

A Traumatology Focus in Trauma Bonding

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Author Note

I have no known conflicts of interest to disclose.

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Abstract

This paper presents a traumatology focus in trauma bonding. A background of trauma in general and its definitions are provided. A description of trauma bonding is presented. The relational environments trauma bonding exists in are included along with the indicators and predictors involved in trauma bonding. Prevalence rates, symptomology, sequelae, comorbidities of trauma bonding specific to its relational environments are discussed. Clinical assessment and treatment considerations are shared. A mixed-methods clinical assessment protocol of the Emotional Quotient Inventory 2.0 (EQi 2.0®) and the Biopsychosocial-Spiritual Model (BPSS) that uses trauma bonding indicators is introduced. Treatment outcomes are presented from trauma bonding predictors. A transtheoretical treatment plan is introduced. A Trauma Bonding Rate of Prevalence Scale is introduced as a future consideration, along with other future research considerations.

Keywords: trauma, trauma bonding, complex trauma, attachment disorder, emotional power differential; mixed-methods clinical assessment; EQi 2.0®, BPSS

Traumatology Focus: Trauma Bonding

Every year in the United States, trauma costs the healthcare industry \$671 billion, is the leading cause of death in children, and kills over 174,000 people; consequentially, creating a never-ending major public health crisis (Coalition for National Trauma Research, n.d.). The nature of trauma is determined by its cause and is subjective to how an individual experiences the traumatic stressor in the form of an event (Berger, 2015; Briere & Scott, 2015; Levers, 2012; van der Kolk, 2014).

According to the *Diagnostic and Statistical Manual of Mental Disorders* [DSM-5] (American Psychiatric Association, 2013), a traumatic stressor is described as, “Any event (or events) that may cause or threaten death, serious injury, or sexual violence to an individual, a close family member, or a close friend” (p. 830). Briere and Scott (2015) more broadly describe trauma as an extremely upsetting traumatic event that temporarily overtakes a person’s “internal resources and produces lasting psychological symptoms” (p. 10). According to the *APA Dictionary of Psychology* (American Psychological Association, 2015) trauma is defined as a disturbing experience from an event caused by a serious physical injury, human behavior, or nature that generates intense, long-term feelings of fear, helplessness, dissociation, and confusion; maladaptively effectuating a person’s affective and cognitive behaviors. When thinking about a prolonged, recurrent traumatic stressor or event in relation to its psychological outcome on the whole person, perhaps the most relevant description that correlates to trauma bonding, is defined by the Center for Substance Abuse Treatment [CSAT], (2014) as “an event, series of events, or set of circumstances ... physically or emotionally harmful or threatening” with “lasting adverse effects on the individual’s functioning and physical, social, emotional, or spiritual well-being” (p. 7).

Trauma Bonding

According to the *APA Dictionary of Psychology* (American Psychological Association, 2015), the term ‘bonding’ refers to the positive, close relationship or attachment, that exists between individuals that exhibits friendship, trust, and alliance with a desire for its continuation. Conversely, according to Carnes (1997), ‘bonding’ is neither negative or positive, but rather neutral; how an individual *uses* the close relationship or attachment is what determines the bond to continue as either positive or negative. Carnes (1997) refers to the *negative use* of a bonding attachment as a *betrayal* by the individual, who is now considered the perpetrator in the relationship; thereby, breaking the trust, disrupting the established, once-believed, positive alliance, and creating a sense of abandonment in the other individual, who is now considered the victim in the relationship.

Dutton and Painter (1993) developed a ‘trauma bonding’ theory described as “powerful emotional attachments” (p. 105) that are developed, continued, and repeated “from two specific features of abusive relationships: power imbalances and intermittent good-bad treatment” (p. 105). According to Dutton and Painter (1993), the power imbalance is created and sustained from the victim’s dependency and powerlessness to the perpetrator who has absolute control and dominance over the victim; fueled by the perpetrator’s intermittent good-bad treatment cycle of abuse, in which trauma bonding dysfunction is at its most powerful and interferes with the victim wanting to leave and influences the victim to stay.

Consequently, trauma bonding is a vicious dysfunctional attachment that thrives within the traumatic feelings of danger, shame, fear, and exploitation (Carnes, 1997; Dutton & Painter, 1993); and while other terms have been used instead of trauma bonding, e.g., traumatic bonding, trauma-coerced attachment, and recidivism, there remains a consensus to its description in lieu of

a standardized definition as follows: *When an individual continues to go back to the perpetrator due to an emotional connection, borne from and sustained through, rewards and punishments to control the individual; and posited to be medically rooted in psychological coercion* (Casassa et al., 2021; Chambers et al., 2022; Department of State, 2022; Deshpande & Nour, 2013; Dutton, 2006; Dutton & Painter, 1993; Kung, 2014; Mumey et al., 2021; Toney-Butler et al., 2022).

Thus, for the purposes of the paper herein, the term *trauma bonding* will be used along with its description by consensus.

The Relational Environments within Trauma Bonding

The relational environments that give life to trauma bonding are highly prevalent and, oftentimes, invisible to societal, cultural, and spiritual frameworks, e.g., prostitution; labor and sex trafficking; kidnapping and hostage situations; domestic and intimate partner violence; dysfunctional relationships; workplace exploitation; incest and child abuse; elder abuse; and addictions like substance abuse, gambling, and sex (Carnes, 1997; Chambers et al., 2022; Dutton, 2006). There is a dysfunctional polarity of positive and negative components that concurrently exists within the trauma bonding attachment, in which perpetrators are visibly nice, loving, and devoted *and* invisibly controlling, manipulative, and emotionally abusive; subsequently, leading the victim to stay in an environment that supports a never-ending cycle of dysfunctional attachment (Bell & Naugle, 2005; Carnes, 1997; Casassa et al., 2021; Dutton & Painter, 1993).

According to Casassa et al. (2021) and Cecchet and Thoburn (2014), the two key factors involved in trauma bonding are first, victims wanting to be loved; and second, victims having a dysfunctional concept of love that includes emotional and physical abuse – both of which stem from adverse childhood experiences. Other factors that strengthen trauma bonding, in which

victims stay or return to the perpetrator, include the following (Adorjan et al., 2012; Bell & Naugle, 2005; Casassa et al., 2021; Dutton & Painter, 1993; Levine, 2017):

- the length of the abusive relationship with the perpetrator;
- the strength of the emotional attachment to the perpetrator;
- lack of family and friends available to help the victim;
- lack of financial and housing resources for the victim;
- custody consideration of involved children between victim and perpetrator;
- low self-esteem, meaning making, and purpose in life of the victim;
- fear of being physically harmed or killed by the perpetrator;
- a sense of helplessness, powerlessness, and self-blame in the victim;
- societal, cultural, and spiritual pressures;
- lack of knowledge about psychological abuse;
- isolation from the outside world;
- feeling demoralized and worthless;
- denial, minimalization, and rationalization of the abuse;
- decreased physical health;
- the perpetrator's promise to change intermittently; and
- the victim feeling trapped with a need to survive.

Conversely, predictors that help break the trauma bond and provide the victim reason(s) to leave the perpetrator, include the following (Bell & Naugle, 2005; Dutton, 2006; Dutton & Painter, 1993; Warria & Chikadzi, 2019):

- increased physical violence and emotional abuse of the perpetrator;
- increased potential of the perpetrator to commit physical violence on children;

- increased emotional abuse of children;
- increased educational and occupational resources for the victim;
- economic independence of the victim;
- increased self-esteem, meaning making, and purpose in the victim's life;
- reconnecting with a faith-based organization by the victim;
- (re)establishment of spirituality in the victim's life; and
- an increased social support system.

While it is important to consider the factors and predictors of why a victim stays or leaves a perpetrator, it is not that simple; if it were, trauma bonding and its relational environments would decrease, and this paper would be negated. It is the opinion of the author herein, that the complexity of trauma bonding is not because of one or two factors and trauma bonding is not broken because of one or two predictors; rather, trauma bonding occurs and is broken as an integrative, morphing, intertwined, dual-capacity-generating, and unified relational concept – each factor or predictor working concurrently, not independently, as a negative or positive motivator within the existing complex trauma bonding relationship.

