CASE CONCEPTUALIZATION AND TREATMENT PLANNING

Integrating Theory With Clinical Practice

Pearl S. Berman

Case Conceptualization and Treatment Planning

Fourth Edition

Case Conceptualization and Treatment Planning

Integrating Theory With Clinical Practice

Fourth Edition

Pearl S. Berman

Indiana University of Pennsylvania, USA

SAGE

Los Angeles | London | New Delhi
Singapore | Washington DC | Melbourne

FOR INFORMATION:

SAGE Publications, Inc.
2455 Teller Road
Thousand Oaks, California 91320
E-mail: order@sagepub.com

SAGE Publications Ltd.
1 Oliver's Yard
55 City Road
London EC1Y 1SP
United Kingdom

SAGE Publications India Pvt. Ltd.
B 1/I 1 Mohan Cooperative Industrial Area
Mathura Road, New Delhi 110 044
India

SAGE Publications Asia-Pacific Pte. Ltd.
3 Church Street
#10-04 Samsung Hub
Singapore 049483

Printed in the United States of America

Library of Congress Cataloging-in-Publication Data

Names: Berman, Pearl, author.

Title: Case conceptualization and treatment planning : integrating theory with clinical practice / Pearl S. Berman, Indiana University of Pennsylvania, USA.

Description: 4th edition. | Los Angeles : SAGE, [2019] | Includes bibliographical references and index.

Identifiers: LCCN 2018008338 | ISBN 9781506331386 (pbk. : alk. paper)

Subjects: LCSH: Psychiatry—Case formulation. | Psychiatry—Differential therapeutics.

Classification: LCC RC473.C37 B47 2019 | DDC 616.89—dc23
LC record available at https://lccn.loc.gov/2018008338

This book is printed on acid-free paper.

Acquisitions Editor: Abbie Rickard
Editorial Assistant: Elizabeth Cruz
Production Editor: Kimaya Khashnobish
Copy Editor: Michelle Ponce
Typesetter: C&M Digitals (P) Ltd.
Proofreader: Ellen Howard
Indexer: Judy Hunt
Cover Designer: Anupama Krishnan
Marketing Manager: Susannah Goldes

18 19 20 21 22 10 9 8 7 6 5 4 3 2 1

CONTENTS

PREFACE

This book is designed to help clinicians develop effective case conceptualization and treatment-planning skills. *Clinicians* is a general term used to refer to individuals who have obtained, or are in the process of obtaining, professional training in psychology, counseling, education, or social work at universities, medical centers, or training institutes.

The goals of case conceptualization are to provide a clear, theoretical explanation for *what the client is like* as well as theoretical hypotheses for *why the client is like this*. Based on this conceptualization, the clinician develops a treatment plan that will help the client change. The treatment plan also provides a mechanism for assessing client progress in the change process. When progress is not being made, the conceptualization is a resource for assessing barriers to progress. Case conceptualization and treatment-planning skills have always been important in providing quality care to clients. These skills are even more vital in today's managed care market, as they can be used to document the need a client has for treatment and to support interventions for brief, intermediate, or long-term services.

You will need to deepen your understanding of current research in the field of clinical practice and learn how to integrate these domains of knowledge into your clinical work with clients. As you increase your ability to do this, your effectiveness at achieving positive outcomes with your clients will increase. This text will introduce you to seven knowledge bases that have relevance to your clinical work and give you practice integrating them into your case conceptualizations and treatment plans, including psychological theory; trauma-informed care; human complexity; intersectionality of oppressions; self-reflection on personal values, strengths, and weaknesses; evidence-based treatment strategies; and, effective writing to increase the clarity of your thinking and to increase client motivation to engage in the treatment process.

The intent of practicing case conceptualization and treatment-planning skills using diverse knowledge bases is to encourage you to think about clients in an in-depth and flexible manner. Research on evidence-based practices and procedures indicate that we need to adjust how we provide our clinical work to the specific needs, wishes, and demographics of our clients. This is not a *know it all* book. There are many important issues that might be more relevant to one or more of your clients than those introduced within this text. If you seek to become an excellent clinician, it will take many years. You will need to seek out other knowledge bases and provide yourself with many more scholarly readings and extensive study. This is a *know how to* book. This book teaches a process that can be used in integrating any theory, any domain of complexity, and any new knowledge base that is developed over your clinical career into your clinical work. It is implicit to this approach that clinicians need to keep up-to-date on new developments within the treatment literature and integrate this new knowledge into their work, to maintain ethical and effective treatment. This text will also help you sharpen your professional writing skills.

OVERVIEW OF TEXT

SECTION ONE

Chapter 1 will provide a discussion of the case conceptualization and treatment-planning process used within the text. In addition, it includes a discussion of different writing styles and how adapting the way you think and write about clients can increase their motivation. Four styles of writing case conceptualizations and treatment plans are modeled within the text to help clinicians develop the ability to write using different styles. These styles are labeled assumption-based, historically based, symptom-based, and interpersonally based. In addition, three formats for presenting treatment goals are modeled. These formats have been labeled the basic format, the problem format, and the SOAP format.

The text instructions for case conceptualizations and treatment plans use a variety of key words to explain important concepts. The intent is for you to use the key word that is most congruent with the way you think about and understand information. This variety of key words is maintained in the exercise instructions contained throughout the text. You can locate specific client examples or exercises quickly by theoretical perspective using the table of contents. Each of the Chapters 10 through 19 provides two full examples of case conceptualizations and treatment plans. The first case conceptualization and treatment plan will always follow the assumption-based style. The second case conceptualization and treatment plan will follow different styles depending on the chapter. To locate case conceptualization and treatment plan examples quickly by domain, conceptualization style, or treatment goal style, see Table 1.1 in the middle of the chapter.

Chapter 2 will provide an overview of the impact of violence across the life span, factors that promote resilience, and trauma-informed care. For each of the clinical cases presented at the end of Chapters 10 through 19, you will be asked to consider assessment data that includes a screen for violence and trauma and decide in what way, and in how much depth, it should influence your treatment plan for the client. The National Partnership to End Interpersonal Violence (NPEIV) and The Substance Abuse and Mental Health Services Administration (SAMSHA) have underscored the critical need for all clinicians to understand and be responsive to the impact of trauma. In trauma-informed care, you are assessing clients to determine if in fact they have been impacted by trauma; you develop a mutually respectful relationship with your clients that emphasizes their human right to emotional, physical, and sexual safety in all environments and with all people; and ensure that all services are provided within a welcoming, respectful environment, and safe environment (Bassuk, Unick, Paquette, & Richard, 2017; National Plan to End Interpersonal Violence, 2017; SAMSHA, 2014).

Chapter 3 will provide you with an introduction to the research literature on human complexity as well as intersectionality of oppressions. Throughout the clinical Chapters 10-19, you will read an example of how to integrate one of these domains of complexity into the first clinical case provided in the chapter, and you will then be given the opportunity to practice integrating a domain of complexity into a conceptualization and treatment plan using the second case in the text. If you would like to see where different domains of human complexity are located within the different chapters of this text, see Table 3.1 at the end of the chapter.

Chapters 4 through 8 will introduce you to the domains of development, gender, race and ethnicity, sexual orientation, and socioeconomic status. Each chapter will provide Red Flag Guidelines for integrating the domain into your case conceptualizations and treatment plans. Each chapter provides a table where you

can see where the domain of complexity is highlighted throughout the text. Each chapter ends with Red Flag Guidelines and recommended resources including books, websites, and videos.

SECTION TWO

Chapter 9 will provide an introduction to the client, Bandita, and what she comes into treatment requesting help with. The chapter discusses how the different theoretical domains covered in Chapters 10 through 19 might conceptualize her needs. You are introduced to how trauma-informed care might apply to her case. Finally, you are introduced to three strategies for improving your treatment effectiveness with her based on the research on evidence-based treatments, evidenced-based programs and practices, common factors in effective treatment, and the deliberate practice of master clinicians.

