of violence does not develop this full range of symptoms and disorders, of course. The frequency, severity, and type of postvictimization impacts are determined by a number of factors, including the direct effects of the victimization experience and its various characteristics, historical variables and other victim-specific factors that were in place prior to the victimization, and the social and cultural context in which the violence took place. These various contributions to postvictimization outcome are described below. Unfortunately, most of the studies available link these factors to the likelihood or severity of a given symptom or syndrome. Very few examine why one person might develop a PTSD in response to an assault, whereas another might become clinically depressed or begin to abuse alcohol.

Direct Victimization Effects

Most obviously, many acts of violence against women are intrinsically injurious, psychologically and physically, and often produce acute trauma symptoms. Typically subsumed under the *Diagnostic and Statistical Manual* (4th ed.) *DSM-IV-TR*; American Psychiatric Association [APA], 2000) categories of PTSD or acute stress disorder (ASD), these symptoms are often easily linked to specific victimization experiences by virtue of their temporal proximity to the assault. In addition, some posttraumatic symptoms (e.g., flashbacks, intrusive thoughts and memories) involve specific memories of the traumatic event and thus make their immediate etiology relatively clear.

Other responses, however, are less obviously trauma related. Relational dynamics associated with interpersonal victimization may result in repeated assaults in time, producing more chronic and less specific psychological symptoms. Because they often occur in the context of an existing relationship, for example, interpersonal victimization experiences may disrupt or

reinforce the victim's prior cognitive schemas regarding safety, relatedness, intimacy, the trustworthiness of others, as well as her previous assumptions regarding her ability to detect and avoid interpersonal danger (Dutton, Hohnecker, Halle, & Burghardt, 1994; Janoff-Bullman, 1992). These cognitive distortions, in turn, may lead to negative mood states and dysfunctional behaviors (Koss, Figueredo, & Prince, 2001).

A number of studies indicate that specific characteristics of a victimization event are associated with the severity of subsequent psychological outcomes. For example, life threat, injury, substantial use of force, and especially invasive acts are associated with a greater likelihood (and probably greater intensity) of PTSD (Davidson & Foa, 1993; Ozer, Best, Lipsey, & Weiss, 2003; Resnick, Kilpatrick, Dansky, Saunders, & Best, 1993). In addition, the frequency, severity, chronicity, and recency of interpersonal victimization has been associated in numerous studies with greater levels of psychological distress, including PTSD, anxiety, depression, and other psychological symptoms (Blaauw, Winkel, Arensman, Sheridan, & Freeve, 2002; Dutton, 1992; Holtzworth-Munroe, Smultzler, & Sandin, 1997; Housekamp & Foy, 1991; Mechanic, Uhlmansiek, Weaver, & Resick, 2000; Saunders, 1994). In many cases, victimization occurs not as a single event but rather as continued exposure to multiple forms of abuse over time (e.g., Jordan, Nietzel, Walker, & Logan, 2004; Kaysen, Resick, & Wise, 2003), with such multiple assaults being associated with more extreme psychological outcomes (Briere & Spinazzola, *in press*; Follette, Polusny, Bechtle, & Naugle, 1996; Nishith, Mechanic, & Resick, 2000). These data suggest that part of the complexity of postvictimization response arises from the equivalent complexity of many acts of interpersonal violence.

Victim-Specific Variables

In addition to aspects of the assault itself, various studies indicate that a number of variables specific to the victim also affect psychological outcome (Brewin, Andrews, & Valentine, 2000). In the general traumatic stress literature, victim variables associated with more severe or frequent symptomatic outcomes include female gender (Breslau, Davis, Andreski, & Peterson, 1991), age (Norris, Kaniasty, Conrad, Inman, & Murphy, 2002), race (Kulka et al., 1990), lower socioeconomic status (Rosenman, 2002), previous psychological dysfunction or disorder (Brady, Killeen, Brewerton, & Lucerini, 2000), less functional coping styles (Silver, Holman, McIntosh, Poulin, & Gil-Rivas, 2002), family dysfunction and history of psychopathology (Bassuk, Dawson, Perloff, & Weinreb, 2001), and genetic predisposition (Stein, Jang, Taylor, Vernon, & Livesley, 2002). Several of these variables are

especially relevant to the genesis of postvictimization responses and are outlined below. Others, such as gender, race, and socioeconomic status are probably best understood as socially mediated variables that increase the likelihood of being victimized (Kessler, Sonnega, Bromet, Hughes, & Nelson, 1995; Kulka et al., 1990) and thus are addressed separately in a later section.

