Introduction

Psychology is the study of the mind and behaviour (American Psychological Association, 2020). As such, it focuses on the scientific study of a broad scope of themes, from a neural level to a societal level. Subjects of focus include neural processes, group processes, mental health problems, human development, and the impact and consequences of adversity, including violence and abuse. Psychologists have in some way concerned themselves with the consequences of domestic violence and abuse since the profession’s early years, but in a systematic, scientific perspective, domestic violence entered into psychology in the seventies. The impact of the women’s liberation movement prompted researchers to investigate issues that bore particular importance to women, including violence in the home. Psychologist Leonore Walker studied women who had experienced violence from their male partners, and she was one of the first to describe the symptoms of the battered women and the violence they suffered (Walker, 1977, 1979). The scientific focus on domestic violence led to such terms as ‘the battered woman syndrome’ (Appleton, 1980) and, taking children’s experiences into account, ‘the battered child syndrome’ (Hicks, 1987; Kempe, Silverman, Droegemueller, & Silver, 1962). As these terms imply, much of the psychological literature on this subject focuses on the detrimental consequences violence and abuse may have on victims’ health, particularly on their mental health. The decades that followed these publications have seen great development in theory and research on domestic violence, which has given us a deeper understanding of the mechanisms involved in, potential risk factors for, and the health consequences of, domestic violence victimization, as well as advances in treatment models.

Psychological research on domestic violence and abuse often takes a perspective of trauma psychology, focusing on the risk for trauma-related mental health problems and treatment of such problems. In the current chapter, we will therefore discuss the psychological angle of domestic violence research, with a focus on psychotraumatology. When considering violence against children, we will take perspectives from developmental psychology. With a background in theory and research from these perspectives, we will consider the phenomenology of domestic violence, risk and protective factors in terms of health problems, with a specific focus on social relationship factors, and briefly describe models of psychological treatment of victims suffering from the health consequences of domestic violence. Although psychology may inform
the study of violence perpetration, we will limit this chapter to research on victims, and not discuss psychological perspectives on perpetrator behaviour.

**Discussion and analysis**

**Domestic violence as a trauma**

The word ‘trauma’ (derived from the Greek word for ‘wound’) originally referred to an injury caused by an external factor. Using this term in the context of psychological trauma implies that an external event can cause psychological injury, much like a blow to the head can cause physiological injury. A traumatic event is defined as exposure to actual or threatened death, serious injury, or sexual violence, either directed towards the person her-/himself or indirectly, such as when a person witnesses a traumatic event happening to someone else (American Psychiatric Association, 2013). Using trauma as an overarching term for events as diverse as exposure to a natural disaster, being imprisoned in a concentration camp, experiencing a sexual assault, and being abused by one’s parent or partner, entails an acknowledgement that while these events differ in important ways, there are many similarities in the mental health consequences that they may have.

*Psychotraumatology* is the study of psychological trauma, hereunder factors occurring before, during, and after the traumatic event. Whereas certain instances of domestic violence may not fall under the definition of trauma (e.g., some forms of low-intensity physical violence would perhaps not entail actual or threatened serious injury), domestic violence is generally considered a potential trauma, and because it may cause considerable psychological damage, it has been extensively studied within the field of psychotraumatology.

**Characteristics of the traumatic event**

Domestic violence has some characteristics that can make it a particularly damaging form of trauma. Interpersonal traumatic events are frequently found to be more severe than non-interpersonal trauma in terms of mental health outcomes (Alisic et al., 2014). Violence is interpersonal in character, and the notion that someone wilfully inflicted the traumatic event upon them can make it harder for victims to cope with the trauma. Further, violence committed in families is often part of a pattern that persists over time, as the victim is bound to the perpetrator in ways that are not easily escapable. Children depend on their parents to meet their needs for a home, food, and clothes, as well as for safety, love, and support. If parents are abusive, the chances of escape are often few and risky. Children are at the mercy of their parents, and child maltreatment in many cases continues for large parts of childhood, meaning that it is a repeated and persistent form of trauma. While adults in comparison may appear freer to leave a violent romantic relationship, adult victims of partner violence are also bound to the perpetrator, and often remain with the abusive partner over time. The various ways in which adult victims of domestic violence are constrained within the relationship is covered in more detail elsewhere in the Handbook.