Prevalence Rates, Symptomology, Sequelae, and Comorbidity of Trauma Bonding

To date, the American Psychiatric Association (2013) has not included trauma bonding, traumatic bonding, trauma-coerced attachment, or recidivism as a separate, diagnosable mental health illness contained in the DSM-5. While the American Psychological Association (2015) includes in the *APA Dictionary of Psychology* the definitions for trauma, bond, bonding, and recidivism (specific to repeat perpetrator criminal behavior), it does not include separate definitions for trauma bonding, trauma-coerced attachment, or recidivism (specific to repeat victim dysfunctional attachment behavior). Thus, it is challenging to estimate overall prevalence

rates as trauma bonding has not been comprehensively studied as a specific disorder outside of a possible subcategory of posttraumatic stress disorder (PTSD) or as a physical and psychological violent act in the numerous relational environments that trauma bonding exists.

Adding to this challenge are the variety of causes and pre-existing risk factors associated with trauma bonding, e.g., emotional dysregulation and dysfunctional attachments rooted in childhood trauma (Carnes, 1997; Walker et al., 2019); lack of societal and healthcare awareness (Correu, 2020; Marburger & Pickover, 2020; Mumey et al., 2021); and misdiagnoses of co-existing primary, secondary, and tertiary diagnoses of depression-, anxiety-, and stress-related conditions, e.g., PTSD, substance abuse, and suicidal tendencies (Center for Substance Abuse Treatment, 2014; Levine, 2017; Wright, 2020) – each with separate prevalence rates, symptomology, sequelae, and comorbidity. Additionally, there is limited research in the trauma bonding generalizability as most studies only include women as the victims and men as the perpetrators, not bidirectional; without a specific, focused consideration of age, ethnicity, sexual orientation, gender identity outside of male and female, culture, or spirituality.

However, trauma bonding, as an attachment disorder phenomenon, has been researched in the following relational environments, which can provide some insight into its symptomology, sequelae, and comorbidity:

- hostage and kidnapping situations (Adorjan et al., 2012);
- human trafficking and prostitution (Casassa et al., 2021; Chambers et al., 2022; Karan & Hansen, 2018; Wright, 2020);
- domestic violence (Dutton, 2006; Dutton & Painter, 1993); and
- intimate partner violence (Bell & Naugle, 2005; Dutton, 2006; Dutton & Painter, 1993; Henderson et al., 2005).

According to the research examined for the paper herein (Adorjan et al., 2012; Bell & Naugle, 2005; Casassa et al., 2021; Chambers et al., 2022; Dutton, 2006; Dutton & Painter, 1993; Henderson et al., 2005; Karan & Hansen, 2018; Wright, 2020), common symptoms associated with experiencing trauma bonding are diverse, dependent on the extent and duration of the perpetrated trauma, and subjective to how the victim perceives the experienced trauma, which may include the following: adjustment disorders; stress-, anxiety-, and obsessive-compulsive disorders, e.g., PTSD and panic attacks; depressive, personality, dissociative, and psychotic disorders; substance use disorders; and emotional and interpersonal dysfunction.

According to the research examined for the paper herein (Adorjan et al., 2012; Bell & Naugle, 2005; Casassa et al., 2021; Chambers et al., 2022; Dutton, 2006; Dutton & Painter, 1993; Henderson et al., 2005; Karan & Hansen, 2018; Wright, 2020), common abnormal conditions, or sequelae, with the potentiated varied symptomology may include the following:

- an increased risk of physical health issues, e.g., sexually transmitted diseases, pelvic pain, vaginal and anal tearing, rectal trauma, urinary tract infections and lifelong urinating issues, repeat coerced abortions, sterility, menstrual issues, self-harming behaviors, broken bones and teeth, burns, scars, concussions, and traumatic brain injury from physical beatings and torture;
- an increased risk of psychological health issues, e.g., low self-esteem; absence of a self-concept or identity; hopelessness; suicidal ideation and tendencies; decreased life satisfaction, meaning making, and purpose in life; reduced problem-solving skills; and
- an increased risk of spiritual issues, e.g., questioning faith and perceptions of God.

The complexity, abundance, and potentiality of the associated symptoms and sequelae of trauma bonding negates the accurate identification of the related comorbidities, in which an “as-presented” approach is recommended.

Clinical Assessment and Treatment Considerations for Trauma Bonding

Because the American Psychiatric Association (2013) has not included trauma bonding as a separate, diagnosable mental health illness in the DSM-5 with associated and concurrently occurring primary, secondary, and tertiary disorders aligned with its symptoms, sequelae, and comorbidities, one approach that could be taken is a traditional clinical assessment to identify and diagnose the primary, secondary, and tertiary disorders with then developing a separate or integrated therapeutic treatment plan. Clinical assessment of a victim’s trauma history and related symptoms through structured and unstructured clinical interviews and psychological assessments help determine any immediate life threat, psychological stability, stress tolerance, and other related elements, e.g., the severity of trauma, risks of self-harm and aggression, and possible substance use disorders (Briere & Scott, 2015; Briere et al., 2015; Center for Substance Abuse Treatment, 2014; Evans, 2012). A clinical assessment and treatment approach that is anchored in humanistic psychology is person-centered and supports the victim’s autonomy throughout the therapeutic process (Center for Substance Abuse Treatment, 2014). Also important is an affirmative, safe, and culturally, spatially, and linguistically supportive setting throughout the assessment and treatment process (Center for Substance Abuse Treatment, 2014). When selecting the appropriate psychological assessment there are several considerations, e.g., identify the purpose, consider the victim population, and confirm the measure’s validity and availability (Center for Substance Abuse Treatment, 2014).

Other considerations in clinical assessment and treatment that were uniformly recommended according to the research examined for the paper herein (Adorjan et al., 2012; Bell & Naugle, 2005; Casassa et al., 2021; Chambers et al., 2022; Dutton, 2006; Dutton & Painter, 1993; Henderson et al., 2005; Hopper, E. K., 2017; Karan & Hansen, 2018; Wright, 2020), included prioritizing the victim's safety, rights, and dignity; actively involving the victim in the treatment process; and using psychoeducational counseling with or without pharmacological treatment in the victim's realization of a dysfunctional attachment in trauma bonding. The common, recommended pharmacological treatments used in conjunction with psychotherapy for the complex symptoms of trauma bonding, according to Chambers et al. (2022), include the selective serotonin reuptake inhibitors of Fluoxetine and Paroxetine for use with depressive and anxiety disorders, and the serotonin-norepinephrine reuptake inhibitor of Venlafaxine for use with numerous disorders, e.g., major depressive, anxiety, obsessive-compulsive, and social phobia. However, pharmacological treatment should be used only with victims who experience high levels of symptomatology and cannot tolerate the heightened activation and stress involved in the therapeutic processing of their trauma (Briere & Scott, 2015).

Spiritual considerations in the clinical assessment and treatment plan also can be incorporated with faith-based victims, in which the Holy Spirit, agape love, and God's Living Word guide the following principles for effective spiritual counseling (Tan, 2011): depend on the Holy Spirit; use the Bible as a counseling guide; pray; be of good spiritual constitution; be flexible; and use Scripturally consistent counseling techniques, e.g., 2 Corinthians 3:18 – "But we all, with open face beholding as in a glass the glory of the Lord, are changed into the same image from glory to glory, *even* as by the Spirit of the Lord" (*Holy Bible*, 1964).

Numerous clinical assessments are available that gather data in efforts to accurately diagnose the mental health illness(es) that are occurring, and there are numerous therapeutic treatment approaches that can be used depending on the diagnosed mental health illness; subsequently, the clinical assessment, treatment approach, and therapeutic treatment plan should be targeted to the needs of the client (Levers, 2012; Briere & Scott, 2015). According to the research examined for the paper herein (Briere & Scott, 2015; Casassa et al., 2021; Chambers et al., 2022; Department of State, 2022; Hopper, 2017; Levers, 2012; Tan, 2011; Toney-Butler et al., 2022), treatment approaches that could be integratively or separately used for trauma bonding victims, within the relational environments discussed herein, who suffer from complex physical, psychological, and spiritual symptomology, sequelae, and potential comorbidities include the following: victim-centered; survivor-informed; trauma-informed; culturally competent; and Christ-centered.

However, when a client presents with trauma bonding symptoms it is important to remember that the author herein considers trauma bonding as an integrative, morphing, intertwined, dual-capacity-generating, and unified relational concept, in which each factor or predictor work concurrently, not independently, as a negative or positive motivator within the existing complex trauma bonding relationship. Thus, the clinical assessment, treatment approach, and therapeutic treatment plan should parallel trauma bonding and how it exists within the victim; conducted by a highly skilled, educated, and trained therapist in trauma bonding. Also important, is the need for the American Psychiatric Association to clearly define, create, and include trauma bonding as a separate mental health illness so more mental health professionals can better identify, diagnose, and treat trauma bonding in its relational environments and diversified demographic populations.