Effects of a Prior Trauma History

An important aspect of the relationship between victimization and subsequent symptomatology is the tendency for trauma to be associated with prior trauma. For example, various studies indicate that women assaulted as adults are statistically more likely than women who are not assaulted to have histories of childhood sexual or physical abuse (Stermac, Reist, Addison, & Millar, 2002; Tjaden & Thoennes, 2000; Whitfield, Anda, Dube, & Felitti, 2003). As a result, a woman presenting with psychological symptoms following a rape or other assault may suffer not only from that event but also from earlier victimization experiences that have their own negative effects (e.g., Nishith et al., 2000). The impacts of these different incidents may be additive (i.e., the woman's current symptomatic state may reflect earlier—but still present—symptoms, plus those symptoms arising from the current assault), or may be interactive (i.e., effects of the earlier trauma may magnify the impacts of the latter trauma, or the latter trauma may trigger a resurgence of symptoms from the earlier assault) (Briere, 2004). Examples of interactive victimization effects might include child-abuse-related problems in affect regulation that lead to more extreme emotional response to later victimization experiences, and acute victimization experiences of fear, betrayal, or helplessness that trigger otherwise dormant or suppressed negative cognitive schema or posttraumatic stress related to an earlier trauma.

Reactivity

Studies suggest that those who interpret a traumatic experience as intensely negative are more at risk for posttraumatic distress and disorder than those who view the event as less traumatic (APA, 2000). Specifically, a woman's reaction at the time of her victimization is likely to be an important predictor of her later psychological state. For example, a tendency to react to traumas with greater fearfulness, horror, panic, and/or especially negative cognitions (e.g., high levels of helplessness, guilt, or shame), or to dissociate during or after the event is associated with greater subsequent psychological symptoms (Bernat, Ronfeldt, Calhoun, & Arias, 1998; Birmes et al., 2001; Brewin et al., 2000; Ozer et al., 2003).

An important question when judging the role of a victim's peritraumatic reaction in her subsequent symptomatic response is how, in fact, she came to develop these response tendencies. One obvious source of more severe peritraumatic response, whether cognitive, emotional, or dissociative, would seem to be the victim's prior exposure to trauma. Prior trauma exposure may exacerbate the individual's emotional response to her current trauma (Coker, Smith, Bethea, King, & McKeown, 2002; King, King, Foy, & Gudanowski, 1996), for example, when a former victim of sexual abuse has an especially fearful or overwhelming response to a current rape. For this reason, seemingly extreme reactions to a victimization event should not necessarily be considered a reflection of an inborn affect regulation problem or characterologic hyperresponsiveness, but instead as at least partially an interaction between prior trauma exposure and current victimization experiences (Briere et al., 1995).

Comorbid Mental Disturbance

Psychological symptoms that exist prior to the assault also may influence the relationship between victimization and symptomatology. Women with debilitating psychological symptoms and problems (e.g., psychosis, substance addiction, severe personality disorder, extreme passivity, or helplessness) are easier targets for predatory individuals in the general population (Gearon, Kaltman, Brown, & Bellack, 2003; Goodman, Salyers, et al., 2001). For example, in a recent review of studies on physical and sexual violence against women diagnosed with a serious mental illness, between 51% and 97% reported experiencing lifetime physical and sexual assault (Goodman, Rosenberg, Mueser, & Drake, 1997). The finding that psychotic disorders are more common among women who were victimized than women who were not victimized in such studies (see also Gearon, et al., 2003; Rosenberg, Mueser, Jankowski, & Hamblen, 2002) may not mean that assaults regularly produce full-blown psychosis, but, more typically, that women with chronic psychotic illness (e.g., schizophrenia) are easier prey for sexually or physically assaultive men (Goodman, Salyers, et al., 2001). Similarly, although drug and alcohol abuse most likely serve as a way of self-medicating posttraumatic dysphoria for some victims (Epstein et al., 1998; Kilpatrick, Acierno, Resnick, et al., 1997), it also can impair women's subsequent ability to successfully identify, counter, or escape victimization (especially sexual assault) by others (Acierno, Resnick, Kilpatrick, Saunders, & Best, 1999; Kilpatrick, Acierno, Resnick, et al., 1997; Testa & Livingston, 2000). This dual-pathway model of reactive substance abuse and subsequent vulnerability to revictimization may explain the substantial association