Chapters 10 through 19 follow a parallel format and introduce behavioral treatment, cognitive treatment, cognitive-behavioral treatment, feminist treatment, emotion-focused treatment, dynamic treatment, family systems treatment, cultural treatment, constructivist treatment, and transtheoretical treatment. Each chapter starts with an introduction to a client through the lens of a specific theoretical perspective. This is followed by overviews of how research on treatment effectiveness might influence treatment with this client. This is followed by an in-depth interview with the client with a clinician who is grounded in the theoretical perspective of the chapter. The author then provides two case conceptualizations and treatment plans as examples of how to integrate psychological theory as well as a domain of human complexity into clinical work with the client; these are modeled using different writing styles. A second client is then introduced in the chapter, and you are given another in-depth interview to read. After the interview, you are provided with 10 exercises to help you develop an in-depth understanding of this second client and develop a comprehensive case conceptualization and treatment plan for this client. Each chapter ends with a list of recommended resources in terms of books, websites, and videos.

The client interviews used within Chapters 10 through 19 have been simulated by the author of this text. Any similarities between the simulated clients and real individuals are coincidental. These interviews all take place after an earlier, brief appointment in which the limits of confidentiality, fees, and basic treatment induction information is provided. In addition, some brief assessment instruments are completed by the client. The clients in each interview, unlike many of those in real life, will always provide the clinician with enough information to formulate a conceptualization based on the first interview. Why the interview format? It is through interviews that clinicians gather information about clients in real-world settings. Although the text author shifts her perspective in different theoretical chapters, her own personal style and self-identifications including her stage of development, gender, race/ethnicity, sexual orientation, and socioeconomic status might still come across at times in the interviews in the text. Do your best to put yourself into the role of the clinician even though your own style and self-identifications may differ significantly from hers.

Chapter 20 discusses treatment planning over time and important issues in clinical decision making. The case of Kayla, introduced to you in the transtheoretical treatment chapter is revisited to provide an example of how your treatment plans might need to change based on your deepening understanding of a client's needs. The chapter ends with Red Flag Guidelines to use in developing case conceptualizations and treatment plans based on the assumptions of any theoretical perspective.

ACKNOWLEDGMENTS

I would like to express my deep appreciation to my aunt, Cleo Marantis, for being such an outstanding role model for outrageous womanhood. I would also like to thank my daughters, Irene and Rachel, for telling me that I was living up to her example.

SAGE would like to thank the following reviewers for their input that shaped the new edition of this text:

Jae A. Puckett, The University of South Dakota

Jennifer Waugh, Kent State University

Michelle L. Bruno, Indiana University of Pennsylvania

ABOUT THE AUTHOR

Dr. Pearl Berman is a full professor and the Chair of the Psychology Department at Indiana University of Pennsylvania. She is also a licensed, clinical psychologist. Her long-standing interest in violence prevention has led her to integrate information and skill building relevant to interpersonal violence into all of her teaching at both the undergraduate and doctoral level.

She is an active member of the National Partnership to End Interpersonal Violence and is the senior co-chair of the Training and Mentoring Action Team. She is also a member of The National Committee to Prevent Elder Abuse, The Academy on Violence and Abuse, and The American Psychological Association. She has been collaborating with the National Child Protection Training Center to expand their Child Advocacy Studies Program to be a Child and Adult Advocacy Studies Program. She is the incoming Pennsylvania administrator for ChildFirst PA, a forensic training program for first responders in cases of interpersonal violence. Dr. Berman has published doctoral-level textbooks for individuals in training to be psychologists, counselors, social workers, and therapists and has provided her research and clinical workshops nationally and internationally.

SECTION

1

1 DEVELOPING CASE CONCEPTUALIZATIONS AND TREATMENT PLANS

This book was designed to help you develop effective case conceptualization and treatment-planning skills. In this chapter, a structure for developing these skills is introduced that includes four steps: (1) selecting the theoretical perspective that is most appropriate to the client; (2) using a premise, supporting material, and a conclusion as key features of a case conceptualization; (3) using a treatment plan overview, long-term goals, and short-term goals as key features in developing a treatment plan; and (4) developing a flexible writing style that is comfortable for you and may be motivating to your client.

The text provides exercises for helping you through these steps while paying close attention to the extratherapeutic factors that the client brings into treatment including difficulties, strengths, and resources. The exercises also stress writing treatment goals in a manner that helps the client see them as relevant and credible, creates a sense of hope and expectancy, and builds trust between you and the client. These factors have been found to be critical in developing a positive therapeutic alliance and in achieving a positive treatment outcome (Duncan, 2014).

Developing conceptualizations is time-consuming, so why not just go directly to the treatment plan and just think through the case as you go along? When there is no careful conceptualization completed first, treatment chaos may result as it is not always easy to know at first what the most important goals will be to work on with your client versus those that are actually lower priority. The case of Veona and her son will be used to illustrate these points. Veona, a White female in her mid-30s, comes in to consult with you because her teenage son has just been arrested, and she doesn't know what to do. She expresses a lot of fears for his safety in jail. She is overwhelmed with emotion and can barely give you any coherent information about her son. You decide that crisis management is called for. You provide her with emotional support to help her regain control of her emotions. You help her think through how to get an attorney so she can gain her son legal representation. You plan to do a careful intake at the next session. Week 2 arrives and, before you can try to do this, she presents with a new crisis; her relationship with her significant other seems to be breaking up, and she's desperate for help in saving it. You try to initiate a conversation about her son, but she quickly diverts back to this relationship crisis. You go into crisis management mode and give her emotional support to calm her down and try to initiate a constructive conversation about her relationship issues. You're determined to conduct your intake in the next session. However, the client comes in drunk. You make several attempts to find out what happened with her teenage son and her significant other but quickly give up and send her home. Your plan is to be very firm when she comes in for her fourth session; thus, before she has a chance to tell you anything, you indicate the need to conduct a thorough intake. Veona interrupts you and indicates she is about to become homeless if she can't find the money to pay her rent by tomorrow. She used her rent money to pay the attorney you recommended she get to represent her son. Frustrated, you go into crisis intervention mode and try to connect the client with community resources so that she won't end up on the street.

Treatment is in a state of chaos. You don't know whether Veona's son is out of jail or not. You don't know if Veona is still with her significant other. Finally, you don't know if she has a long-standing problem with alcohol

or if her drunkenness was just a reaction to extreme stress. You may also be exhausted from all these crises and wish she was someone else's client. Rewind and assume that while acknowledging the seriousness of her son's difficulties, when she brings them up, you still carry out an intake during the first session. Based on this intake, you come up with a behavioral conceptualization to capture what you consider to be her basic needs. The following is the premise or theory-driven introduction to this conceptualization:

> Veona is a 35-year-old Caucasian woman who was raised by parents who modeled aggressive expressions of anger and aggressive or neglectful problem solving. Either Veona's parents ignored how she was behaving or what was happening to her, or they overreacted to her mistakes and developmental struggles and used abusive punishment. Veona survived this history by developing a people-pleasing style where she carefully observed the people around her and tried to meet their needs so that they would accept her and not hurt her. Her passive approach to her own needs led to an early pregnancy outside of marriage. As she raised her son alone, she sought to be a "better parent" than she had had herself. She strove to attend to all of her son's needs and deny him nothing. As she had no role models for effective parenting, her wish to be a loving parent led her to overindulge the desires of her son. Her desire to avoid abusive parenting practices has led her to avoid setting limits on her son's behavior. Veona's strengths lie in her sincere desire to be a good parent, her ability to observe and predict the moods of others, and her average level of intelligence that allows her to understand the consequences of her son's present behavior. At this time, Veona is very aware that she and her son are having serious difficulties, but she is not aware of how her permissive and people-pleasing style is related to these difficulties.

After completing the full conceptualization process, you decide that Veona would profit from a treatment plan that will teach her communication and problem-solving skills. Your long-term goals are as follows:

LONG-TERM GOAL 1: Veona will learn how to recognize and express her feelings assertively.

LONG-TERM GOAL 2: Veona will learn to express concerns in a relationship without blaming others.