Proposed Clinical Assessments for Trauma Bonding

Interestingly, and in the opinion of the author herein, the factors associated with a victim's reason to stay or return to the perpetrator can also be used as indicators (adapted from Adorjan et al., 2012; Bell & Naugle, 2005; Casassa et al., 2021; Dutton & Painter, 1993; Levine, 2017) of trauma bonding. For instance, during the clinical assessment and diagnosis of the presenting trauma, indicators to look for include the following:

- relationship length;
- emotional attachment strength;
- little or no family and friends along with isolating behaviors;
- financial and housing dependency;
- children in the relationship;
- low self-esteem;
- decreased meaning making and purpose in life;
- fear of being physically harmed or killed;
- feeling helpless, powerless, demoralized, and worthless with self-blaming tendencies;
- pressures from external societal, cultural, and spiritual frameworks;
- cannot define or describe psychological abuse;
- denies, minimalizes, or rationalizes any perceived abuse;
- decreased physical health;
- feeling trapped with a need to survive; and
- believing the perpetrator will change after repeated, yet intermittent abuses.

The two clinical assessments chosen to help identify trauma bonding are the Emotional Quotient Inventory 2.0 [EQi 2.0®] (see Addendum A; Bar-On, 1997; Multi-Health Systems, Inc., 2011)

and the Biopsychosocial-Spiritual Model [BPSS] (see Addendum B; Robinson & Taylor, 2017).

The proposed chronological administration would be to conduct the quantitative EQi 2.0® measure first, and the qualitative BPSS measure second; thereby, taking a mix-methods assessment approach with the potentiality of introducing a new protocol to identify and diagnose trauma bonding (see Addendum C).

Proposed Treatment Approach for Trauma Bonding

Interestingly, and in the opinion of the author herein, the predictors associated with a victim's reason to leave the perpetrator can also be used in the victim's therapeutic treatment plan that routinely begins with the treatment outcomes. For instance, after the clinical assessment and diagnosis of trauma bonding, treatment outcomes to establish include the following (adapted from Adorjan et al., 2012; Bell & Naugle, 2005; Casassa et al., 2021; Dutton & Painter, 1993; Levine, 2017):

- how to remove the increased physical and emotional abuse of the perpetrator;
- how to remove the potentiality of physical abuse by the perpetrator on the children;
- how to alleviate any current and future emotional abuse of the children;
- how to obtain an education or vocational training toward financial independence;
- how to develop self-esteem, meaning making, and purpose in life;
- how to establish a physically healthy lifestyle;
- if appropriate, how to reconnect and (re)establish spirituality with a faith-based organization; and
- how to identify and increase affirmative support systems.

It is recommended that treatment outcomes be periodically checked throughout the therapeutic treatment process (Levers, 2012; Briere & Scott, 2015) with the same quantitative and qualitative

assessment measures of the EQi 2.0® and BPSS, respectively; thereby, showing the victim and therapist whether the therapeutic treatment plan is working and how the treatment plan may need to be adapted along the way.

It is the opinion of the author herein that an integrative, adaptive, affirmative, and transtheoretical treatment plan be developed that works in tandem with the proposed clinical assessments of the EQi 2.0® and BPSS *and* parallel to the complex nature of trauma bonding and its associated treatment outcomes. The transtheoretical treatment plan would include methodologies, strategies, and principles from the domains of positive psychology, applied creativity, spirituality, and emotional-social intelligence as supported by the following –

- Historical and more contemporary literature suggests that an affirmative environment allows an individual to heal, grow, and thrive in their positive psychological health (Duckworth et al., 2005; Jahoda, 1958; Jahoda, 1953; Peterson & Seligman, 2004; Yalom & Leszcz, 2005).
- Literature suggests that transcendence and growth within an individual occurs from the ability to problem solve in an environment that utilizes the cognitive and affective skills found in applied creativity (Brown, 2009; Parnes, 1981; Puccio et al., 2011). Research also suggests that engaging in creative activities offer posttraumatic growth and healing benefits (Kaufman, 2014).
- Research shows the importance of individuals experiencing agape love in a therapeutic environment (Entwistle, 2015; Hage, 2006; Tan, 2011), in addition to the Biblical precedent of Matthew 19:26 – “But Jesus beheld *them*, and said unto them, With men this is impossible; but with God all things are possible” (*Holy Bible*, 1964).

- Literature and research suggest that reframing the emotional-social intelligence competencies as learned skills can serve as a baseline for behavioral modification (Bar-On, 2006; Bar-On, 1997; Bar-On, 1988; Kaufman, 2014; Multi-Health Systems, Inc., 2011; Stein & Book, 2006).

A proposed transtheoretical treatment plan, in the form of a psychoeducational group for human trafficked victims suffering from trauma bonding, has been developed from the proposed mix-methods clinical assessment protocol with treatment outcomes previously established by author herein (see Addendum D; Dorey et al., 2019).

Conclusions and Future Research

While prevalence rates specific to trauma bonding could not be accurately obtained as noted in the *Prevalence Rates, Symptomology, Sequelae, and Comorbidity of Trauma Bonding* section (see page 7), research presented herein (Adorjan et al., 2012; Bell & Naugle, 2005; Casassa et al., 2021; Chambers et al., 2022; Dutton, 2006; Dutton & Painter, 1993; Henderson et al., 2005; Karan & Hansen, 2018; Levine, 2017; Wright, 2020), shows that trauma bonding is the dominating health concern in the relational environments of prostitution, human trafficking, domestic violence, interpersonal violence, and hostage-kidnapping situations; and that trauma bonding affects all people regardless of age, gender, sexual orientation, socio-economic status, race, religion, or nationality. General statistics, however, have been obtained as follows –

- According to the National Coalition Against Domestic Violence (n.d.), domestic violence and interpersonal violence affect 10 million women and men every year: 1 in 4 women and 1 in 10 men experience physical abuse, respectively; and 4 in 10 women and men each experience psychological abuse, respectively.

- According to the United Nations (2021), human trafficking, which includes the sex trade of prostitution, affects 40 million people every year with 65% female and 35% male; and the United States leads all the global countries in demand.
- According to Hostage US (n.d.), an average of 200–300 Americans are taken hostage every year.

With the general statistics and research presented herein (Adorjan et al., 2012; Bell & Naugle, 2005; Casassa et al., 2021; Chambers et al., 2022; Dutton, 2006; Dutton & Painter, 1993; Henderson et al., 2005; Karan & Hansen, 2018; Levine, 2017; Wright, 2020), it can be concluded that trauma bonding is a dominating, maladaptive behavior and force that mandates its prioritization as a separate, independent mental health illness from the American Psychiatric Association.

Future research considerations include the following –

1. Studying the trauma bonding relationship as a two-person transactional system as reflected in Bronfenbrenner's Bioecological Systems Theory (Hertler et al., 2018; Shelton, 2019) to advance how trauma bonding indicators and predictors work within the transactional nature of the dyadic trauma bonding relationship.
2. Studying the family structure from a generational, maladaptive cycle of childhood trauma perspective to stop the dysfunctional cycle from becoming functional.
3. Continuing the development of a Trauma Bonding Rate of Prevalence Scale (TBRPS), by author herein, so trauma bonding can be specifically researched in its relational environments and diversified demographic populations.

4. Conducting longitudinal research studies that take an integrated, multi-modality treatment approach toward studying the indicators of trauma bonding development and the predictors of trauma bonding breaking.
5. Studying how learned emotional-social intelligence skills, e.g., self-esteem, reality testing, decision-making, stress management, optimism, and interpersonal relationships, can prevent or break trauma bonding.

As often is done with faith-based counselors, a closing prayer is offered for the millions of victims and thousands of mental health professionals who work together every day to triumph over the physical, psychological, and spiritual effects of trauma bonding: “He healeth the broken in heart, and bindeth up their wounds” (Psalms 147:3; *Holy Bible*, 1964).