Psychologist Judith Herman (1992) describes how victims of domestic violence are captive in the abusive situation, and compares this captivity to that of political prisoners and prisoners in concentration camps. While there are fewer physical barriers to escape domestic violence, there are still extremely powerful barriers, she writes, but these barriers are invisible, and the domestic captivity of victims of violence is often unseen. Domestic violence is thus often protracted, and victims stay in close contact with their abuser over time, with acts of violence repeated,
sometimes on an almost daily basis, creating what Herman describes as a relationship dominated by coercive control (Herman, 1992). Further, in some violent families, the victim may care deeply for the perpetrator. Jennifer Freyd has described how traumatic experiences may involve betrayal, that is, the violation of trust or well-being by people or institutions upon which the individual depends (Freyd, 2008). One can argue that betrayal is part of all violence, as violent acts go against underlying assumptions of how people behave towards each other. However, the closer the relationship to the perpetrator is, the higher the level of betrayal will presumably be, and domestic violence is clearly a high-betrayal trauma.

Further, domestic violence often consists of multiple violence types. For example, it is difficult to imagine severe physical abuse of a child without there being some component of emotional abuse as well. Michael Johnson’s description of ‘intimate terrorism’ in relationships covers multiple forms of abuse, including physical, sexual, emotional and economic abuse (Johnson, 2010). Studies tend to find that the number of violence types is associated with negative consequences; the more types, the worse the health outcome, for example (Thoresen, Myhre, Wentzel-Larsen, Aakvaag, & Hjemdal, 2015). For survivors living in violent families over years, it may not make sense to count the number of events, or even consider each violent episode a specific event. Rather, the violence may be experienced as ever-present, with patterns of control, threat, and violent assaults influencing almost every aspect of life.

In sum, while cases of domestic violence may vary in severity, they often contain several qualities indicating trauma severity, such as being protracted and inescapable, interpersonal, as well as often involving betrayal and multiple types of violence. With this in mind, we will turn to the potential mental health consequences of violence.

**Domestic violence and mental health**

Exposure to violence and abuse can have devastating effects on health, including severe physical injuries, heart disease, cancer, and obesity (Campbell, 2002; Felitti et al., 2019). Importantly, domestic violence may also result in death. It is estimated that between 40 and 60% of murdered women in North America are killed by their intimate partners (Campbell, 2002; see chapter 4.10 for a fuller discussion of intimate partner homicide). For psychologists, the mental health aspects of such violence have been of particular interest. Experiences of domestic violence, in childhood and adulthood, increase the risk for a wide variety of mental health problems, including (but not limited to) posttraumatic stress disorder (PTSD), depression, suicidal behaviour, and substance abuse disorders. All of these can have a large impact on the individual’s life and well-being. They may persist long after the abuse has ended, and can be one way in which survivors carry with them experiences of violence through life.

Posttraumatic stress disorder (PTSD) can only be diagnosed in the presence of a traumatic event, for example violence, accidents, or terrorist attacks. The disorder entails symptoms of re-experiencing the trauma, avoiding things that remind the person of the trauma, and exhibiting alterations in arousal and in cognitions and mood (American Psychiatric Association, 2013). Rape, often a component of domestic violence (see Chapter 4, this volume), is the trauma type most strongly associated with PTSD among women (Kessler, Sonnega, Bromet, Hughes, & Nelson, 1995). A review of the literature found that a significant proportion (31% to 84%) of women who had experienced domestic violence showed symptoms of PTSD (Jones, Hughes, & Untersteller, 2001). Studies find that the more traumatic events a person experiences, the higher the risk for PTSD (Vrana & Lauterbach, 1994). Domestic violence survivors may have a particularly high risk of PTSD symptoms, as this type of violence often persists over time, with multiple traumatic events, and is severe in various ways, as described earlier. Many psychologists
researching domestic violence, or working clinically with victims, have argued that the full impact of this prolonged, inescapable violence is not sufficiently captured within the framework of PTSD (e.g., Herman, 1992). A group of trauma psychologists suggested that the exposure to complex trauma, where a person experiences repeated or multiple forms of trauma they cannot escape, might result in a more complex symptom picture than that of PTSD (Cloitre, Garvert, Brewin, Bryant, & Maercker, 2013). A suggestion of a separate Complex PTSD diagnosis resulted in much debate, but critics also recognized that prolonged trauma might result in a more complex constellation of symptoms than single traumas (Resick et al., 2012).