LONG-TERM GOAL 3: Veona will learn how to negotiate solutions that respect her own needs and those of others.

LONG-TERM GOAL 4: Veona will learn how to recognize her goals for a relationship.

LONG-TERM GOAL 5: Veona will learn how to break down goals into small steps that can be accomplished.

When Veona comes in for Session 2, if she wants to talk about her son's legal problems, you will (a) work on Veona communicating clearly to the police and her teen and (b) help Veona set goals around the arrest situation. If she wants to discuss imminent relationship failure, you will (a) work on Veona communicating clearly to her significant other and (b) help Veona set goals around the relationship. In both situations, you are not ignoring the crisis Veona wants to discuss. However, you are helping her build the skills she needs no matter what "issue" she wants to talk about. As she progresses through the treatment plan, her new skills may help her avert a life full of emergencies. Thus, while the process of developing a case conceptualization and treatment plan is time-consuming at first, over time it will increase the likelihood you will provide effective and time-efficient treatment. The four-step case conceptualization and treatment-planning process will now be discussed in detail using the case of Pat.

SELECTING A THEORETICAL PERSPECTIVE

Reason for Referral

Pat is a 25-year-old European-American male who was released four and a half months ago from prison after serving three years of a five-year prison sentence for assault. He was sentenced to jail after beating a man unconscious in a drunken bar brawl following a football game; he denies any memory of the reason for the fight, but Pat is sure the other man started it. This was Pat's only stint in prison, but he had been arrested on a regular basis before this for getting into fights at bars. For these prior incidents, he had first received fines, then probation, and finally, time in prison. His current probation officer insisted he attend treatment to decrease his aggressive behavior and alcohol abuse in an attempt to break his cycle of getting into trouble at bars.

Case History

Pat indicated being raised by two people who could never stop either drinking or fighting. He denied having any memories of home that didn't involve his parents being violent or passed out somewhere in the house. Pat has been responsible for himself for as long as he can remember. Neither of his parents seemed to believe they were responsible for making sure he had meals. He learned early on how to grab food and then run off to a corner of the house to eat. Otherwise, one or the other of his parents was bound to find him, give him a few swift kicks, and then grab his food. No one in his neighborhood or at school seemed to notice that Pat was always covered in bruises and was mostly skin and bones. However, there were people in the neighborhood who would pay him for walking their pets or cleaning out their garages. Pat quickly learned the value of work as the money he earned helped him buy food to eat.

Pat indicated being an average student in high school. At school, he intentionally kept a low profile, doing the minimum necessary to stay out of trouble. He said he had no friends until high school when he was old enough to begin working after school at a gas station. After long hours at night pumping gas, he and the other attendants would go drinking in the woods after the station closed down. Once they started drinking, they kept drinking till all the alcohol was gone. While binging on weekends, he never drank on a school day. Pat achieved an associate's degree in computer repair after graduating from high school. He then spent a year working as a computer technician in a small company. He was holding this job until he was sent to prison.

Pat was proud of holding down his computer technician job for so long; he enjoyed figuring out why computers would stop working properly. He wanted to return to computer repair if he could ever "get a break." He said that after release from prison, no one wanted a computer technician with a history of violent behavior. Determined to work, Pat finally gained employment as the custodian of a large department store. Pat said he treats his boss very respectfully both because he had to work very hard to find any job and because this man was the only one who would give him a try despite his criminal record. Although he was a self-described loner, Pat has been carefully observing his boss and the other store employees trying to understand what makes them "tick"—this has been a game he has played with himself since high school. There have been no aggressive episodes within the work environment to date nor did he ever have a history of fighting at work. Pat was determined not to lose this job until he could move back into computer repair. The probation officer has met with Pat weekly and has made it very clear that he planned to monitor Pat's progress in treatment.

Pat has never been married and presently has no children. He has been involved for two months in an intimate relationship with Alice, a 19-year-old European-American female. Pat has had a number of intimate relationships, which have never lasted beyond six months. He has met these women in his neighborhood and, after a brief dating period, has invited them to move in if he enjoyed having sex with them. He has always found these relationships satisfying, but the women always disappeared one day when he was at work. He reported they seem to move out of the neighborhood because he never sees them again. Pat denied understanding why

women run out on him. Pat did admit that he has been in quite a few fights with men when they get "in his face." During his time in jail, Pat realized that he was tired of having problems with the police and tired of changing women; he wanted Alice to "stay put."

There are many theoretical approaches or systems of treatment currently available for understanding Pat that research supports as being effective (Editors of Consumer Reports, 2004; Lambert, Garfield, & Bergin, 2004). So, how will you choose an approach to use with Pat? Some clinicians have made this choice based on their personal preferences. When a client wasn't appropriate for this approach, they would refer the individual to another clinician; this would be a completely ethical choice. However, the outcome literature suggests that clinicians would maximize treatment effectiveness for Pat if his characteristics and presenting concerns were used to guide the choice rather than the preferences of the clinician (Baldwin & Imel, 2013; Duncan, 2014). This type of approach that "fits" the theoretical orientation to the client has been referred to as *integrationism* or systematic eclecticism (Lambert, 2013; Lambert et al., 2004).

While it would be legitimate to conceptualize Pat's concerns from many different theoretical perspectives, the theory chosen will have important repercussions for treatment, including how hard it might be for Pat to understand/perceive his problems from that perspective, how unconscious or deep in the unconscious the precipitants of his problems would be, and how long treatment might take to resolve these problems (Prochaska & Norcross, 2009). For example, a behavioral approach to Pat's case would analyze his symptoms and immediate life circumstances. The focus of a treatment session might be on the immediate antecedents and consequences of a recent violent episode. The precipitants of a particular episode of violence, and the immediate consequences of it, would be in his immediate past and therefore relatively easy for Pat to recall and contemplate. In contrast, a dynamic approach to Pat's case would focus on unconscious psychological conflicts as the root cause of his violence. Pat would need to become aware of events in his distant past that resulted in his experiencing, for example, unmet needs for security and nurturance. To avoid the anxiety generated by these unmet needs, Pat might have had to develop an aggressive lifestyle, whereby through acts of violence he provided himself with a facade of security and safety. As an adult, he might have perfected a violent interpersonal style that provided him with "protection" from a hostile world. Only under the influence of alcohol might Pat's anxiety be low enough for him to try to relate to women and address his need for nurturance. From this dynamic perspective, Pat would first need to develop significant insight into his unconscious conflicts before he could address his current issues with violence. Thus, Prochaska and Norcross (2009) would assume that Pat would need more treatment sessions to change constructively using dynamic treatment than he would using behavioral treatment.

Developing Your Theoretical Understanding of Pat

The first step in developing a case conceptualization of Pat would be to choose the theoretical viewpoint that would guide an understanding of him at the time that he entered treatment. This theoretical viewpoint would determine the types of questions you asked him and thus the type of information that was included in your case conceptualization and treatment plan. Your case conceptualization of Pat would provide a theoretical perspective for understanding who he was and why he behaved as he did. In general, conceptualizations have contained case history information that was theoretically based and included a formulation of the client's difficulties as well as strengths. Professionals prepare many other types of reports on clients that might include this type of information, such as case histories, intakes, and assessment reports. There has been no consensus across clinical settings for what constituted each type of report. In general, case histories have provided the greatest detail about the client's past history, intakes have focused more on the client's present functioning, assessment reports focused on the interpretation of psychological testing, and case conceptualizations stressed a theoretical understanding of the client to use in guiding treatment decisions. Comprehensive client files would include several types of reports,

and what a clinician included in the case record would be a combination of legal or funding requirements as well as what was most useful clinically (American Psychiatric Association, 2002, Section 2; American Psychological Association [APA], 2007b, Guideline 2).