References

- Adorjan, M., Christensen, T., Kelly, B., & Pawluch, D. (2012). Stockholm syndrome as vernacular resource. *The Sociological Quarterly*, 53(3), 454–474.
<https://doi.org/10.1111/j.1533-8525.2012.01241.x>
- American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders (DSM-5)*. (5th ed.). American Psychiatric Association Publishing.
- American Psychological Association. (2015). *APA dictionary of psychology*. (2nd ed.). VandenBos, G. R. (Ed.). American Psychological Association.
- Bar-On, R. (2006). The Bar-On model of emotional-social intelligence (ESI). *Psicothema*, 18(Suplemento), 13–25.
- Bar-On, R. (1997). *Bar-On emotional quotient inventory: Technical manual*. Multi-Health Systems, Inc.
- Bar-On, R. (1988). *The development of a concept of psychological well-being* (Publication No. 10962/d1002437) [Doctoral dissertation, Rhodes University]. South East Academic Libraries System Global View. <http://hdl.handle.net/10962/d1002437>
- Bell, K. M., & Naugle, A. E. (2005). Understanding stay/leave decisions in violent relationships: A behavior analytic approach. *Behavior and Social Issues*, 14(1), 21–45.
<https://doi.org/10.5210/bsi.v14i1.119>
- Berger, R. (2015). *Stress, trauma, and posttraumatic growth: Social context, environment, and identities*. Routledge.
- Briere, J. N., & Scott, C. (2015). *Principles of trauma therapy: A guide to symptoms, evaluation, and treatment*. (2nd ed.). SAGE Publications, Inc.

- Briere, J. N., Scott, C., & Jones, J. (2015). The effects of trauma. In J. N. Briere & C. Scott *Principles of trauma therapy: A guide to symptoms, evaluation, and treatment*. (2nd ed., pp. 25–61). SAGE Publications, Inc.
- Brown, S. (2009). *Play: How it shapes the brain, opens the imagination, and invigorates the soul*. Penguin Group.
- Carnes, P. J. (1997). *The betrayal bond: Breaking free of exploitive relationships*. Health Communications, Inc.
- Casassa, K., Knight, L., & Mengo, C. (2021). Trauma bonding perspectives from service providers and survivors of sex trafficking: A scoping review. *Trauma, Violence, & Abuse*. Advanced online publication, 1–16. <https://doi.org/10.1177/1524838020985542>
- Cecchet, S. J., & Thoburn, J. (2014). The psychological experience of child and adolescent sex trafficking in the United States: Trauma and resilience in survivors. *Psychological Trauma: Theory, Research, Practice, and Policy*, 6(5), 482–493. <https://doi.org/10.1037/a0035763>
- Center for Substance Abuse Treatment. (2014). *Trauma-informed care in behavioral health services*. Treatment Improvement Protocol (TIP) Series, No. 57. HHS Publication No. (SMA) 14–4816. Substance Abuse and Mental Health Services Administration. <https://www.ncbi.nlm.nih.gov/books/NBK207201/>
- Chambers, R., Gibson, M., Chaffin, S., Takagi, T., Nguyen, N., & Mears-Clark, T. (2022). Trauma-coerced attachment and complex PTSD: Informed care for survivors of human trafficking. *Journal of Human Trafficking*, Open Access Article. <https://doi.org/10.1080/23322705.2021.2012386>

- Coalition for National Trauma Research (n.d.). *Mission of the coalition for national trauma research*. Retrieved October 5, 2022, from <https://www.nattrauma.org/who-we-are/mission/>
- Correu, J. C. (2020). *Evaluating the effectiveness of the type and level of human trafficking victims' services received against recidivism rates in the San Antonio metro area* (Order No. 28314650) [Doctoral dissertation, Northcentral University]. ProQuest Dissertations and Theses Global.
- Department of State. (2022). *2022 Trafficking in persons report*. (22nd ed.). United States of America.
- Deshpande, N. A., & Nour, N. M. (2013). Sex trafficking of women and girls. *Reviews in Obstetrics & Gynecology*, 6(1), e22–e27. Retrieved from <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3651545/>
- Dorey, K., Patel, R., & Fanwi, S. K. (2019, January 30–February 2). *The Dorey method® program of integrated study: An innovative and dynamic approach to restoration after trauma* [Poster presentation]. Building the Next Generation of Academic Physicians 10th Year Anniversary Conference and 2nd Pre-Faculty Conference, University of Arizona, Phoenix, AZ, United States.
- Duckworth, A. L., Steen, T. A., & Seligman, M. E. P. (2005). Positive psychology in clinical practice. *Annual Review of Clinical Psychology*, 1, 629–651.
<https://doi.org/10.1146/annurev.clinpsy.1.102803.144154>
- Dutton, D. G. (2006). *Rethinking domestic violence*. UBC Press.

Dutton, D. G., & Painter, S. (1993). Emotional attachments in abusive relationships: A test of traumatic bonding theory. *Violence and Victims*, 8(2), 105–120.

<https://doi.org/10.1891/0886-6708.8.2.105>

Entwistle, D. E. (2015). *Integrative approaches to psychology and Christianity: An introduction to worldview issues, philosophical foundations, and models of integration*. (3rd ed.). Cascade Books.

Evans, F. B. (2012). Assessment in psychological trauma: Methods and intervention. In L. L. Levers (Ed.) *Trauma counseling: Theories and interventions* (pp. 471–492). Springer Publishing Company, LLC.

Hage, S. M. (2006). A closer look at the role of spirituality in psychology training programs. *Professional Psychology: Research and Practice*, 37(3), 303–310.

<https://doi.org/10.1037/0735-7028.37.3.303>

Henderson, A. J. Z., Bartholomew, K., Trinke, S. J., & Kwong, M. J. (2005). When loving means hurting: An exploration of attachment and intimate abuse in a community sample.

Journal of Family Violence, 20(4), 219–230. <https://doi.org/10.1007/s10896-005-5985-y>

Hertler S. C., Fernandes, H. B. F., Figueredo, A. J., Penaherrera-Aguirre, M., & Woodley of

Menie, M. A. (2018). Urie Bronfenbrenner: Toward an evolutionary ecological systems theory. In Hertler et al. (Eds.), *Life history evolution: A biological meta-theory for the social sciences* (pp. 323–339). Palgrave Macmillan. https://doi.org/10.1007/978-3-319-90125-1_19

Holy Bible. (Authorized or King James Version). 1964. (Red Letter ed.). Heirloom Bible Publishers, Inc.

- Hopper, E. K. (2017). Trauma-informed psychological assessment of human trafficking survivors. *Women & Therapy, 40*(1–2), 12–30.
<https://doi.org/10.1080/02703149.2016.1205905>
- Hostage US. (n.d.). *Information about kidnapping*. Retrieved on October 8, 2022, from <https://hostageus.org/media/information-about-kidnapping/>
- Jahoda, M. (1958). *Current concepts of positive mental health*. Basic Books.
<https://doi.org/10.1037/11258-000>
- Jahoda, M. (1953). The meaning of psychological health. *Social Casework, 34*(8), 349–354.
<https://doi.org/10.1177/104438945303400805>
- Karan, A., & Hansen, N. (2018). Does the Stockholm syndrome affect female sex workers? The case for a ‘sonagachi syndrome.’ *BMC International Health and Human Rights, 18*, Article 10. <https://doi.org/10.1186/s12914-018-0148-4>
- Kaufman, J. C. (Ed.). (2014). *Creativity and mental illness*. Cambridge University Press.
- Kung, J. (2014). *Sex trafficking: An exploration of clinician perspectives of the type and efficacy of treatment interventions* [Master’s thesis, Smith College]. Smith Scholar Works.
<https://scholarworks.smith.edu/theses/764>
- Levers, L. L. (Ed.). (2012). *Trauma counseling: Theories and interventions*. Springer Publishing Company, LLC.
- Levine, J. A. (2017). Mental health issues in survivors of sex trafficking. *Cogent Medicine, 4*(Article 1278841), 1–13. <http://doi.org/10.1080/2331205X.2017.1278841>
- Marburger, K., & Pickover, S. (2020). A comprehensive perspective on treating victims of human trafficking. *The Professional Counselor, 10*(1), 13–24.
<http://doi.org/10.15241/km.10.1.13>

Multi-Health Systems, Inc. (2011). *EQ-i® 2.0 manual*. Multi-Health Systems, Inc.

Mumey, A., Sardana, S., Richardson-Vejlgaard, R., & Akinsulure-Smith, A. M. (2021). Mental health needs of sex trafficking survivors in New York City: Reflections on exploitation, coping, and recovery. *Psychological Trauma: Theory, Research, Practice, and Policy*, 13(2), 185–192. <https://doi.org/10.1037/tra0000603>

National Coalition Against Domestic Violence. (n.d.). *Statistics*. Retrieved on October 7, 2022, from <https://ncadv.org/STATISTICS>

Parnes, S. (1981). *The magic of your mind*. The Creative Education Foundation, Inc.