between substance abuse and trauma in the clinical literature (Logan, Walker, Cole, & Leukefeld, 2002; Walker, Logan, Jordan, & Campbell, 2004).

Beyond increasing vulnerability to assault, preexisting psychological disturbance also can reduce the victim's resilience to the effects of victimization, thereby producing greater symptomatologic response to a given adverse experience. For example, those with preexisting depression or anxiety are more likely to respond to interpersonal victimization with posttraumatic stress than individuals without those antecedent symptoms (Breslau, 2001; Koenen et al., 2002). As has been suggested for peritraumatic responses, however, at least part of this preassault symptomatology may be the result of prior trauma exposure. For example, preexisting anxiety may be associated with a prior victimization experience, and the symptom and the history may be independently associated with a more severe reaction to a current victimization experience. As a result, it is not always easy to determine if a specific symptom associated with a prior assault increases a victim's psychological susceptibility to a more recent assault, or whether such symptomatology is as much a marker for having been victimized in the past as it is a causal variable, *per se*.

Sociocultural Variables

The relationship between victimization and symptoms also may be influenced by social phenomena that not only are associated with negative psychological outcomes but also increase the likelihood that a woman will be assaulted or otherwise victimized. Examples of this phenomena include living in violent, degrading, exploitive, or invalidating environments, such as those associated with poverty (Bassuk, Melnick, & Browne, 1998), social inequality (De Zulueta, 1998), homelessness (Buhrich, Hodder, & Teesson, 2000; Goodman, Saxe, & Harvey, 1991), prostitution and other commercial sexual exploitation (Farley, 2004), and the diffuse but potentially potent impacts of sexism and racism (Berg, 2001; Briere, 1992; Loo et al., 2001; West, 2002). In addition, such social disempowerment has been associated with lower levels of social support before and after victimization (Allen, 1996; Bassuk, Weinreb, Buckner, Browne, Salomon, & Bassuk, 1996). Reduced social support, in turn, is commonly associated with more frequent and severe postvictimization outcomes (Davis, Brickman, & Baker, 1991; Follingstad, Wright, Lloyd, & Sebastian, 1991; Ozer et al., 2003; Ruch & Chandler, 1983; Ullman, 1995). The flip side of social support is also an issue here: Research indicates that negative responses from one's social network (e.g., criticism, blaming responses, or stigmatization) are especially power-

ful predictors of postvictimization outcome, especially for women (Andrews, Brewin, & Rose, 2003). In a culture where sexism remains a significant phenomenon, the tendency to blame or devalue women for their victimization may, in fact, contribute to their greater levels of postassault distress relative to men.

Models of Complex Impact

If no single disorder or symptom cluster is inevitably representative of interpersonal violence effects, another option would be to define more broad and complex syndromes that incorporate most of the outcomes listed above. In this regard, clinicians have suggested several postassault syndromes or disorders that include a wider range of symptoms. Three of the most prominent of these, rape trauma syndrome (RTS), battered woman syndrome (BWS), and complex PTSD, are described briefly here. Although BWS and RTS are less commonly used among clinicians of late, they are still invoked in some legal settings. Complex PTSD, however, is currently a popular descriptive label, although it is not codified in *DSM-IV-TR*.

Rape trauma syndrome. In the early 1970s, Burgess and Holstrom (1974) described a syndrome consisting of two phases: an acute stage immediately following a rape and a reorganizational phase that occurred in the months after the assault. Symptoms of this RTS were typically described as including anxiety and phobias, depression, anger, emotional and social withdrawal, sleep and eating disturbance, various signs of posttraumatic stress, self-blame, shame and guilt, somatization, and sexual dysfunction (Burgess & Holmstrom, 1979).