A treatment plan for Pat would be a theory-driven action plan for helping him change constructively. It might focus on the goals to be attained, such as "Pat will learn new methods of anger control," or on what needed to change, such as "Pat will stop assaulting others when angry." Research links positive outcomes with treatment plans that have been designed around a client's unique characteristics and that take advantage of the client's personal strengths and resources (Bohart & Tallman, 2010; Hubble, Duncan, & Miller, 2010). Treatment progress, within the first few sessions, has also been related to positive outcomes for 80% of clients (Haas, Hill, Lambert, & Morrell, 2002; Lambert, 2010; Shimokawa, Lambert, & Smart, 2010). Thus, a treatment plan that aided the clinician in conducting effective and time-efficient treatment sessions might improve client outcomes.

There have been no standard criteria for evaluating treatment plans beyond their need to meet legal and ethical mandates and be in a format acceptable to licensing agencies and insurance companies (American Psychiatric Association, 2002; APA, 2007b). However, the research literature has found that treatment goals stated in small and specific terms that Pat could understand and see as valuable to attain were most likely to influence him (Hubble, Duncan, & Miller, 1999). In addition, goals written so that they matched Pat's expectations, wishes, and values might be more motivating (Egan, 2013). Thus, this text recommends an overall strategy for writing these types of goals that also, whenever possible, take advantage of Pat's strengths and resources. The effectiveness of treatment could be documented through the step-by-step attainment of these specific goals. In addition, seeing progress documented in this way could help maintain Pat's hope that he can change; this has been found to be an important common factor in effective treatment (Hubble et al., 2010).

KEY FEATURES IN DEVELOPING A CASE CONCEPTUALIZATION

In writing conceptualizations, two key organizational features are recommended in this text. The first feature is the premise. The premise is a succinct analysis of the client's core strengths and weaknesses, tied to the assumptions of a selected theoretical perspective. It can be organized in many ways but should always set up an organizational structure for the entire conceptualization and be theoretically sound. If *premise* is not a meaningful term to you, think of this feature as serving to provide an overview of the client, or as *preliminary* or *explanatory* statements, or as a summary of the key features of the client, or as a *proposition* on which arguments are based, or as *hypotheses,* or as a *thesis statement,* or as a *theory-driven introduction*. This series of alternative key words is provided so that you can select the words that have the clearest meaning for you.

A premise gives the reader a concise understanding of the main issues to be covered in the conceptualization, and the topic sentence of the premise serves this same function for this introductory paragraph through setting up what is going to be discussed. The premise topic sentence can include an overview of the client demographics and reason for referral—for example, "Pat is a 25-year-old, European-American male who is referred for treatment of his violent behavior by his probation officer." However, there are many other possibilities. For example, "Pat enters treatment with two major goals: to keep Alice in his life and to keep himself out of jail" or "Pat doesn't agree that he has problems with aggressive behavior, but he does agree that his current life consists of a controlling probation officer, an unstable relationship with Alice, and a boring job." After the topic sentence, the premise will go on to consider both Pat's strengths and his weaknesses, as understood through the lens of the theory that is selected to guide treatment, and it will end with a sentence that draws a general conclusion about Pat's prognosis or ties the paragraph together in some way before transitioning to the next one.

The second organizational feature, which follows the premise, is the theoretically based *supporting material.* It can also be understood as a *detailed case analysis* that provides evidence to back up the statements made in the premise. This supportive material includes an in-depth analysis of the client's strengths (strong points, positive features, successes, coping strategies, skills, factors facilitating change) and weaknesses (concerns, issues, problems, symptoms, skill deficits, treatment barriers) considered from within the same theoretical perspective that guides the premise. Information from the client's past history, the client's present history, behavioral observations in the treatment session, and other sources may be included in the overall case conceptualization as *appropriate* to building an effective analysis of the client.

The support paragraphs should be written following a coherent organizational structure that is set up by the premise. At the end of these support paragraphs, the conceptualization should draw conclusions about the client's overall level of functioning at this time, contain broad treatment goals, include any windows of opportunity for achieving these goals, and note any barriers to goal attainment that exist at this time.

KEY FEATURES IN DEVELOPING A TREATMENT PLAN

Three organizational features will be suggested for developing an effective treatment plan in this text. The first feature is the treatment plan overview. This is a brief paragraph, in client-friendly language that can help increase clients' ownership of their treatment plan and responsibility for their own outcomes in treatment. The overview can also be used to help a referral source understand the intent of your treatment plan and your respect for the client's role in it as appropriate.

The second feature is the development of long-term (major, large, ambitious, comprehensive, broad) goals that stem from the main concepts developed in the premise of the case conceptualization. These are goals that the client ideally will have achieved by the time treatment is terminated. The information contained in the premise, and the topic sentences of the support paragraphs, should provide the information needed to develop your long-term goals as they should reflect the most important or basic needs, issues, or goals of the client at this time.

The third organizational feature is the development of short-term (small, brief, encapsulated, specific, measurable) goals that the client and clinician will expect to see accomplished within a brief time frame to chart treatment progress, instill hope for change, and help the clinician plan treatment sessions. Early positive change is part of the trajectory toward successful treatment (Hubble et al., 2010). Therefore, a plan that helps highlight for the client even small steps taken toward change is more likely to lead the client toward a positive outcome.

Every long-term goal should have a series of short-term goals that will be used to move the client toward its accomplishment. Expect to need more short-term goals to support ambitious, versus moderately difficult, long-term goals. If treatment is stalled, it may be that the short-term goals you selected are too large or difficult and need to be broken down further. It also may be that the goals are inappropriate and need to be redesigned.

Ideas for the development of short-term goals may come from the supportive detail contained in the case conceptualization. While a client's difficulties have a clear connection to treatment goals, so do strengths. For example, if Pat has strategies that help him keep his aggression under control at work, then treatment goals for expanding his use of these strategies at home and in the neighborhood would capitalize on these strengths. Additional ideas for goals will come from the theoretical model that is chosen to guide treatment. For example, in behavioral therapy, the clinician takes on the role of an educator. Therefore, treatment goals may center on the skills, or information base, that the clinician will help the client master. Taken together, the long- and short-term goals provide an action plan for helping the client change effectively.

The text exercises will guide you to develop goals that are (a) stated in specific terms that the client can understand, (b) congruent with what the client wants to achieve, and (c) viewed as attainable by the client, as

such goals are the most motivating (Egan, 2013; Hubble et al., 2010). In some cases, all the long-term goals may be worked on simultaneously. In other cases, goal achievement will follow a specific order as each goal builds on what came before. The strategy for implementing the plan should be included in the treatment plan overview and clearly explained to the client since a collaborative, working relationship is critical for a positive treatment outcome (Hubble et al., 2010).

DEVELOPING A FLEXIBLE WRITING STYLE

Professional writing requires a clear and specific organizational plan. Within this plan, there are many different styles for organizing an effective case conceptualization and treatment plan. Based on your prior training or style of viewing the world, it may seem at first as if professional writing requires you to abandon the style that comes most easily to you. This viewpoint often develops because the examples provided during training may follow one specific style (or use one type of organizational strategy). This text seeks to demonstrate the power and legitimacy of different writing styles by modeling the effective use of four different styles of writing conceptualizations and treatment plans; the intent is to encourage you to identify, and practice developing, a flexible professional writing style.

Each theoretical chapter in this book contains two complete case conceptualizations and treatment plans. The first one always uses the assumptions of the theory to guide its organization. The second follows another style that might be particularly potent in connecting with the client (see Table 1.1). Research shows that instilling hope is an important factor in positive treatment outcomes (Wampold, 2010). Thus, the language you use in writing a treatment plan can increase clients' sense of hope that you understand them and what they want; this may lead them to take a greater amount of ownership in their treatment. At the end of this chapter, abbreviated examples of four different styles for adapting your clinical work will be provided. These examples include

TABLE 1.1 ■ Location of Case Conceptualization and Treatment Plan Examples by Domain, Chapter, Style, and Format

Domain	Chapter	Style	Format
Gender	10	Assumption, Historical	Basic, Problem
Gender	11	Assumption, Symptom	Basic, SOAP
Socioeconomic Status	12	Assumption, Interpersonal	Basic, Problem
Race & Ethnicity	13	Assumption, Historical	Basic, Problem
Sexual Orientation	14	Assumption, Interpersonal	Problem, Basic
Race & Ethnicity	15	Assumption, Interpersonal	Basic, Basic
Development	16	Assumption, Symptom	Problem, Basic
Development	17	Assumption, Symptom	Basic, SOAP
Socioeconomic Status	18	Assumption, Symptom	Problem, Problem
Socioeconomic Status	19	Assumption, Historical	Problem, Problem

premises, treatment plan overviews, and partially completed treatment plans. All of these examples are based on a behavioral analysis of the case of Pat in order to highlight differences based on writing style versus theory. The labels used to describe each style have been created by the author and include assumption-based, symptom-based, interpersonally based, and historically based.