Peterson, C., & Seligman, M. E. P. (2004). *Character strengths and virtues: A handbook and classification*. American Psychological Association and Oxford University Press.

Puccio, G. J., Murdock, M. C., & Mance, M. (2011). *Creative leadership: Skills that drive change*. (2nd ed.). SAGE Publications, Inc.

Robinson, W., & Taylor, N. (2017). Assessment, biopsychosocial. In J. Carlson & S. B. Dermer (Eds.) *The SAGE encyclopedia of marriage, family, and couples counseling* (Vol. 1, pp. 84–90). SAGE Publications, Inc. <https://www.doi.org/10.4135/9781483369532.n25>

Shelton, L. G. (2019). *The Bronfenbrenner primer: A guide to develecology*. Routledge.

Stein, S. J., & Book, H. E. (2006). *The EQ edge: Emotional intelligence and your success*. (3rd ed.). Jossey-Bass.

Tan, S-Y. (2011). *Counseling and psychotherapy: A Christian perspective*. Baker Academic.

Toney-Butler, T. J., Ladd, M., & Mittel, O. (2022). *Human trafficking*. StatPearls Publishing. Retrieved from <https://www.ncbi.nlm.nih.gov/books/NBK430910/>

United Nations. (2021). *Global report on trafficking in persons 2020*. United Nations.

https://www.unodc.org/documents/data-andanalysis/tip/2021/GLOTiP_2020_15jan_web.pdf

van der Kolk, B. A. (2014). *The body keeps the score: Brain, mind, and body in the healing of trauma*. Penguin Books.

Walker, H. E., Freud, J. S., Ellis, R. A., Fraine, S. M., & Wilson, L. C. (2019). The prevalence of sexual revictimization: A meta-analytic review. *Trauma, Violence, & Abuse*, 20(1), 67–80. <https://doi.org/10.1177/1524838017692364>

Warria, A., & Chikadzi, V. (2019). Guidelines for social work spiritual counselling in human trafficking cases. *Journal of Social Development in Africa*, 34(2), 39–65.

Wright, C. V. (2020). Foundations of PTSD treatments. In L. F. Bufka, C. V. Wright, & R. W. Halfond (Eds.), *Casebook to the APA Clinical Practice Guideline for the treatment of PTSD* (pp. 21–46). American Psychological Association.
<https://doi.org/10.1037/0000196-002>

Yalom, I. D., & Leszcz, M. (2005). *The theory and practice of group psychotherapy*. (5th ed.). Basic Books.

Addendum A

The EQi® 2.0 Model of Emotional Intelligence (Bar-On, 1997; Multi-Health Systems, Inc., 2011)

EQ-i 2.0 Model of Emotional Intelligence

**SELF-PERCEPTION**

Self-Regard is respecting oneself while understanding and accepting one's strengths and weaknesses. Self-Regard is often associated with feelings of inner strength and self-confidence.

Self-Actualization is the willingness to persistently try to improve oneself and engage in the pursuit of personally relevant and meaningful objectives that lead to a rich and enjoyable life.

Emotional Self-Awareness includes recognizing and understanding one's own emotions. This includes the ability to differentiate between subtleties in one's own emotions while understanding the cause of these emotions and the impact they have on one's own thoughts and actions and those of others.

STRESS MANAGEMENT

Flexibility is adapting emotions, thoughts and behaviors to unfamiliar, unpredictable, and dynamic circumstances or ideas.

Stress Tolerance involves coping with stressful or difficult situations and believing that one can manage or influence situations in a positive manner.

Optimism is an indicator of one's positive attitude and outlook on life. It involves remaining hopeful and resilient, despite occasional setbacks.

**SELF-EXPRESSION**

Emotional Expression is openly expressing one's feelings verbally and non-verbally.

Assertiveness involves communicating feelings, beliefs and thoughts openly, and defending personal rights and values in a socially acceptable, non-offensive, and non-destructive manner.

Independence is the ability to be self directed and free from emotional dependency on others. Decision-making, planning, and daily tasks are completed autonomously.

DECISION MAKING

Problem Solving is the ability to find solutions to problems in situations where emotions are involved. Problem solving includes the ability to understand how emotions impact decision making.

Reality Testing is the capacity to remain objective by seeing things as they really are. This capacity involves recognizing when emotions or personal bias can cause one to be less objective.

Impulse Control is the ability to resist or delay an impulse, drive or temptation to act and involves avoiding rash behaviors and decision making.

INTERPERSONAL

Interpersonal Relationships refers to the skill of developing and maintaining mutually satisfying relationships that are characterized by trust and compassion.

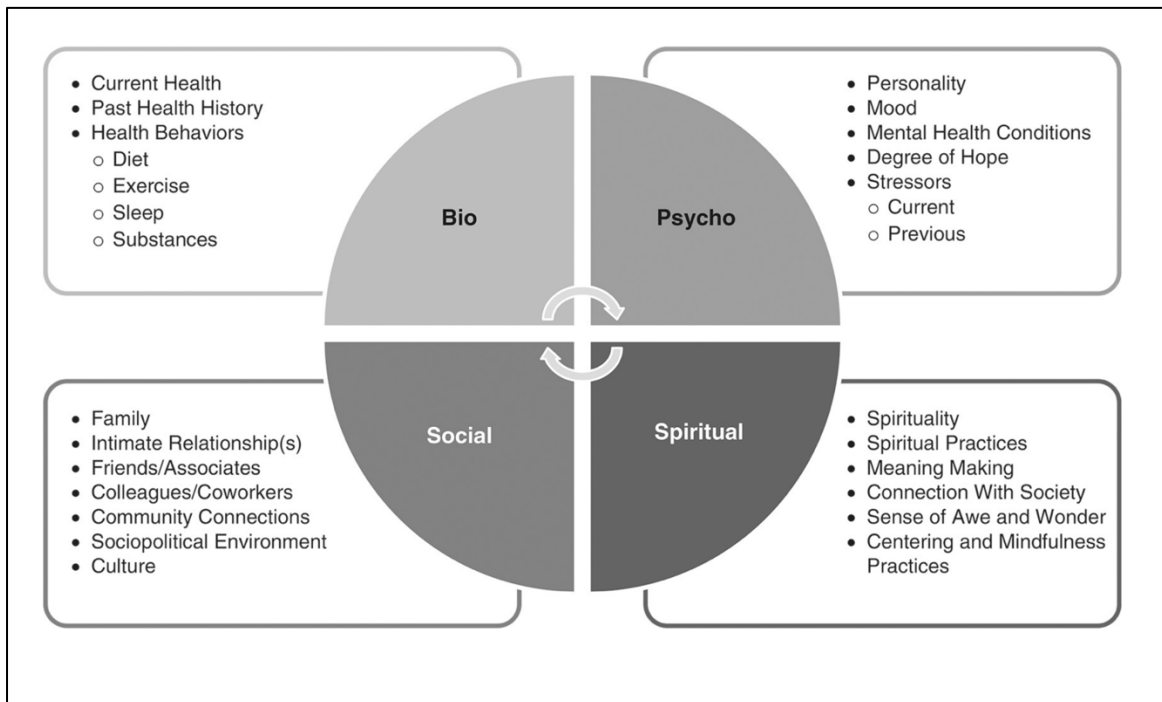
Empathy is recognizing, understanding, and appreciating how other people feel. Empathy involves being able to articulate your understanding of another's perspective and behaving in a way that respects others' feelings.

Social Responsibility is willingly contributing to society, to one's social groups, and generally to the welfare of others. Social Responsibility involves acting responsibly, having social consciousness, and showing concern for the greater community.