Taking into account the complexity of symptoms displayed by survivors, it is not surprising that a variety of mental health problems are associated with domestic violence victimization. Depressive symptoms, including feelings of worthlessness, markedly diminished interest in activities, and recurrent thoughts of death, are not uncommon among victims (Campbell, Kub, Belknap, & Templin, 1997; R. Gilbert et al., 2009). Depression is a debilitating disorder, estimated to be among the most common causes of disability worldwide (Ferrari et al., 2013). Women are at particular risk for depression, and some researchers hypothesize that gender differences in depressive disorders may in part be explained by intimate partner violence (Campbell, 2002).

It is also a consistent finding that victims of domestic violence have an increased risk of substance abuse disorders, including problems with alcohol (Strøm, Birkeland, Aakvaag, & Thoresen, 2019; Testa, Livingston, & Leonard, 2003; White & Chen, 2002). This may be understood as a type of self-medication strategy, in which a person is using alcohol or drugs to ease trauma symptoms, such as flashbacks, nightmares, or feelings of sadness, shame, or guilt. It can also be a way of escaping in a literal sense, where a violence-exposed teenager may gravitate towards social groups where substance use is encouraged because these groups provide an alternative to going home (Finkelhor & Browne, 1985). Survivors of intimate partner violence also have an elevated risk for suicidal behaviour (Ellsberg, Jansen, Heise, Watts, & Garcia-Moreno, 2008).

Many symptoms of mental health problems may be seen as a form of adaptation to a very distressing situation, prompting the question of at what point a normal response to an abnormal situation becomes pathological. While there is no easy, all-encompassing answer to this question, the diagnostic manuals give guidelines for how intense and long-lasting symptoms should be, and how much they should interfere with functioning, before the criteria to a given diagnosis are met. Additionally, the notion that symptoms are painful and disruptive at a diagnostic level, does not mean that they cannot be understood as a form of adaptation. For a child who is severely abused by his or her parents, PTSD-symptoms such as hyper-alertness and dissociation may help the child predict and endure the violent events. At the same time, these symptoms can be deeply problematic for the child, possibly persisting long after escape from the parents.

**Mental health in children who have experienced domestic violence**

There is much evidence that experiencing domestic violence in childhood and adolescence can have severe mental health consequences (Edwards, Holden, Felitti, & Anda, 2003; R. Gilbert et al., 2009). A complicating factor is that violence experienced in childhood may adversely influence development, meaning that not only is the child exposed to something highly negative; violence may also disrupt a natural processes, and deprive the child of positive and necessary conditions for development. Developmental psychology is the scientific study of how humans develop from birth, through childhood, and into adulthood. Often focusing primarily on infancy and childhood, the field has expanded to include the entire lifespan. Childhood in particular is a period with rapid development, and experiences of violence, especially violence
within the family, may interfere with natural development in various ways; for example, it may entail neurodevelopmental consequences, negative physical health outcomes, conduct and behavioural problems (including substance abuse), mental health challenges, delinquency, and academic problems (for a review, see Artz et al., 2014).