Battered woman syndrome. The psychological effects of intimate partner violence have been conceptualized as a battered woman syndrome (BWS; Walker, 1984, 1991). This syndrome was created, in part, to redirect focus from the intrapsychic personality features of women who are battered to the violence itself. BWS was thought to involve a wide range of symptoms, including anxiety and depression, posttraumatic stress, helplessness and passivity in the face of violence, and low self-esteem. Many of these symptoms were thought to arise from the repetitive, arbitrary nature of chronic domestic violence.

Complex PTSD. A less event-specific victimization syndrome has been suggested, described by Herman (1992) as complex PTSD. This syndrome is

also referred to as “disorder of extreme stress, not otherwise specified” (DESNOS; Pelcovitz et al., 1997; van der Kolk, 1999) when certain specific quasi-diagnostic criteria are met. Complex PTSD is thought to arise from severe, prolonged, and repeated interpersonal victimization, such as extended child abuse, chronic spouse abuse, and the multiple victimization experiences associated with forced prostitution or sex trafficking. Such traumatic processes (as opposed to single catastrophic events) have been linked to a wide variety of psychological symptoms, including cognitive, somatic, and dissociative disturbance, chronic difficulties in identity and boundary awareness, interpersonal problems, and affect dysregulation (van der Kolk, Roth, Pelcovitz, Mandel, & Spinazzola, in press).

The Validity of Postassault Syndromes. A central contribution of these three syndrome designations has been their emphasis on the potential complexity of postvictimization responses, suggesting that the effects of rape, for example, may involve a variety of symptoms beyond solely depression, anxiety, or PTSD. Unfortunately, these broader symptom models are problematic, as well. Most important, in the case of RTS and BWS, the proposed syndromes do not appear to be uniquely linked to the experiences of, respectively, victims of rape or spouse abuse. Instead, these symptom clusters overlap considerably, with the same general set of outcomes found for each victim group (e.g., Dutton et al., 1994; Koss & Kilpatrick, 2001; Mechanic et al., 2002), and vary dramatically as a function of different assault characteristics, victim-specific variables, and sociocultural factors. For example, the type and/or intensity of symptoms following sexual assault appear to vary as a function of sex (Elliott, Mok, & Briere, 2004), age (Acierno, Brady, et al., 2002), culture (Lefley, 1999), previous victimization history (Classen et al., 2002), relational status of the perpetrator (Culbertson & Dehle, 2001), severity of the assault (Ullman & Filipas, 2001), and extent of social support (Yoshihama & Horrocks, 2002) or rejection (Ullman & Filipas, 2001) after the rape. Such variability virtually ensures that most victims of rape will have different symptomatic outcomes, and that a specific, one-diagnosis-fits-all syndrome is highly unlikely. This may be even more the case for partner battering, where relationship factors may vary dramatically from dyad to dyad and may significantly influence postbattering outcomes.

As a result of these problems, there is very little reason to believe that the presence or absence of RTS or BWS is diagnostic of assault exposure. Symptoms that might be attributed to a rape, for example, also could be in response to an earlier assault (e.g., battering) or a history of child abuse, or may not even be victimization related at all. Similarly, denying the possibility that a

woman was raped based on the absence of RTS symptoms is not supportable because the level of symptomatology following an assault varies as a function of a wide variety of victimization, victim, and social variables, and some victims may experience numbing or dissociative states that reduce their symptom expression (Allen, 2001).

It may be argued that although RTS and BWS are problematic as indicators of postassault outcome, complex PTSD was specifically developed to describe a clinically observed symptom pattern and thus might better describe at least a general postvictimization syndrome. However, research on the Structured Interview for Disorders of Extreme Stress (Pelcovitz et al., 1997), the most accepted interview for assessing complex PTSD/DESNOS, suggests that the various symptoms listed within complex PTSD (or DESNOS) do not represent a disorder, *per se*, but rather indicate the range of symptoms potentially present in any one traumatized individual (Briere & Spinazzola, *in press*; Spinazzola, Blaustein, & van der Kolk, 2002).