Based on the Bar-On EQ-i model by Reuven Bar-On, copyright 1997.
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Addendum B**Biopsychosocial-Spiritual Model (Robinson & Taylor, 2017)**

Addendum C

Mixed-Methods Clinical Assessment Approach

| Emotional Quotient Inventory 2.0® (Bar-On, 1997; Multi-Health Systems, Inc., 2011) | Biopsychosocial-Spiritual Model (Robinson & Taylor, 2017) |
|--|---|
| SELF-PERCEPTION <ul style="list-style-type: none"> ○ low self-esteem ○ decreased meaning making and purpose in life ○ feeling helpless, powerless, demoralized, and worthless with self-blaming tendencies ○ denies, minimalizes, or rationalizes any perceived abuse | BIO <ul style="list-style-type: none"> ○ decreased physical health |
| SELF-EXPRESSION <ul style="list-style-type: none"> ○ feeling helpless, powerless, demoralized, and worthless with self-blaming tendencies ○ pressures from external societal, cultural, and spiritual frameworks ○ cannot define or describe psychological abuse ○ denies, minimalizes, or rationalizes any perceived abuse | PSYCHO <ul style="list-style-type: none"> ○ low self-esteem ○ emotional attachment strength ○ fear of being physically harmed or killed ○ feeling helpless, powerless, demoralized, and worthless with self-blaming tendencies ○ cannot define or describe psychological abuse ○ denies, minimalizes, or rationalizes any perceived abuse ○ feeling trapped with a need to survive ○ believing the perpetrator will change after repeated, yet intermittent abuses |
| INTERPERSONAL <ul style="list-style-type: none"> ○ emotional attachment strength ○ cannot define or describe psychological abuse ○ believing the perpetrator will change after repeated, yet intermittent abuses | SOCIAL <ul style="list-style-type: none"> ○ relationship length ○ little or no family and friends along with isolating behaviors ○ financial and housing dependency ○ emotional attachment strength ○ children in the relationship ○ pressures from external societal, cultural, and spiritual frameworks |
| DECISION MAKING <ul style="list-style-type: none"> ○ pressures from external societal, cultural, and spiritual frameworks ○ denies, minimalizes, or rationalizes any perceived abuse ○ feeling trapped with a need to survive ○ believing the perpetrator will change after repeated, yet intermittent abuses | SPIRITUAL <ul style="list-style-type: none"> ○ decreased meaning making and purpose in life |
| STRESS MANAGEMENT <ul style="list-style-type: none"> ○ fear of being physically harmed or killed ○ pressures from external societal, cultural, and spiritual frameworks | |

Addendum D

Proposed Transtheoretical Treatment Plan

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Psychoeducational Group Proposal: Trauma Bonding in Human Trafficking Survivors

Kathysue Dorey
Liberty University

1

“Human trafficking erodes personal dignity and destroys the moral fabric of society. It is an affront to humanity that tragically reaches all parts of the world.”

President Donald J. Trump

(Department of State, 2020, p. 5)

2

Contents



3

Definition of Human Trafficking

- “The United States considers *trafficking in persons*, *human trafficking*, and *modern slavery* to be interchangeable umbrella terms that refer to both sex and labor trafficking” (Department of State, 2020, p. 3).
- The Trafficking Victims Protection Act (TVPA) defines human trafficking as “sex trafficking in which a commercial sex act is induced by force, fraud, or coercion ... and is the recruitment, harboring, transportation, provision, or obtaining of a person for labor or services, through ... force, fraud, or coercion for the purpose of subjection to involuntary servitude, peonage, debt bondage, or slavery” (Department of State, p. 10).

4

Definition of Trauma Bonding

- Specifically in human trafficking, *Trauma Bonding* potentially* refers to the relationship between the trafficker and the victim within the cycles of abuse where an emotional connection is borne from and sustained by using rewards and punishments to control the victim; and is posited to be medically rooted in psychological coercion (Department of State, 2020).

*There is currently no medical standard for diagnosis, agreed upon definition, or definitive understanding of its prevalence on trafficking victims (Department of State).

5

Global Overview

- Human trafficking is a \$150 billion worldwide industry that affects 40 million people; 35% are male and 65% are female; and the United States leads all the countries in demand (International Labour Organization, 2017; United Nations Office on Drugs and Crime, 2021).

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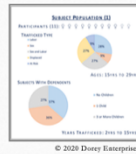
Addendum D (continued)

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Why the Psychoeducational Group?

- Psychoeducational groups do not normally provide therapy for those in crisis with an identifiable challenge (Brown, 2018); however, because of the complex nature of *Trauma Bonding* concurrently with its lack of understanding and available medical diagnoses (Department of State, 2020), the educational format of the psychoeducational group would lend itself to gather data for research and evaluative purposes (Yalom & Leszcz, 2005).



7

Why the Psycho-educational Group? (con't.)

- A *hybrid** group focusing on the inner resources from the Personal Development and Prevention Group format; and inner strength building from the Development Group format [is recommended] (Brown, 2018).

*An integrative approach of incorporating affective and cognitive therapeutic interventions (Farr, 2000).



8

Group Demographics

- Sex or labor trafficked – or a combination of both
- Current trafficking status is *free*
- Female-only participants
- 18 years of age and older
- Ethnically and racially diverse
- English speaking with a 6th grade reading and writing comprehension level
- May or may not have children from trafficking experience



9

Group Design and Rationale

One female group leader

- Female group leaders have a greater influence on empowering members along with creating affirmative outcomes like cohesion (Post, 2015).

Homogeneous closed group for females

- To gain trust and cohesiveness quickly with the goal of in-depth interpersonal behavior, the cohesiveness theory advocates for the homogeneous composition (Yalom & Leszcz, 2005).

Location

- Secure and confidential facility at a faith-based organization as they are strategically located and widely considered safe (Department of State, 2020).

10

Group Design and Rationale (con't.)

Six to ten female participants

- This is an average number of participants selected for brief group therapy in which personal, emotional-social learning is at its greatest advantage (Brown, 2018).

Installment One

- 12 weeks (once per week) – 3 hours per session
- Installment One with option to continue for a second installment (Yalom & Leszcz, 2005); giving group a chance to focus on the successfulness of identified therapeutic interventions for *Trauma Bonding*.

11

Inclusionary Criteria*

1. Should be motivated with a sense of responsibility and commitment to Self and the group process (Yalom & Leszcz, 2005).
2. According to the 2020 *Trafficking In Persons Report* (Department of State, 2020), human trafficking survivors showcase the following *Trauma Bonding* behavior:
 - a lack of emotional independence;
 - a sense of despair and overall pessimistic outlook in life; and
 - have relapsed a minimum of one time back to their previous way of life.

*Both criteria 1 and 2 must be met for a participant's inclusion into the group.

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Addendum D (continued)

Proposed Transtheoretical Treatment Plan

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Group Leader Expectations

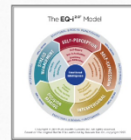
- Establish and facilitate trust from and between the group members (Yalom & Leszcz, 2005).
- Create a safe and affirming environment for group members (Brown, 2018).
- Model the concept of failing forward (Maxwell, 2000).
- Remain focused on the behavior of *Trauma Bonding* with appropriately selected and targeted exercises, interventions, and homeplay* (Furr, 2000).
- Be flexible and adaptive to the group process as it organically transpires (Furr).

**Homeplay is a more affirmative, fun way to accomplish homework for the group members. It is this group leader's preferred term after researching the importance of playfulness as an affective skill (Pinto et al., 2011).*

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Prescreening Evaluation #1: EQi®



The Emotional Quotient Inventory (EQi®) was chosen for two purposes (Bar-On, 1997; Multi-Health Systems, Inc., 2011):

- to establish a baseline in the competencies of *Self Regard, (Emotional) Independence, Optimism, and Problem Solving*, along with the level of *Happiness*; and
- to gather data and evaluate the therapeutic interventions used to better define and understand *Trauma Bonding* and its cognitive and affective behaviors with trafficked survivors.

14

Prescreening Evaluation #2: BPSS

The biopsychosocial-spiritual (BPSS) assessment (Robinson & Taylor, 2017) was chosen for two purposes:

- because of its integrative approach to evaluating an individual; and
- to help identify an individual's level of motivation, responsibility, and commitment to Self and others as required in the Inclusionary Criteria.



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Ethical and Legal Concerns – Group

Informed Consent with Social Media Policy & Confidentiality Disclosure (Yalom & Leszcz, 2005; Brown, 2018) –

- Share the group leader's therapeutic experiences, academic credentials, and trauma-related experiences in order to model risk-taking and authenticity in the self-disclosure process.
- Share the in-group behaviors expected from the group leader and members.
- Share and explain the appropriate social media behavior from the group members.
- Share how confidentiality is expected from the group leader and members.

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Ethical and Legal Concerns – Informal Research
aligned with the International Review Board requirements (FDA, n.d.)

Informed Consent – separate from the Group Informed Consent.

- Includes background and reasoning related to the *Trauma Bonding* relationship; there are minimal risks involved; it is 100% voluntary and not required to participate in Group; and data gathered is confidential without identities being revealed.

Qualitative – the group leader will examine the group members' emotional-social functioning competencies and their impact, if any, from using cognitive and affective strategies and exercises to break the *Trauma Bonding* relationship.