The assumption-based style would organize information about Pat in terms of the major assumptions of the psychological theory chosen for understanding his dynamics. The topic sentences of the premise, support paragraphs, and long-term goals would all be constructed around the assumptions of the theory. There is a complete conceptualization and treatment plan using this style in each theoretical chapter of the textbook.

The symptom-based style would organize information about Pat in terms of the major symptoms he presented with in treatment. Therefore, the topic sentence of the premise would highlight all the symptoms that would be dealt with in the conceptualization, and each long-term goal in the treatment plan would focus on each of these symptoms in turn. The conclusion of the premise would consider an appropriate diagnosis for Pat. The framework of the formal diagnostic system created by the American Psychiatric Association (2013) in its *Diagnostic and Statistical Manual of Mental Disorders: Fifth Edition* (*DSM-V*) has been used in this diagnosis. To read a full conceptualization and treatment plan using this style, read the Case of Eric in Chapter 11, Case of Alice in Chapter 16, Case of Dan in Chapter 17, or the Case of Zechariah in Chapter 18.

The interpersonally based style would organize information about Pat in terms of his relationships with significant others. The topic sentence of the premise would list the significant relationships that would be discussed in the conceptualization. Each of these relationships would have a long-term goal associated with it. Each support paragraph would discuss one of these relationships. If appropriate, another support paragraph could focus on the client's relationship with the self. This could be useful in dealing with personal identity, self-esteem, one's personal view of the world, or other self-focused issues as appropriate to the theoretical orientation chosen for the conceptualization. To read a full conceptualization and treatment plan using this style, see the case of Ann in Chapter 12, John in Chapter 13, and Ellen in Chapter 14.

The historically based style would organize information about Pat based on his personal history using selected time periods from past to present or vice versa. The time periods selected would be individualized to the client's needs and current situation. Examples could be early childhood, elementary school, high school, college/vocational school, and adulthood. Or, for a treatment issue that occurred during disrupted adult development, examples could be early college years, tour of duty in war zone, return to civilian life, and divorce. For a complete example of the historically based style, see the case of Jeff in Chapter 10, of Sharon in Chapter 13, Sergio in Chapter 15, and of Kayla in Chapter 19.

The four styles discussed in this chapter are not intended to be all-inclusive. Other strategies can be used to effectively organize your clinical work. Professional writing allows for a great deal of flexibility in style; however, there needs to be a clear organizational plan that will easily communicate to other professionals your current understanding of your client and your client's treatment plan. This may be needed to support clinical supervision of your work, case reviews by accreditation boards, court-ordered evaluations, and emergency coverage of your cases by another clinician (APA, 2007b, Guideline 5 yes).

Do your conceptualization and treatment plans have to follow a parallel structure? No. An assumption-based case conceptualization does not have to be followed by treatment goals expressed in terms of the theory's assumptions. However, this can be an effective strategy in that the reader, whether it is your supervisor or a judge, can easily follow your professional reasoning. Similarly, if Pat blamed his problems on the alcoholic parents who neglected him, he might be most motivated to work on treatment plan goals that were developmentally expressed. If his treatment plan meets his expectations that his problems today are not "his fault" but due to his alcoholic parents not giving him what he needed, he might be more motivated to work on them.

There is no standardized format for presenting the goals of a treatment plan. Different clinicians and 33 different clinical settings use their preferred formats. Three formats will be modeled in the examples at the end

of this chapter. These have been labeled the basic format (treatment plans 1–3), the problem format (treatment plan 4), and the SOAP format (treatment plan 2).

The basic format has goals stated in terms of what the client needs to achieve/learn/develop. This might be a motivating format for the client, as goals are stated in terms of what the client wants to achieve. It might also be useful when the client, has shown a very negative reaction to any indication that he or she has any "problems" or "issues." The problem format has goals stated in terms of what maladaptive behavior or issues need to be reduced. This might be most motivating for clients who have become very frustrated by their own behavior and have become ready for change. Similarly, it might be a good format for parents who have become very frustrated by the maladaptive behavior of one of their children or for a probation officer who has developed a strong determination to prevent recidivism in a parolee. The final format was developed as an adaptation of the "SOAP" note that has been commonly used in medical settings. This note was first developed by Lawrence L. Weed, MD (Weed, 1968). He developed it to go along with his "Problem-Oriented Medical Record (POMR)."

Dr. Weed wanted the medical record to clearly draw attention to the client's presenting problem, the current status of this problem, and the immediate plan for dealing with the problem and then conclude with why this plan was chosen. The clinician is intended to write a new SOAP note each day (a short-term plan) rather than come up with goals for a more long-term plan. The letter *S* refers to the subjective data provided by the client. The letter *O* refers to the clinician's objective data developed through testing or informal assessment of the client. The letter *A* refers to the clinician's assessment of the client based on the *S* and *O* data. The letter *P* refers to the clinician's immediate plan vis-à-vis the client. The uses of the *S*, *O*, and *A* parts of the note will be used following the procedures described by Weed (1968). For the purposes of this book, the *P* section of the SOAP note will be extended to include the long- and short-term goals described earlier in this chapter.

Some clinical settings set specific methods for documenting treatment that you must follow when working there. The three formats modeled in this text are intended to encourage you, if you have the freedom to choose, to select the format you believe will be most likely to engage the client in constructive change.

Examples of Premises and Treatment Plan Styles

All the examples that follow provide insights concerning the case of Pat described earlier in this chapter. Assume that the clinician has carried out a comprehensive intake with him as well as conferred with Pat's probation officer. As you read each example, assume that the clinician will be monitoring Pat's potential for harm toward others whether or not this has been made explicit in the treatment goals. All the examples have used behavioral theory as the theoretical perspective so that differences in writing style could be highlighted.

Behavioral theory was chosen as it has a number of strengths in considering Pat's unique characteristics at this time. It is action oriented, and he has shown a preference for a quick pace. He was recently in prison, so a highly structured approach should not seem unusual or burdensome to him. In fact, it should provide significantly less structure than he has been used to in the last three years. In addition, his jail term was reduced due to his learning how to be a "good inmate," and this past learning might be effectively incorporated into the treatment plan. Finally, achievement of behavioral goals is relatively quick, and this fast response could well be needed to prevent Pat from being sent back to jail.

Premise 1: Assumption-Based Style

Pat's childhood learning experiences taught him that dysfunctional behavior, such as verbal and physical aggression, were rewarded, and emotional vulnerability was punished. Pat learned a lot from observing his parents; he has become a master of verbal and physical assault and has also learned to associate physical dominance with sexual arousal and fear with emotional vulnerability. He also saw how to take alcohol in gulps rather than sips and to consider the needs of children irrelevant. His parents provided no positive consequences

for Pat showing signs of emotional regulation or nonviolent problem solving; the only strategies for dealing with his parents that led to positive consequences were to eat fast and learn how to hide effectively. Despite this violent upbringing, Pat did learn to inhibit any aggressive impulses he might have in his dealings with neighborhood adults. These neighbors were a good source of income if he was reliable and worked hard. Pat also learned that if he kept a low profile at school, he was safe. While Pat has trouble inhibiting his aggression, particularly when drinking, he did graduate from high school and did gain an associate's degree in computer repair. He has also learned that he wanted to have a stable relationship with a woman rather than a revolving door of sexual partners. Pat's consistent interest in observing others, and his ability to inhibit his aggression, within some environments, might all be signs that he could be able to stop, think, and learn from prosocial role models at work, within the probation, and in the treatment environments.