A central subject in developmental psychology has been the importance of the child-caregiver relationship, and theory and research has focused on the attachment between the child and its caregivers. Attachment theory focuses on a child’s predisposition to form an emotional bond with their caregivers, and the behaviour that goes along with this predisposition (Bowlby, 1958; Cassidy, 2008). At the core of attachment theory is the notion that fear or distress in an infant or toddler activates the attachment system, whereby the child exhibits a set of behaviours aimed at seeking physical proximity to and attention from the caregiver. An important aspect of the caregiver as an attachment figure is his or her function as a safe base for the child. For example, if a child becomes frightened by a loud noise while the mother is in the next room, she will cry for the mother, crawl in her direction, and raise her arms to be picked up. The parent serves as a source of safety and comfort for the child. If parents are the source of fear, stress and anxiety, for example because they are violent, the safe-base function is compromised. Consequently, the child is placed in the dilemma of depending upon the source of danger for protection they are biologically prewired to seek (Kobak & Madsen, 2008). Ainsworth, Blehar, Waters, and Wall (1978) originally identified three patterns of attachment behaviours: secure, anxious-avoidant, and anxious-ambivalent. Further categorization has included the category of disorganized attachment, a sub-type of anxious attachment where the infant, among other behaviours, displays apprehension and contradictory behaviour in relation to the caregiver, overt signs of disorientation, and/or freeze (Main & Solomon, 1986; Reisz, Duschinsky, & Siegel, 2018). While it is stressed in the literature that disorganized attachment should not be used as an indicator of abuse, studies have found that abused children display disorganized attachment behaviour far more often than non-abused children (Baer & Martinez, 2006; Van Ijzendoorn, Schuengel, & Bakermans-Kranenburg, 1999).

Another important perspective on how domestic violence in childhood may influence development comes from the field of neuropsychology. Studies of children, as well as animal studies with primates, show that early maltreatment may involve alterations in hormonal and neurotransmitter systems. Such alterations may involve the hypothalamic pituitary adrenal axis (HPA-axis), which mediates the neural and hormonal response to stress, as well as the immune system (Pollak, 2008). Childhood maltreatment may alter the trajectories of brain development, and is associated with reduced volume of specific brain structures (Teicher, Samson, Anderson, & Ohashi, 2016). Taken together, findings on attachment problems and neurobiological changes after childhood maltreatment may help explain how family violence in childhood is associated with a wide variety of psychiatric, somatic, and social problems. It also demonstrates the previous point that violence in childhood may interfere with important developmental tasks, making it particularly devastating for those who experience it.

Much research on mental health problems after childhood experiences with violence has focused on adult survivors. The mental health problems children suffer may not manifest in the same way as they do in adulthood. Dante Cicchetti is a psychologist who has been influential in describing how a variety of developmental progressions may result in a given disorder (this is referred to as equifinality) (Cicchetti & Rogosch, 1996; Cicchetti & Toth, 2009); for example, ADHD may have biological roots, but may also be diagnosed based on behaviour that originates from problems in the family, such as domestic violence. At the same time, one risk factor may be associated with different outcomes (this is called multifinality) (Cicchetti & Rogosch, 1996).
The problems of a child that experiences severe abuse may have many expressions. There are PTSD criteria adapted for children, but exposure to violence may serve as a risk factor for a variety of child mental health problems.

**Cross-cultural aspects of mental health after domestic violence**

Much research on the health consequences of violence and abuse has been conducted in the global North, with a heavy focus on North American populations (for example the National Comorbidity Study, Kessler et al., 1995). Knowledge about prevalence, risk factors, and mental health consequences is not necessarily transferable from one region to the next; violence occurs in social situations within a given culture, and the way it is talked about, accepted, or even justified is enmeshed in the culture in which it occurs. Thus, critics have noted the need for cross-cultural research on violence and abuse (Kulwicki, 2002). The World Health Organization (WHO) conducted a large multi-country study on women’s health and domestic violence against women (Garcia-Moreno, Jansen, Ellsberg, Heise, & Watts, 2005, 2006). In this study, household interviews were conducted with more than 24,000 women from ten different countries (Bangladesh, Brazil, Ethiopia, Japan, Peru, Namibia, Samoa, Serbia and Montenegro, Thailand, and the United Republic of Tanzania), including, in some countries, both urban and rural settings. Findings showed that prevalence estimates varied widely; for example, estimates of the amount of ever-partnered women who had experienced physical or sexual abuse or both in a relationship varied from varied from 15% to 71%. However, women were abused by their intimate partners in all countries studied, indicating that this problem is not specific to a certain culture, or to countries with certain characteristics. The researchers reflect that taking the great variation in prevalence estimates into account, violence does not appear to be inevitable (Garcia-Moreno et al., 2005, p. xii). Across countries and sites, having experience with intimate partner violence was associated with increased risk for a range of health problems, including problems with mental health (Garcia-Moreno et al., 2005, p. 85). Coping strategies varied greatly among countries, and cultural beliefs on domestic violence may affect service responses (Fernandez, 2006; Garcia-Moreno et al., 2005), highlighting the importance of a cross-cultural focus for research and practice.