17

Ethical and Legal Concerns – Informal Research (con't.)
aligned with the International Review Board requirements (FDA, n.d.)

Quantitative – the EQi® will be administered pre-Group and post-Group to determine an overall emotional-social intelligence baseline score (pre) and then to see if there is any change from the baseline score (post).

- *Self Regard, (Emotional) Independence, Optimism (Hope and Resiliency), and Problem Solving* with the *Happiness* indicator will be of particular importance as these correlate to the Inclusionary Criteria presented herein from the findings of the *Trafficking In Persons Report 2020* (Department of State, 2020).

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Addendum D (continued)

Proposed Transtheoretical Treatment Plan

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Integrated Best Practices

(Puccio et al., 2011; Peterson & Seligman, 2004; Scott & Wolfe, 2015)

Our integrated best practices are based on a shared value system anchored in ethical and moral predicate:


- A shared belief system in love, respect, trust, integrity, informed consent, confidentiality, truthfulness, authenticity, hope, and professional competence and responsibility.
- The pursuit of a life filled with happiness, engagement, and purpose.
- The consideration of any conflicts of interest personally, professionally, and/or spiritually.
- Full transparency and complete disclosure between participants and providers.
- Exercising humility and modesty when consulting colleagues and providers.
- Implementing an affirmative environment toward emotional-social, cognitive, physical, and spiritual wellness.

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Topics for Exploration

(Bar-On, 1997; Multi-Health Systems, Inc., 2011)

- **Self-Regard** – respecting oneself; increasing inner strength and self-confidence
- **(Emotional) Independence** – being self guided; free from emotional dependency on others
- **Optimism (Hope and Resiliency)** – securing a positive attitude; outlook in life
- **Problem Solving** – finding solutions in emotionally charged situations; understanding how emotions affect choices
- **Happiness** – the well-being indicator



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Goals and Objectives

| | |
|----------|---|
| Create | Create a greater sense of self-respect and feeling intrinsically strong and confident. |
| Secure | Secure a happier, more resilient, and positive attitude in life with a renewed hope for the future. |
| Replace | Replace emotional dependency with emotional independence. |
| Find | Find ways to make emotionally void decisions. |
| Teach | Inherently teach what mutually beneficial relationships look like. |
| Activate | Activate the by-product of happiness. |

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Every purpose is established by counsel: and with good advice make war.

Proverbs 20:18 *(Holy Bible, 1964)*

22

The Framework

The Power of the Affirmative and Modes of Structure

23

The Power of the Affirmative

The power of the affirmative to transcend an individual within a safe, confidential environment promotes positive behavior anchored in five self-driven Kegan Thynell principles borne from this group leader hermit from the evolution of the Identity Model (Stryker, 1968; Bassner et al., 2016). These include the following:

1. **Understand Thynell** *understand*
2. **Accept Thynell** *accept*
3. **Embrace Thynell** *embrace*
4. **Live Thynell** *live*
5. **Respect Thynell** *respect*

The Kegan Thynell principles mandate the practice of falling forward in the form of miss steps or miss takes to allow the opportunity to excel in personal and professional growth while overcoming adversities and celebrating successes (Maxwell, 2006).

It is within the affirmative that the ability for individuals to *understand*, *accept*, *embrace*, *live*, and *respect* themselves like presidents, which is essential in rebuilding a self-belief system that uniquely and exclusively reflects their identity in Self, via, self-concept (Hartig, 1997/2014) while also nurturing the emotional-social, cognitive, physical, and spiritual effectiveness, leading to a strong Self-Regard with the ability to take risks.

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Addendum D (continued)

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Modes of Structure

Research has shown a preference for group leaders who provide a structure to their group sessions, e.g., beginning the group, sharing the agenda for the session, inviting active participation from members, and keeping the group on task during group process – resulting in superior results (Yalom & Leszcz, 2005).

The staples or “modes of structure” include:

Welcome. Housekeeping. Shareback. Agenda. Working Phase. Homeplay. Closing Debrief.

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Outline of Group Sessions

12 weeks (once per week) – 3 hours per session

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[Beginning Stage]
Session 1

- **Welcome** – group leader introduces self and thanks the group members for participating; offers a prayer
- **Housekeeping** – group leader reviews the group rules and the importance of the members being accountable and committed to the group process
- The concept of **The Affirmative Environment**¹ is introduced as a group with the importance of failing forward and making miss-takes (Maxwell, 2000)
- **Introductions** – the group members introduce themselves, what brought them to group, and share one learning outcome; an ice breaker is available should the group need warming up (Fall, 2012)

¹Borne from this group leader herein from the evolution of the Identity Model (Seyler, 1998; Brenner et al., 2019).

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[Beginning Stage]
Session 1 (con't.)

- **Homeplay** – the power of miss-takes; think of one miss-take made; bring to session two to discuss
- **Closing Debrief** – group leader closes out the session by recapping the session and asking group members the following questions:
 1. Did you have any surprises?
 2. What did you like about group today?
 3. What didn't you like about group today?
 4. What would you like to see more of? Less of?



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[Beginning Stage]
Session 2

- **Welcome** – group leader welcomes group; group member offers a prayer or inspirational thought
- **Shareback** – group leader checks in with group to see if anyone needs to discuss an issue
- **Agenda** – group leader provides the agenda for session

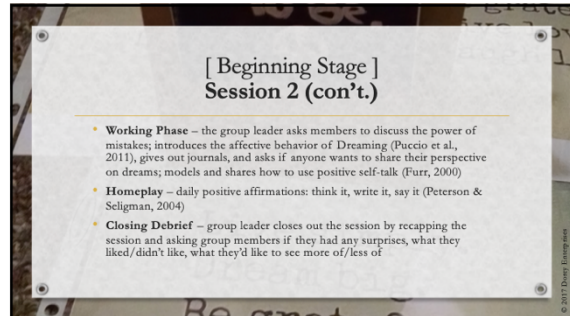


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[Beginning Stage]
Session 2 (con't.)

- **Working Phase** – the group leader asks members to discuss the power of mistakes; introduces the affective behavior of Dreaming (Puccio et al., 2011), gives out journals, and asks if anyone wants to share their perspective on dreams; models and shares how to use positive self-talk (Furr, 2000)
- **Homeplay** – daily positive affirmations: think it, write it, say it (Peterson & Seligman, 2004)
- **Closing Debrief** – group leader closes out the session by recapping the session and asking group members if they had any surprises, what they liked/didn't like, what they'd like to see more of/less of



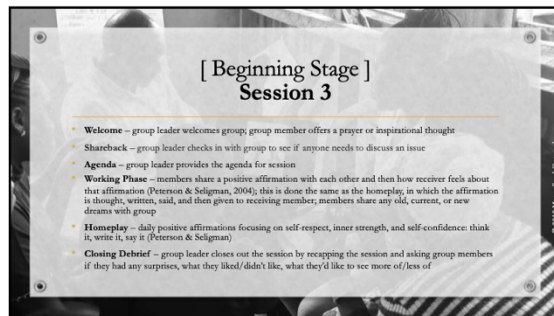
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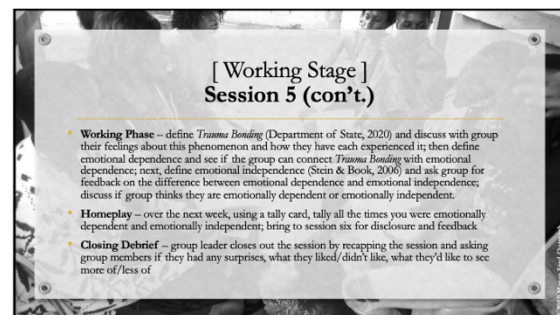
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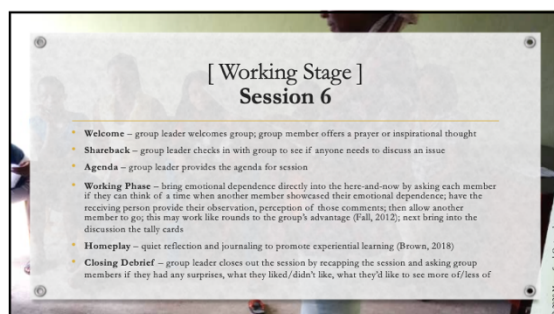
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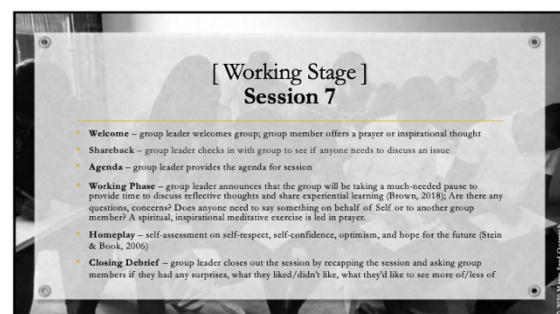
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Proposed Transtheoretical Treatment Plan