Summary: Response Complexity

As suggested by this review, women's responses to interpersonal violence are highly variable, involving a number of different potential psychological symptoms and disorders. In fact, although sexual crimes may produce more sexual symptoms than physical assaults (e.g., Briere et al., 1995), and some forms of victimization are associated with higher rates of PTSD than others (Kilpatrick & Resnick, 1993), generally the same list of psychological outcomes can be found in the literature for each of the major forms of interpersonal violence. Yet, as noted earlier, any given victim is unlikely to develop all these symptoms or disorders, and studies indicate that women who are victimized vary considerably in the severity of their postvictimization reactions. This variability is due not only to differences in the various types and characteristics of interpersonal victimization but also to victim and social variables. These factors are likely to be interrelated: Child abuse, for example, may produce symptoms that ultimately complicate or intensify a woman's response to an adult trauma, previous traumas may alter the intensity of her peritraumatic response to later traumas, living in poverty or working as a prostitute may increase the likelihood of later assault, and current victimization experiences may activate or trigger psychological responses to similar traumas earlier in life. As a result, any given postvictimization response is likely to be complex and hard to predict and easily may involve phenomena and risk factors that go well beyond the traumatic event itself (Yehuda & McFarlane, 1995).

Implications for Assessment

There are two major assessment issues relevant to violence against women: trauma specification and impact. First, given the complex trauma histories reported by many clients, it is obviously important to consider a woman's prior history of adverse events when treating her for psychological distress or disorder. Unfortunately, research indicates that clinicians often do not screen for abuse or detect current or historic victimization in their clinical caseloads (Briere & Zaidi, 1989; Jordan & Walker, 1994; Saunders, Kilpatrick, & Resnick, 1989), although numerous studies show that women will respond—if asked—to victimization inquiries (e.g., Currier & Briere, 2000; O'Leary, Vivian, & Malone, 1992; Read & Fraser, 1998). Furthermore, even when a given form of victimization (e.g., a rape or partner battering) has been identified in a given client, it is common for clinicians to overlook the possibility of other forms of maltreatment (e.g., child abuse or stalking) that also may be relevant. For these reasons, and because it is often not easy for the clinician to recall all possible traumatic events during an assessment interview, structured trauma-exposure questionnaires are frequently indicated in generic and trauma-specialized clinical settings. The interested reader is referred to Wilson and Keane (2004) and Briere (2004) for detailed reviews of trauma-exposure interviews and measures.

In addition to determining an individual's victimization history, it is equally important to identify the exact symptoms and problems that are associated with that history. Unfortunately, because syndromal models (ranging from PTSD to DESNOS) are not especially informative regarding any given assault survivor's psychological state, clinicians must turn to individualized assessments to determine the specific targets of treatment. In many cases, this will mean administering psychological tests or conducting clinical interviews that cover the general areas of potential dysfunction and distress described in this article. Such tests or interviews should ideally include generic measures that review a range of symptoms commonly seen in mental health clients (e.g., the Minnesota Multiphasic Personality Inventory [MMPI-2; Butcher, Dahlstrom, Graham, Tellegen, & Kaemmer, 1989] or Symptom Checklist-90-R [Derogatis, 1983]), as well as more trauma-specific instruments that evaluate posttraumatic stress, dissociation, and other symptoms relevant to psychological trauma (e.g., the Trauma Symptom Inventory [TSI; Briere et al., 1995] or Posttraumatic Stress Diagnostic Scale [PDS; Foa, 1995]). By avoiding assumptions regarding what a given victim ought to have and instead using standardized instruments to determine what a survivor of assault is actually experiencing, treatment is likely to be

more specific and potentially more effective (Briere et al., 1995; Carlson, 1997).

Implications for Treatment

Because a single act of interpersonal violence can have a variety of adverse psychological effects, and may be associated with a history of additional victimization experiences in the past, individualized assessment and a competent clinical interview is likely to reveal a number of different problems or symptoms in a given person who has been victimized. As a result, intervention may need to address several different treatment targets that may be as disparate as PTSD, substance abuse, and somatization.