Treatment Plan 1: Assumption-Based Style

Treatment Plan Overview. Pat has shown the greatest motivation to maintain a romantic relationship with Alice and to stay out of jail; thus, his treatment goals should focus on these issues. Pat's probation officer has regular meetings with Pat to ensure that he has not engaged in any violent behavior. Pat has found these meetings aversive, as the focus has been exclusively on reviewing Pat's past acts of violence. The probation officer has now been asked to change his approach and to reinforce Pat's attempts to exert positive control in relationships within the past week as well as reviewing probation expectations. Long-Term Goals 1 and 2 should be addressed simultaneously. (This treatment plan follows the *basic format*.)

LONG-TERM GOAL 1: Pat will learn to recognize the positive and negative consequences that follow different types of interpersonal behaviors and to determine which behaviors he would like to use to strengthen his relationship with Alice.

Short-Term Goals

1. Pat's behaviors in treatment such as arriving on time, coming regularly, being polite, and not making threats during discussions, will be noted as relationship-building behavior whenever they occur.
2. Pat will consider whether when the clinician responds to him with smiles, a relaxed posture, leaning forward, and so forth, these behaviors are building a relaxing or stressful relationship.
3. Pat will gain practice tuning into his own immediate behavior within the treatment session, identifying the obvious and subtle cues he is using in his interactions with the clinician, and asking the clinician whether they are being experienced as building a relaxing or stressful relationship.
4. Pat will discuss what Alice does when he comes home that he wants her to continue and will consider telling Alice that he likes these behaviors and wants them to continue.
5. Pat will discuss with clinician if there is a value to providing positive consequences to Alice, and ignoring behaviors that he does not like, for building a positive relationship with her.
6. Pat will learn about the power of deep breathing, progressive muscle relaxation, and self-hypnosis as consequences he can give to himself to control behaviors that could damage his relationship with Alice.
7. Pat will select a method of controlling his own negative behaviors and practice it in the session with the clinician during role-plays of situations he usually finds provoking.
8. Pat will use his preferred method of relaxing immediately before walking into his home after work.

9. Other goals will be developed as needed for mastering Long-Term Goal 1.

LONG-TERM GOAL 2: Pat will use his observational skills to determine how his boss, coworkers, and store customers provide positive and negative consequences to each other that don't involve verbal or physical aggression.

LONG-TERM GOAL 3: Pat will learn how to tune into his body and recognize when he is having reflexive positive or negative responses to the behavior of others and to decide whether he wants to continue to learn or unlearn these reflexive responses.

Premise 2: Symptom-Based Style

Pat's most serious problems have been that he loses control of his anger and assaults men, drinks excessively, and has used control tactics and verbal hostility in his relationships with women. Pat was abused by both of his parents and neglected by the other adults he came in contact with. His parents never showed emotional or behavioral regulation in their interactions with each other or him. They frequently lost control of their anger and were violent and verbally abusive toward each other. No one taught him social skills; but to protect himself from his violent parents, he learned how to be very watchful. Through observational learning, he came to see relationships with men as based on drinking and relationships with women as involving drinking and sex. Pat has viewed the world as a hostile place in which sane people have learned to be on their guard. His neighbors and teachers did not reach out to save him from his abusive parents, but they did pay him to walk their dogs, and his teachers did encourage his academic success as a road to earning money. Pat has recognized that some people, like his current boss, are not dangerous and deserve respect. He has also learned that hard work and responsibility can get him physical security, that is, a warm place to live and enough food to eat. Pat has worked hard and has the ability to learn new skills, such as computer skills, if given the opportunity. In addition, he has shown evidence of regretting the time he spent in prison and the loss of some of his past relationships with women. Pat's profile of episodic losses of control of his anger, drinking, and control tactics and verbal abuse of women can be considered compatible with a primary *DSM V* of 312.34 Intermittent Explosive Disorder. Further assessment would be needed to determine if a diagnosis of an Alcohol-Related Disorder is also appropriate. While showing serious episodes of loss of control of his anger, Pat also has a long-standing history of seeking constructive employment and learning new job skills. These might bode well for his ability to profit from new learning experiences that would teach him how to regulate his emotions and sustain intimate relationships without violence.

Treatment Plan 2: Symptom-Based Style

Treatment Plan Overview. Pat has indicated wanting to stay out of jail and continue his relationship with Alice. However, he has not currently shown an understanding that learning emotional regulation skills and ending or reducing his alcohol use would be necessary to achieve these goals. His current situation will first be described from his point of view. Then, information that the clinician has garnered from other sources will be summarized. And, finally, a plan based on an integration of this information will be offered to help Pat stay out of jail and strengthen his relationship with Alice. (This treatment plan follows the adapted *SOAP format.*)

Subjective Data

Personal history: Pat is a 25-year-old, European-American male who was the only child of two alcoholic parents. He described being treated by his parents with indifference and hostility. He stated that he was often beaten for reasons he did not understand. He witnessed many acts of violence between his parents as well as episodes of their drinking until they passed out. Pat indicated being an average student in high school and

going on to get an associate's degree in computer repair after high school. Before going to prison, Pat spent a year working as a computer technician in a small company. He was proud of holding down this job so long and admitted to enjoying work with computers. Pat first came into contact with the law for drinking as a teenager. He was arrested several times as an adult for drunken bar fights. He was sent to prison after his last episode of fighting due to seriously injuring his opponent. He has no memory for why the fight broke out but denies any culpability.

Relationship history: Pat has been involved in many short-term relationships with women. He met these women in bars or in his neighborhood and, after a few weeks of dating, invited them to move in with him if they were good sexual partners. In each past relationship, the woman would secretly move out of the apartment while he was at work and disappear. He denied any understanding of why they left but said he wanted Alice, his newest partner, to stay put and not leave him.

Legal history: Pat was convicted of assault with intent to harm after a bar fight and given a prison sentence of three to five years. Pat was released after three years for good behavior; he kept to himself in prison and avoided all fighting. He is currently on parole and has weekly appointments with his parole officer. Pat has been participating in treatment as a requirement of his parole. The officer has told Pat he expects treatment to help him decrease his alcohol use and prevent him from engaging in further violent behavior.

Work history: Pat began earning money as a child when his neighbors paid him to walk their dogs or clean out their garages. Since learning how to earn money, Pat has been gainfully employed throughout school and afterward. The only disruption of this employment was his time in prison. Immediately on release from prison, he set out to get a job and is now a custodian at a store.

Objective Data

Standardized intellectual testing using the Wechsler Adult Intelligence Scale 4 (WAIS-IV) revealed that Pat has an above-average level of intelligence. Pat has denied any memory loss, cognitive disorientation, or history of head injury, so no neuropsychological testing was considered necessary at this time. Self-report using the Adverse Experiences Scale indicated that he was a victim of physical and verbal abuse as well as neglect as a child and that he began engaging in his own violent behavior toward males in adolescence. He admitted to acts of verbal violence toward women also starting in adolescence. Personality testing using the Minnesota Multiphasic Personality Inventory-2 (MMPI-2) revealed no signs of cognitive confusion, personal turmoil or distress, or physical symptoms. Rather, his profile suggested a history of severe family and interpersonal discord. His relationships with others could be characterized by suspiciousness, jealousy, and hostility. His scores on items reflective of alcohol abuse were ambiguous, and thus further assessment in this area was called for. His profile suggested a pattern of behavior consistent with episodic losses of control and risk-taking tendencies as well as severe family disruption. As a result, Pat would be unlikely to view the clinician as trustworthy. Pat's working diagnosis at this time would be consistent with 312.34 Intermittent Explosive Disorder. His current functioning at this time has reflected at least average level of intelligence, stable employment, and motivation to have a stable relationship with Alice. He has minimal social support in the form of weekly parole meetings; there has been no evidence at this time about whether Alice has the desire to remain in a relationship with Pat.