**Risk factors for mental health problems**

The potential effects of violence and abuse on mental health underscore the importance of a mental health response to domestic violence. However, not all victims experience such consequences. When discussing risk and protective factors, it is important to note that while certain factors relating to the event, the person, or the surroundings may increase vulnerability, domestic violence in and of itself makes a person vulnerable for a range of health problems. However, knowledge about risk and protective factors may help us identify those at particular risk, as well as prevent health problems.

Risk factors for negative consequences after exposure to domestic violence can take many forms. One way of sub-categorizing them is based on when they occur, relative to the trauma: before, during, or after. Pre-trauma risk factors include gender, age, previous mental health problems, and poverty. It is, for example, a consistent finding that women are at higher risk for PTSD after trauma than men, even after controlling for trauma type (Olff, Langeland, Drai- jer, & Gersons, 2007).
Peri-trauma risk factors include high levels of stress during the trauma, as well as particular characteristics of the violent event. While trauma is often discussed as a singular concept, there are large variations in the experiences that fall under this category. For example, was it a single event, or multiple events? How grave was the threat to life? Was it an accident, or something that another person did intentionally? If the trauma was interpersonal, what relationship did the victim have to the perpetrator? Was the traumatic event over in an instant, or protracted over time? Did physical injury occur? Was the event particularly degrading or invasive, for example including sexual penetration? These are some of the characteristics on which a traumatic event can vary, and although it is not given in all cases, there is no doubt that much domestic violence tends to fall on the severe end of the scale.

Post-trauma risk factors can include life stress following trauma and lack of social support post-trauma, including the response of services, or the availability and quality of social support (see more about this later). A meta-study of risk factors for PTSD found that any one single risk factor had limited effect on PTSD, but that peri- and post-trauma risk factors showed stronger effects than pre-trauma factors (Brewin, Andrews, & Valentine, 2000).

Risk and protection in the social environment

The social environment of a person may help or complicate recovery after trauma. Among social factors that have received much research attention is social support. Social support may be instrumental (e.g., having someone to help with practical tasks) or emotional (e.g., having someone who can listen, offer advice and comfort) (Santini, Koyanagi, Tyrovolas, Mason, & Haro, 2015). It is a consistent finding that social support protects against mental health problems after adverse events (see for example Thoits, 2011, for a review). A meta-analysis found lack of social support to be among the strongest risk factors for PTSD (Brewin et al., 2000). One way to sub-categorize social support is to separate perceived support from received support. Perceived social support can be seen as a sort of fund from which the person can make a withdrawal in times of need, and this perception that you have support available should you need it seems to be more consistently related to health than actually received support (Thoits, 2011). For trauma victims, it may be of high importance to perceive the people around them as supportive. However, many survivors may find it difficult to use this support when they need it. Such barriers to seeking social support may involve perceptions that others have enough with their own problems or that survivors worry about overburdening their friends (Thoresen, Jensen, Wentzel-Larsen, & Dyb, 2014). A study of young survivors of a terrorist attack found that social support barriers were associated with symptoms of PTSD. Further, when controlling for barriers, social support was no longer significantly associated with PTSD symptoms (Thoresen et al., 2014). Another study found that adults with experiences of violence in childhood scored lower on social support and higher on support-seeking barriers (Aakvaag & Strom, 2019), indicating a double negative; not only did they have less support available, they also had trouble utilizing the support that they had.