This deconstructive approach is not especially revolutionary; for example, psychiatrists have increasingly focused on treating the individual symptom clusters of PTSD separately with psychoactive medications, as opposed to attempting to resolve the entire disorder with a single pharmacologic agent (Friedman, 2000). Similarly, cognitive-behavioral clinicians (e.g., Cloitre, Koenen, Cohen, & Han, 2002; Linehan, 1993) have suggested that borderline personality disorder and other complex outcomes are best treated by addressing its component parts with separate interventions.

From this perspective, clinical intervention is likely to be most effective if it is to some extent multimodal. For example, treatment of a woman with a history of childhood sexual abuse who was recently battered by her ex-husband might include interventions that (a) provide a safety plan to address her risk of being assaulted again in the near future, (b) offer a therapeutic relationship that is a source of support and validation, (c) promote emotional processing of trauma memories, (d) address deleterious assumptions and beliefs about her intrinsic "badness" and deservingness of having been assaulted, (e) ameliorate other comorbid symptoms, such as depression or panic attacks, (f) reduce her need for substance abuse as a way to reduce her distress, (g) advocate for her with police and other social agencies regarding the assault, and (h) consider the possible utility of psychoactive medications.

Fortunately, this range of treatment goals may be addressable by a smaller number of actual clinical activities. Cognitive-behavioral therapy (CBT), for example, is well known for facilitating the emotional processing of traumatic memories as well as restructuring trauma-related cognitions, both of which, in turn, commonly reduce posttraumatic and depressive symptoms (Rothbaum, Meadows, Resick, & Foy, 2000). Similarly, psychodynamic therapy typically provides a sustained therapeutic relationship, within which the activation and processing of traumatic memories and schemas may occur

(Briere, 2002). In either case, however, additional concerns typically not the focus of these therapies should be taken into account, such as safety planning or the possibility of psychiatric medication.

Although there are little data bearing on this issue one way or the other, we also suspect that CBT or dynamic models that especially focus on cognitive issues may generalize from the effects of one trauma to another, whereas interventions more specifically focused on processing individual trauma memories may have less impact on painful memories associated with other traumas. For example, addressing a client's feelings of inadequacy, self-blame, and chronic expectation of interpersonal danger may directly or indirectly ameliorate the cognitive effects of a number of different victimization experiences, whereas therapeutic exposure to her memory of having been raped on occasion #1 may have only a small effect on the posttraumatic effects of rape #2. This is not meant to imply that therapeutic exposure activities are not indicated in most treatments for postvictimization effects because this is one of the most powerful components of modern trauma therapy (Rothbaum et al., 2000). However, it is possible that those with a history of multiple victimization experiences and a variety of different posttraumatic outcomes will especially gain from therapeutic interventions that address underlying schemas, cognitive distortions, and relational issues. Therapeutic exposure to victimization memories is also necessary for most such individuals; however, the clinician may have to adapt existing single-trauma exposure approaches to address the proliferation of traumatic memories associated with multiple victimization experiences. As well, given the number of potentially symptom-producing trauma experiences in some clients' histories, treatment in such instances may have to be extended significantly beyond the several months specified by some therapies.

Victimization-Specific Concerns

Although there appears to be little reason to assume that different types of victimization confer different assault syndromes, it is nevertheless true that interpersonal violence exposure varies on a number of social and psychological dimensions and, in some cases, may require different treatment approaches. For example, some assaults are of longer duration, involve more relational issues, and include more invasive acts than others. As noted earlier, such assault characteristics, in turn, may produce more severe or chronic psychological effects and, thus, potentially more or different treatment. For example, rape outside of a relationship may be a relatively time-constrained, albeit terrifying experience that varies in the number of perpetrators and the time involved, but often is not a chronic occurrence. In contrast, partner bat-

tering or partner rape may involve sexual and physical assaults that occur for years, often involve considerable significant psychological accommodation to ongoing maltreatment, and frequently include other forms of victimization (e.g., psychological and emotional abuse) as well. Victims of other acts (e.g., stalking, victimization via prostitution or sex trafficking) may experience acute and chronic threats: at one point being victimized by their assailant(s), and at many other times worrying that they might be assaulted or killed at some point in the future. In addition, these various crimes vary in terms of the amount of sexual victimization involved, a form of maltreatment that is especially associated with negative outcomes (Briere et al., 1995). Finally, some victimization experiences (e.g., partner battering, or childhood sexual abuse that extends into late adolescence or early adulthood) are assumed to have occurred in the past, when, in fact, they are still ongoing in the present—an issue that must be routinely assessed to ensure that no intervention inadvertently reduces the victim's self-protective resources and actually increases her risk of harm from victimization.