Assessment

There have been no signs at this time of significant emotional turmoil or distress related to his past violent behavior or alcohol abuse except for a clear desire to not return to jail and not lose his relationship with Alice.

While Pat's adult behavior is consistent with a diagnosis of Intermittent Explosive Disorder, this adult behavior would also be consistent with viewing Pat as an adult survivor of an abusive and neglectful upbringing. Based on his self-report, he was not given needed physical or emotional support as a child to develop emotional regulation skills or constructive relationship skills. Both Pat's high level of intelligence and his ability to observe and analyze others might be used in supporting his learning of these needed skills. However, safety issues must be monitored carefully as Pat is angry about the referral for treatment. While there were no signs of any loss of control of anger within the treatment session, he has a history of explosive, violent outbursts. Thus, Pat's potential for being a danger to others, including the clinician, would need to be monitored on an ongoing basis.

Treatment Plan Overview. Pat's probation officer has been monitoring his aggressive behavior and level of drinking. If Pat lost control of his aggressive behavior, his parole would be violated, and he would be sent back to jail. Thus, it would be critical for Pat to develop behavioral strategies that ensured he maintained control of his aggressive impulses. He must also learn to recognize when he needs to stop drinking so he could be able to remain clear headed and avoid situations that could land him back in jail. While Pat did not agree with his probation officer that he has problems with aggression and excessive alcohol use, he did agree with the clinician that he did not want to go back to jail, and he did not want to lose his relationship with Alice. Long-Term Goals 1, 2, and 3 would need to be worked on simultaneously to decrease the likelihood that Pat would come into conflict with the law. (This treatment plan follows the *basic format.*)

LONG-TERM GOAL 1: Decrease Pat's violent behavior to keep him out of jail.

Short-Term Goals

1. Pat will discuss the antecedents he can remember to the fight that resulted in his prison sentence.
2. Pat will discuss the immediate and long-term consequences (positive, negative) of the fight that resulted in his prison sentence.
3. Pat will consider what consequences he would prefer to have following his fights with other men.
4. Pat will become aware of what has happened immediately before he becomes verbally or physically aggressive (thoughts, feelings, behavior) so he can be in control of himself at all times.
    a. During the session, after warning him this is about to happen, the clinician will intentionally bring up incidents that have made Pat angry that involved treatment sessions and probationary appointments to help him develop personal awareness of when his anger is rising.
    b. The clinician will follow the same procedures as in (a) but after first asking Pat about a recent provocation at work.
    c. The clinician will follow the same procedure as in (a) but after first asking Pat to describe a recent provocation by Alice or a neighbor.
5. Pat will become aware of what happens immediately after he has been verbally or physically aggressive (thoughts, feelings, behavior) and decide if these are positive or negative consequences.
    a. Pat will reenact with the clinician a recent act of his aggression within the treatment session to heighten his awareness of his thoughts, feelings, and behavior and whether or not he was in control of himself.
    b. Pat will reenact with the clinician a recent act of his aggression at work to heighten his awareness of his thoughts, feelings, and behavior and whether or not he was in control of himself.

   c. Pat will reenact with the clinician a recent act of his aggression at home to heighten his awareness of his thoughts, feelings, and behavior and whether or not he was in control of himself.

6. Pat will consider taking a personal time-out (taking several deep breaths, looking away, walking away, etc.) when he becomes aware that he might be verbally or physically aggressive.

   a. Pat will develop the ability to calm himself down, using strategies such as deep breathing, progressive muscle relaxation, and self-hypnosis.

   b. Pat will select the method of relaxation he prefers based on making him feel most in control of himself.

   c. Pat will try using this method when he is in a session but recalling a recent confrontation at home or at work so that he can feel in control of himself.

   d. Pat will be aware of when he becomes angry with the clinician within a session and practice taking control of his anger in the moment.

   e. Pat will try to use one of these methods when he becomes angry with Alice at home so he is in control of what he does.

   f. Other goals will be developed as appropriate to ensure Pat is in control of his actions when he feels that others are provoking him.

7. Pat will learn, within sessions, problem-solving strategies that do not involve aggressive behavior that he can use during provoking situations if he wants to.

   a. Pat will try to identify what he wanted to achieve in his most recent interpersonal conflict and whether he achieved it.

   b. Pat will learn to recognize verbally assertive, aggressive, and passive responses within conflict situations that are role-played within the session with the clinician.

   c. Pat will consider which type of response gives him what he wants without leading to a consequence that could send him to jail.

   d. Within role-plays with the clinician, Pat will practice assertive verbal responses to getting what he wants, as these are least likely to get him in trouble with the law.

   e. Pat will practice using assertive responses within his next conflict with the probation officer. (The probation officer will be notified, in advance, that Pat will be practicing assertiveness within the probationary appointment so that he provides appropriate consequences for this effort.)

   f. If Pat has developed enough behavioral control, he will practice how to use assertiveness in conflicts with Alice that take place within the treatment setting.

8. Other goals will be developed as it becomes safe for Pat to practice new behaviors with Alice both within sessions and later at home without harming his relationship with her or coming into conflict with the law.

9. Other goals involving men at work will be developed once it is safe for Pat to practice his new behaviors within the employment setting without being in danger of losing his employment or coming into conflict with the law.

LONG-TERM GOAL 2: Decrease the level of Pat's drinking to the point where he feels in control at all times in order to decrease the danger of his being sent back to jail.

LONG-TERM GOAL 3: Increase Pat's relationship-building skills so that it will be more likely he can maintain his relationship with Alice or another woman.

Premise 3: Interpersonally Based Style

Whether in relation to his parents, peers, or intimate partners, Pat has not learned how to develop relationships free from physical violence, unless he has kept himself at an emotional distance. His parents modeled a violent, drunken relationship with each other and emotional neglect of him. To avoid physical abuse, he had to hide from them; he was able to develop no idea of what a secure attachment would be like. The closest thing Pat has ever had to emotional contact with others has been the male peers he has gone drinking with and the feelings of physical closeness he gained from engaging in sexual intercourse with his female peers. From his parents and male peers, he learned that you never drank unless you continued until you blacked out, and you never fought unless you fought to put the other person down to the ground. As an adult, he continued to fight like this, despite receiving steadily increasing sanctions from the police; the feelings of dominance he gained during the fight had been more powerful reinforcement than the punishments he was getting from the police—until he was sent to jail. Pat had enjoyed the sex he had both as an adolescent and man—until as a man he noticed "his" women always walked out on him; puzzling about this during his time in jail, he has decided this pattern of being left behind by women needed to end. He has indicated being determined to make his intimate relationship with Alice last. Pat has shown signs of being highly intelligent and able to learn quickly when he motivated. He has shown a long-standing interest in learning through observing others. He has shown respect for his boss and has been observing this man and his coworkers in order to understand their relationships with others. Focusing first on what Pat has shown he cares about most, having a solid relationship with Alice, might be most motivating to him at this time. Working to build Pat's relationship skills through observational learning and other indirect methods might decrease his defensiveness and help improve his guarded prognosis for overcoming his destructive learning history.

Treatment Plan 3: Interpersonally Based Style

Treatment Plan Overview. Pat has been highly motivated at this time to maintain his relationship with Alice. Thus, his treatment goals should focus on types of learning that Pat could understand might strengthen this relationship. Treatment that started indirectly, through Pat's reading a book on relationship-building skills, rather than directly teaching these skills in treatment, might cause him to be less likely to view himself as being "dominated" by the clinician; feeling dominated would likely trigger his defensiveness and aggression. Discussing the different skills he read about with the clinician, and having his views heard on the "how and why" they might build rather than damage relationships, might strengthen his view of treatment as a collaborative effort rather than a contest in domination. Once Pat has developed some insight into what skills helped versus damaged relationships, he might be ready to analyze the major relationships he has experienced in his life. Once he has understood the damage he sustained from his parents' method of raising him, he might be ready to use different skills to develop an emotionally intimate relationship with Alice and cooperative relationships with other people. Long-Term Goal 1 would be achieved prior to working on Long-Term Goals 2, 3, & 4 simultaneously in order to support maintaining his relationship with Alice, staying out of jail, and pursuing employment in computer repair. (The treatment plan follows the *basic format.*)

LONG-TERM GOAL 1: Pat will read a book that explains the concepts of relationship-building, relationship-damaging, and neutral behaviors and consider whether he wants to be more conscious of when he uses these types of skills in his own relationships.