In addition, many survivors of domestic violence feel shame after their victimization. Trauma-related shame is associated with symptoms of PTSD, and symptoms of anxiety and depression (Aakvaag et al., 2016; La Bash & Papa, 2014), making it a risk factor for mental health problems. Shame is a painful emotion, connected to perceptions that some part of oneself is unattractive to others, and may lead to rejection or devaluation (P. Gilbert, 2000). Thus, shame is closely connected to an individual’s social surroundings, and is for this reason sometimes referred to as a ‘social emotion’ (P. Gilbert, 1997). Shame after violence is not uncommon, and experiencing multiple
types of violence is associated with more shame (Aakvaag et al., 2016; Andrews, Brewin, Rose, & Kirk, 2000). This association may be puzzling, because, after all, why should a person feel shame for having been a victim of violence? The evolutionary psychologist Paul Gilbert sees shame as motivating defensive behaviour, where the individual attempts to protect her- or himself from social devaluation (P. Gilbert, 2000). If shame has as its purpose to protect the individual’s social standing, this should also be the case for violence-related shame. The question, then, is whether victims are justified to worry that others will look down on them or reject them. In the case of shame after sexual violence, researchers have found that stereotypical beliefs about rape and so-called rape myths (for example that rape only happens to women who are careless or deserving; Payne, Lonsway, & Fitzgerald, 1999) are quite common. Domestic violence myths have been researched to a lesser degree, but studies find that they, too, are more common than we would like to think (Policastro & Payne, 2013). One study found that participants ascribed more blame to a woman who returned to her abusive partner than to a woman in a scenario with no such information (Yamawaki, Ochoa-Shipp, Pulsipher, Harlos, & Swindler, 2012). Participants who believed domestic violence myths tended to blame the abused woman more, and men tended to minimize the violence more than female participants did. Further, a meta-study on disclosure after domestic violence found that while women generally reported more positive than negative responses, a mixture of the two appeared to be more common (Sylaska & Edwards, 2013). Negative responses could involve pressuring the victim to act in a certain way, expressing disbelief, blaming the victim, or minimizing the violence. Negative social responses after abuse have been found to be closely linked to poor mental health outcomes (Ullman, Townsend, Filipas, & Starzynski, 2007), and one study found that negative social responses had a stronger effect on mental health than social support (Andrews, Brewin, & Rose, 2003).

Based on this, domestic violence survivors who fear rejection and devaluation from others, may be somewhat realistic in their expectations. Shame may be understood as protecting the individual from harmful social consequences; a woman who is abused by her partner may feel shame based on expectations that friends, family and colleagues would think less of her if they knew about the abuse. These feelings of shame may motivate her not to disclose the abuse, thereby avoiding the social devaluation. However, secrecy may have severe negative consequences. If nobody knows about the abuse, it is more likely to continue. On a societal level, secrecy may mean that the problem is silenced, and does not get the political attention needed. Importantly, secrecy also protects the abuser. For the individual, there may be valuable social support available that victims cannot utilize when they do not share their experiences. It is perhaps not surprising, then, that shame is associated with loneliness (Thoresen, Aakvaag, Strøm, Wentzel-Larsen, & Birkeland, 2018).

In sum, violence may damage victims’ social lives through different pathways. Non-supportive social networks, barriers to support-seeking, and trauma-related shame are risk factors for mental health problems, but can also be negative consequences of violence in and of themselves. Social relationships are important for people’s well-being. The findings discussed here imply that in order to diminish violence-related shame, and improve victims’ social support, there is a need to change social perceptions of domestic violence and its victims, not only those of perpetrators and survivors, but of their social surroundings and society at large as well.

**Psychological treatment of mental health problems after violence**

The devastating impact violence and other types of trauma can have on survivors’ mental health points to the need for psychological treatment of trauma-related mental problems. To date,
a variety of such treatment models exist, for example trauma-focused cognitive behavioural therapy (TF-CBT), narrative exposure therapy, eye-movement desensitization and reprocessing (EMDR), and brief eclectic therapy (for an overview, see Schnyder et al., 2015). While these approaches differ in a number of ways, the following six key interventions have been identified by pioneers in the field: psychoeducation; emotion regulation and coping skills; imaginal exposure; cognitive processing, restructuring, and/or meaning making; targeting emotions; and memory processing (Schnyder et al., 2015). The current recommendation in international clinical guidelines is that adults suffering from PTSD should be offered TF-CBT or EMDR (National Institute for Health and Care Excellence, 2018). TF-CBT programmes include psychoeducation about reactions to trauma, strategies for managing arousal and flashbacks, processing the trauma memory and trauma-related emotions, and restructuring the meaning of the trauma. EMDR includes many of the same interventions, but also repeated exposure combined with in-session bilateral eye-movement stimulation for specific target memories. For children and adolescents, clinicians are also recommended to provide TF-CBT or, for children older than seven years of age, EMDR (National Institute for Health and Care Excellence, 2018). Given the potential detrimental effects domestic violence may have on attachment, several researchers have emphasized the need to target the parent-child relationship in treatment (Borrego, Gutow, Reicher, & Barker, 2008; Humphreys, Mullender, Thiara, & Skamballis, 2006). Strategies towards this end have been developed for various disciplines, and include treatment approaches used not only by psychologists, but also by other professionals, such as social workers and family therapists (Humphreys et al., 2006; Thomas, Abell, Webb, Avdagic, & Zimmer-Gembeck, 2017).