Because of these differences, the type of therapy provided to victims of interpersonal violence must be tailored to fit the survivor's unique victimization experience and its psychological effects. Thus, for example, treatment of a victim of stranger rape who has had few other victimization experiences in her life may require interventions such as CBT that are most effective for dealing with acute traumatic memories and their cognitive sequelae. On the other hand, a victim of ongoing partner battering may need greater attention to safety, psychological and logistic help with separating herself from her partner, assistance with shelter, and advocacy with the social service and law enforcement system and perhaps should not involve intensive treatment of her traumatic stress until after she is stable and no longer in immediate danger. In a third instance, a woman with a long history of incest as a child who has been repeatedly abused in a series of dysfunctional adult relationships, and who presents with serious emotional regulation and identity problems, may require relatively longer treatment in a therapeutic environment characterized by the gradual processing of early relational schemas and conditioned emotional responses in the context of a caring therapeutic relationship (Briere, 2002; Courtois, 1988), and/or cognitive-behavioral interventions specifically developed for survivors of sexual abuse (Chard, Weaver, & Resick, 1997).

Unfortunately, there are few studies to inform us about what sorts of victimization are best treated by what sorts of therapies. Although there are a large number of treatment outcome studies on the treatment of rape victims, primarily following models developed by Resick (e.g., Resick & Schnicke, 1993) and Foa (e.g., Foa & Rothbaum, 1998), there are far fewer available on

the treatment of women who are battered (Lundy & Grossman, 2001), and no empirical studies on the treatment of stalking or sexual exploitation effects. A review of psychosocial interventions with women who are battered, for example, found only nine articles that included outcome measures (Abel, 2000). The majority of those reported weak or no efficacy, perhaps partially as a result of small sample sizes, high drop-out rates, weak research designs, and inconsistent outcome measures. In addition, Abel's review included residential shelter stays, counseling, support groups, advocacy, and outreach following a woman's departure from a shelter; research focused on clinical intervention, per se, is limited to a single study of cognitive trauma therapy for women who are battered (CTT-BW; Kubany, Hill, & Owens, 2003). It is interesting to note this latter study revealed the positive impacts of a variety of different targeted interventions, ranging from psycho-education and stress management to interventions in negative self-talk, assertiveness training, and revictimization avoidance.

Safety Planning and Social Network Issues

Individuals who have been recently assaulted, battered, or stalked often require more than emotional processing and cognitive interventions; attention also must be paid to their continuing physical safety. Safety planning usually involves engaging the victim in ways to reduce physical and psychological danger. Physical safety planning typically involves developing detailed, prearranged plans for ensuring a woman's safety and that of her children when domestic violence is imminent or is in progress (Hart & Stuehling, 1992). Psychological safety planning, on the other hand, includes assessments for suicidality, homicidality, substance use, and involvement in high-risk behaviors (Jordan et al., 2004). Studies suggest that the client-therapist problem-solving activities that involve safety planning are helpful for victims of partner violence (e.g., Arias & Pape, 1999), not only because they increase her safety but also because the process itself—by reducing feelings of helplessness and being implicitly empowering—can lessen depression and related victimization effects. Similarly, victimized women who are involved in high-risk activities such as intravenous drug abuse or unprotected sexual behavior may gain from interventions that stress a problem-solving approach and that are focused on improved self-care and safety (Koenig, O'Leary, Doll, & Pequenat, 2003).