Short-Term Goals

1. Pat will discuss what he has read in the book during treatment sessions and discuss in what ways he agrees or disagrees with how behaviors are categorized as relationship building, damaging, or neutral.
2. Pat will observe relationships in the TV shows that he watches and keep a record of the relationship-building, relationship-damaging, and neutral behaviors that he observes and discuss this record during treatment sessions.
3. Pat will observe his boss and keep a record of the relationship-building, relationship-damaging, and neutral behaviors that he observes and discuss this record during treatment sessions.
4. Pat will observe Alice and keep a record of the relationship-building, relationship-damaging, and neutral behaviors that he observes and discuss this record during treatment sessions.
5. Pat will watch a movie with the clinician that covers relationship skills and discuss the advantages and disadvantages to using different behaviors within his own relationships.
6. Other goals as needed to clarify the differences between types of relationship behaviors.

LONG-TERM GOAL 2: Pat will analyze his relationship with Alice for examples of relationship-building, relationship-damaging, and neutral relationship behaviors and consider whether he wants to make any changes in his relationship with her.

LONG-TERM GOAL 3: Pat will analyze his relationship with his parents for examples of relationship-building, relationship-damaging, and neutral relationship behaviors and consider the consequences these behaviors had for himself as a child and for their marital relationship.

LONG-TERM GOAL 4: Pat will analyze his relationships with his boss and coworkers for examples of relationship-building, relationship-damaging, and neutral relationship behaviors and consider whether he wants to make any changes in his current or future relationships in order to regain employment in computer repair.

Premise 4: Historically Based Style

As Pat developed from childhood through adulthood, he learned that you were either the one who got hit or the one who did the hitting. As a young child, Pat witnessed nothing from his parents' interactions but violence as a problem-solving strategy and heavy drinking and sexual intercourse as methods of relaxation. His parents ignored his basic needs, would physically abuse him if they felt he was in their way, and would take food literally out of his mouth if they were hungry. Thus, Pat learned how to avoid them and attend to his own basic needs; but he couldn't learn how to develop healthy attachments on his own. Once he started going out in his neighborhood, he found that adult neighbors did nothing to help end the violent or neglectful treatment they sometimes witnessed him receiving from his parents. Thus, he developed the view that violent problem solving was typical and that adults would not protect him. However, adult neighbors did pay Pat money when he worked hard enough on their chores. At school, the teachers never expressed concern for his visible bruising but did provide him with the training he needed to gain an associate's degree in computer repair. Pat's adult life improved financially when he was able to maintain a stable job in computer repair. However, he socialized with males only through hard drinking and hard fighting, and this eventually led him to receive a three- to five-year prison sentence. In prison, Pat reflected on what he

had gotten from life and decided somethings needed to change upon his release. For example, he recognized that while he had used the quality of sex to determine what women to invite into relationships with him, these women had always ended up secretively walking out on him—thus he needed to learn something different. While he didn't decide that his heavy drinking and fighting were problems, he did decide he never wanted to end up in prison again—thus he needed to learn something different. Through observation, Pat has recognized that his boss is not a danger to him, neither are the other men at work, and they have shown signs of knowing more about successful relationships than he does. If treatment took advantage of Pat's strong observational skills, and ability to learn when he felt safe, treatment could become a learning environment for Pat.

Treatment Plan 4: Historically Based Style

Treatment Plan Overview. Due to the neglectful and violent behaviors of his parents, Pat raised himself and did not get help learning from adults how to develop relationships in which he would be safe, without the use of violence. Pat has little motivation at this time to explore his own aggressive behavior as he hasn't agreed that it has been a problem. However, he has been able to recognize that he needed more from his parents than what they gave him and that even as an adult, he has needed to learn more to get what he wants from life. Thus, his motivation for learning adaptive skills might be built through examining the relationship skills his parents did and did not demonstrate and what other adults during his life have and have not taught him. Long-Term Goal 1 will be achieved before progressing to further goals. (This treatment plan follows the *problem format*.)

PROBLEM: Pat did not learn how to solve relationship problems without violence or develop emotionally intimate relationships with others.

LONG-TERM GOAL 1: Pat will examine what he learned from his upbringing and how this might have influenced his current interpersonal skills.

Short-Term Goals

1. Pat will articulate what behaviors he specifically witnessed between his mother and father.
2. Pat will articulate what behaviors he specifically witnessed between his mother and other adults.
3. Pat will articulate what behaviors he specifically witnessed between his father and other adults.
4. Pat will reflect on how his parents' behavior influenced his choice to be a loner.
5. Pat will discuss his parents' aggressive and neglectful behavior toward him as a child and how this might have influenced his choice to be a loner.
6. Pat will discuss his parents' behavior toward each other, and toward himself, and how this might have influenced the interpersonal skills he currently has.
7. Other goals will be developed as appropriate to helping Pat see the impact of his past violent and neglectful learning history on his current interpersonal skills.

LONG-TERM GOAL 2: Pat will examine what he learned from his adult neighbors not responding to his physical signs of being abused and neglected yet helping him learn how to earn money when he was a child and a teen.

LONG-TERM GOAL 3: Pat will examine what he learned from his teachers not responding to his physical signs of being abused and neglected yet helping him be an effective learner when he was a child and a teen.

LONG-TERM GOAL 4: Pat will examine what he learned from the criminal justice system sending him to prison in response to his violence toward other men and consider what he might want to learn in order to avoid any further contact with the criminal justice system.

LONG-TERM GOAL 5: Pat will examine what he learned from his relationships with women in the past and what he might want to learn in order to have a more satisfying relationship with Alice or another woman.

LONG-TERM GOAL 6: Pat will examine what he has been learning from his relationships with his current boss and coworkers and consider what he might want to learn from them in order to avoid the criminal justice system and regain employment in computer repair.

CONCLUSIONS

The detailed case conceptualizations and treatment plans recommended within this chapter have been designed to support you through the early years of your training as clinicians as you seek to integrate all the information that encompasses the uniqueness of clients into effective and time-efficient treatment. Although these detailed clinical tools will be initially very time-consuming for you, this critical thinking will serve you well as you develop your clinical reasoning skills. As you progress into later phases of your training, some of this critical thinking will begin to be internalized and automatic. Once you have entered the independent stages of your clinical practices, most of this work will be automatic and thus not time-consuming. Professional practice settings all have their own unique case record files and documentation guidelines. It is likely you will only put "the premise" that describes your clients in a nutshell, at the end of an intake report or at the beginning of the termination report. You will only provide the type of detailed case conceptualization and treatment plan if you are presenting a case to a group or to an insurance company in order to validate your need for the length of treatment you provided. While community practice can allow you to go into "automatic pilot" and provide only very brief treatment plans, it is important for you to remember what reflects the work of an excellent versus adequate clinician and make your own decision as to how much clinical reasoning is needed to truly serve your clients. You will be introduced to the literature on what makes a "super" clinician in Chapter 9 of this textbook.

RECOMMENDED RESOURCES

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders (5th ed.) [DSM-V]*. Washington, DC: American Psychiatric publishing.

American Psychological Association. (2007b). Record keeping guidelines. *American Psychologist, 62*(9), 993–1004.

Egan, G. (2013). *The skilled helper: A problem-management and opportunity-development approach to helping (*10th ed.). Belmont, CA: Brooks/Cole.

Weed, L. L. (1968). "Medical records that guide and teach." *The New England Journal of Medicine*, *278*(11), 593–600. doi:10.1056/NEJM196803142781105.

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

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

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 monoperpetration (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, Catallozzi, & 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).