Evidence-based psychological treatment has been found to be effective in treatment of PTSD symptomatology (Kline, Cooper, Rytwinksi, & Feeny, 2018). This gives reason to some optimism for the health and well-being of those affected by domestic violence. However, importantly, many people never seek treatment, and among those who do, some do not recover and some only achieve moderate improvement. Furthermore, for many people exposed to trauma, including domestic violence, health services are unavailable (e.g., too costly). Current innovation in the field of trauma treatment addresses some of these issues; for example, technological advances have made it possible to administer psychological treatment modules online. This is an emerging field, and much is still unknown, but promising results may mean that trauma treatment can be made available for people who would otherwise not have access (Olff et al., 2019).

Conclusion

Traditionally, psychologists who study violence and abuse have tended to focus on mental health consequences. However, the field is moving towards a more comprehensive understanding of how such experiences may influence victims’ lives. Studies on how experiences with violence and abuse influence survivors’ social lives underscore that the psychological impact of violence and abuse go well beyond symptoms of mental health problems. Other areas that violence exposure may influence include work-life participation, financial status, closeness in relationships, and quality of life.

The monumental health effects of violence and abuse combined with evidence that it is prevalent all around the globe imply that violence should be considered a public health issue. Societal efforts are needed to prevent its occurrence, and also to diminish the risk of problems (mental health and otherwise) after exposure. Shame after trauma is pervasive and is one example of a violence-related issue that warrants a societal response. While shame is an emotion
within the person him- or herself, it is highly contingent on the social surroundings of the individual, including myths and perceptions in society at large. Advances in areas such as legislation and law enforcement, as well as political movements like #metoo, may work in a shame-reducing way. While the recent decades have seen important advances in de-shaming various types of violence and abuse, findings discussed in this chapter imply that there is still a way to go to reduce shame after violence, in specific cultures and sub-cultures, but also across cultures.

Critical findings

• Exposure to domestic violence can be considered a trauma. There is a large literature on how traumatic events can impact victims’ psychological functioning.
• Mental health consequences of domestic violence and abuse can be devastating. These can include symptoms of posttraumatic stress disorder (PTSD) and depression, suicidal behaviour, and substance abuse.
• An additional problem for children who experience domestic violence and abuse is that the trauma may disrupt their natural development, including the child-caregiver relationship.
• Social relationships bear importance for how violence impacts a person. Non-supportive social networks, barriers to social support-seeking, and trauma-related shame have all been found to negatively affect mental health after trauma.
• There are several evidence-supported models for the treatment of trauma-related mental health problems.

Implications for policy, practice, and research

• Prevalence estimates imply that domestic violence and abuse affect people all over the world. Domestic violence is often considered a severe trauma, and health consequences can be long-lasting, severe, and complex. Consequently, domestic violence should be considered a public health issue.
• The potential effects of violence and abuse on mental health underscore the importance of a mental health response to domestic violence.
• While there are effective ways to treat mental health problems after trauma, many victims do not have access to treatment. Emerging innovations may help meet this challenge; for example, online treatment modules may make treatment more accessible.
• Shame after violence is pervasive. As shame closely reflects other people’s view, the reduction of shame after violence must entail society at large playing a big part.

Note


References


Through a psychological lens


Helene Flood Aakvaag and Kristin Alve Glad


Through a psychological lens