More important, however, safety planning is likely to be most effective when the woman has access to social support and social services (Kocot & Goodman, 2003). In fact, developing a safety plan when a victim does not understand the resources available to her, and when she perceives herself as

having few social supports may actually exacerbate her feelings of being overwhelmed, and thereby worsen her mental health status (Jordan et al., 2004). In many treatment programs for women who are battered, this component is addressed through the use of advocates: individuals whose work is primarily to increase the victim's access to social services and to facilitate her progress through the criminal justice system, if indicated. The small literature on advocacy reinforces the view that ongoing support and assistance with the social system is beneficial. In a randomized experimental design, for example, Sullivan and Bybee (1999) found that women who are battered who worked with advocates reported being more effective in accessing resources, having a higher quality of life and sense of social support, and experiencing lower partner revictimization rates than did the women who were not provided advocates.

CONCLUSION

As indicated by this review, the effects of interpersonal violence vary substantially from person to person and cannot be defined by preformulated assault syndromes or lists of expected symptoms. Instead, postvictimization outcomes are the complex result of a wide variety of trauma-specific, historic, victim, and sociocultural factors, ensuring that the clinical presentation of any given individual cannot be summarized merely by the fact of her assault, an assault syndrome, or even by her *DSM-IV-TR* diagnosis. This is not to say that some effects are not relatively common among women who are victimized, such as depression, anxiety, or posttraumatic stress. Even these sequelae, however, are not inevitable, nor are they specific to a given type of assault.

The implications of this variability rest primarily in the need for clinicians to intervene with each woman based on her own specific clinical and social situation, as opposed to making assumptions that certain symptoms or problems are present and, therefore, that an assault-specific treatment is indicated. In this regard, there is probably no specific treatment for rape trauma or battering, per se. In addition, the clinician should be ready to consider the full range of potential victimization effects experienced by a given client, as opposed to merely those symptoms for which he or she is prepared or that are thought to be characteristic of a given type of assault. For example, if the therapist is a specialist in the use of CBT to treat PTSD, this does not mean that he or she should overlook the substance abuse, depression, or relational symptoms of a given client who is traumatized. This complexity is magnified in the case of multiple victimization experiences; a woman with a history of numer-

ous childhood and adult maltreatment experiences may (or may not) be prey to difficulties ranging from identity and affect regulation problems, substance abuse, risky sexual behaviors, and dissociation, to anxiety, depression, PTSD, suicidality, and somatoform disorder. In response, relevant interventions may range from treatment for victimization-related symptoms (e.g., exposure therapy, cognitive therapy, dialectical behavior therapy, psychodynamic therapy, group therapy, and/or pharmacotherapy), assistance with maladaptive behaviors (e.g., chemical dependence treatment, safer-sex education, or parenting training), and advocacy with social service institutions for basic life requirements (e.g., referral to a battered women's shelter, assistance with finding financial aid, guidance through the criminal justice system, or even facilitating access to job training).

In this general context, certain therapeutic approaches have proved their worth. CBT tends to be focused on objective problems and symptoms (rather than theoretical clinical constructs) and employs a variety of techniques that directly address the presenting problems of many victims. Psychodynamic therapy is especially useful for its focus on support, empathic attunement, and the relational processing provided by a working therapeutic relationship. In addition, advocacy has been shown to be especially helpful when interpersonal violence (and the cultural neglect that increases the likelihood of victimization) results in social deprivation and disconnection from needed social resources. Because every victim of violence differs in her relative need for such interventions, the clinician must be prepared to provide a range of services and to refer the client to other helpers when indicated.

Research on effective clinical assistance for the effects of violence on women has only begun. Thus far, we know that certain therapies are relatively effective for the posttraumatic stress, cognitive disturbance, and negative mood states experienced by some victims, especially those who have experienced sexual assault. We know less about the successful treatment of these problems in those with highly complex trauma histories and comorbid problems such as substance abuse, dysfunctional personality traits, especially debilitating symptoms (e.g., psychosis), and unstable social situations. Furthermore, treatment outcome studies are far less common regarding the effects of partner battering, stalking, and forced involvement in the sex trade. Fortunately, several innovative treatments are being developed to address at least some of these problems, most of which stress multimodal, multigoal approaches (e.g., Cloitre et al., 2002; Kubany et al., 2003; Najavits, 2002). Although prevention efforts are, ultimately, the only true answer to violence against women, these new approaches—along with further development of established trauma treatments—signal optimism for our growing capacity to help those who suffer from gender-based victimization.

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