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[Working Stage]
Session 8

- **Welcome** – group leader welcomes group; group member offers a prayer or inspirational thought
- **Shareback** – group leader checks in with group to see if anyone needs to discuss an issue
- **Agenda** – group leader provides the agenda for session
- **Working Phase** – group discusses their self-assessments on self-respect, self-confidence, optimism, and hope for the future in the here-and-now (Stein & Book, 2006)
- **Homeplay** – continued reflection and journaling deepen experiential learning (Brown, 2018)
- **Closing Debrief** – group leader closes out the session by recapping the session and asking group members if they had any surprises, what they liked/didn't like, what they'd like to see more of/less of

37

[Closing-Termination Stage]
Session 9

- **Welcome** – group leader welcomes group; group member offers a prayer or inspirational thought
- **Shareback** – group leader checks in with group to see if anyone needs to discuss an issue
- **Agenda** – group leader provides the agenda for session
- **Working Phase** – group leader should remind the group they are now in the final stages of group with 4 sessions remaining; have an open discussion about how that makes members feel inclusive of the good-bye process and the importance of honoring the work done in group (Fall, 2012); next, link the cognitive to the affective by facilitating the group through a meditative exercise in visualizing one future outcome that brings hope, happiness, and purpose (Torrance & Sater, 1998); group discusses future outcome with each other
- **Homeplay** – journal about how you might achieve this future outcome (Brown, 2018; Stein & Book, 2006)
- **Closing Debrief** – group leader closes out the session by recapping the session and asking group members if they had any surprises, what they liked/didn't like, what they'd like to see more of/less of

38

[Closing-Termination Stage]
Session 10

- **Welcome** – group leader welcomes group; group member offers a prayer or inspirational thought
- **Shareback** – group leader checks in with group to see if anyone needs to discuss an issue
- **Agenda** – group leader provides the agenda for session
- **Working Phase** – group leader defines the emotional-social competency of problem solving (Stein & Book, 2006); group members discuss what solving problems without emotion might look like; share decisions made that were emotionally charged and ramifications of those; look at that decision word of emotion and discuss
- **Homeplay** – revisit your journal entries about how you might achieve this future outcome making sure not to have it wrapped up in emotion (Stein & Book); discuss in session 11
- **Closing Debrief** – group leader closes out the session by recapping the session and asking group members if they had any surprises, what they liked/didn't like, what they'd like to see more of/less of


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[Closing-Termination Stage]
Session 11

- **Welcome** – group leader welcomes group; group member offers a prayer or inspirational thought
- **Shareback** – group leader checks in with group to see if anyone needs to discuss an issue
- **Agenda** – group leader provides the agenda for session
- **Working Phase** – group leader reminds group that the next session will be the final session; group needs to come to final session with thoughts on how to close down with a final good-bye, along with any comments in order to tie things up for closure (Fall, 2012); next, group discusses how to implement one future outcome with group offering ideas to support each
- **Homeplay** – think about how you might want to say good-bye in final session, as well as any final thoughts, comments to share (Fall)
- **Closing Debrief** – group leader closes out the session by recapping the session and asking group members if they had any surprises, what they liked/didn't like, what they'd like to see more of/less of

40

[Closing-Termination Stage]
Session 12



- **Welcome** – group leader welcomes group; group member offers a prayer or inspirational thought
- **Shareback** – group leader checks in with group to see if anyone needs to discuss an issue; group leader shares that this group has completed its qualitative data gathering for the informal research on *Trauma Bonding* and will move to its post-quantitative data with sending out the EQ®
- **Agenda** – group leader provides the agenda for session

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[Closing-Termination Stage]
Session 12 (con't.)

- **Working Phase** – group leader facilitates the final closing session; group shares any last thoughts, issues, comments with each other; group leader reminds group that this has been installment one and checks in with group to see if anyone wants to continue with installment two and if so, how many sessions that might look like; if the group is unanimous or at least six participants want to continue, the group leader will initiate the next phase (Valom & Leszcz, 2005); post EQ® assessments will be sent out with results made available for independent review at a date to be determined; group determines unanimously what the good-bye process will involve; good-byes are completed (Fall, 2012); group ends
- **Final Closing Debrief** – group leader recaps and summarizes installment one group therapy; group also comments on what group therapy has meant to them

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Addendum D (continued)

Proposed Transtheoretical Treatment Plan

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Future Directions

Qualitative and quantitative *informal* research data will be conducted by the group leader to determine the following individually and as a group:

1. What affect was there on Self-Regard, (emotional) Independence, Optimism (Hope and Resilience), Problem Solving, and Happiness overall?
2. Are the group members happier and more hopeful for a better future?
3. Can the group members make decisions without their emotions getting in the way?
4. Have the group members inherently learned how to have mutually beneficial relationships?

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Future Directions (con't.)

Upon review of the qualitative and quantitative *informal* research data, a determination will be made if the applied cognitive and affective strategies and exercises broke the trauma bonding relationship* from the following behaviors (Department of State, 2020):

- a lack of emotional independence;
- a sense of despair and overall pessimistic outlook in life; and
- have "relapsed" a minimum of one time back to their previous way of life.

**If data supports this assertion, formal research through the International Review Board will be initiated on a wider, more broad application nationwide.*

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References

Burke, B. (1997). *Real/Unreal personal inventory*. Technical manual. Multi-Health Systems, Inc.

Burnett, P. J., Sorens, R. T., & Taylor, S. (2018). Role-specific self-efficacy in persistence and product of the identity model. *Intelligence*, 67-80. <https://doi.org/10.1016/j.intell.2018.07.007>

Brown, N. W. (2018). *Psychosocial group: Process and practice* (3rd ed.). Routledge.

Department of State. (2020). *2020 Trafficking in persons report*. United States of America. <https://www.state.gov/trafficking-in-persons-report-2020/>

Fall, K. (2012). Group counseling, process and technique [Video]. wVET Productions. <https://www.youtube.com/watch?v=72201087020>

Frost, S. (2005). Structuring the group experience: A format for designing psychosocial groups. *The Journal for Specialists in Group Work*, 25(1), 29-49. <https://doi.org/10.1177/0898010105279416>

45

References

Harlow, J. (2014). *Self-concept*. Psychology Press. (Original work published 1992, Lawrence Erlbaum Associates, Inc.)

Help Bible. (Authorized or King James Version). 1964. (Red Letter ed.). Hendon: Bible Publishers, Inc.

International Labour Organization. (2017). *Global estimates of modern slavery: Forced labour and forced marriage*. International Labour Office.

Retrieved on May 4, 2021, from <https://www.ilo.org/public/english/convenc/2017/04/20170420/20170420.htm>

Maxwell, J. C. (2000). *Finding forward: Turning mistakes into stepping stones for success*. Thomas Nelson Publishers.

Multi-Health Systems, Inc. (2011). *EQ-48 2.0 manual*. Multi-Health Systems, Inc.

Peterson, C., & Seligman, M. E. P. (2004). *Character strengths and virtues: A handbook and classification*. American Psychological Association and Oxford University Press, Inc.

46

References

Pruitt, C. (2013). When is female leadership an advantage? Coordination requirements, team cohesion, and team interaction norms. *Journal of Organizational Behavior*, 34, 1153-1175.

Purcell, G. J., Mumford, M. C., & Mayer, M. (2011). *Creative leadership: Skills that drive change* (2nd ed.). SAGE Publications, Inc.

Robinson, W., & Taylor, N. (2017). Assessment, biopsychosocial. In J. Carlson, & S. B. Derringer (Eds.), *The SAGE encyclopedia of marriage, family, and couple counseling*, 1, 84-90. SAGE Publications, Inc. <https://doi.org/10.1177/1545731916633333>

Scott, V. C., & Wolfe, S. M. (2015). *Community psychology: Foundations for practice*. SAGE Publications, Inc.

Stein, S. J., & Book, H. E. (2006). *The EQ edge: Emotional intelligence and your success* (2nd ed.). Jossey-Bass.

47

References

Steyler, S. (1968). Identity salience and role performance: The relevance of symbolic interaction theory for family research. *Journal of Marriage and Family*, 30, 558-561. <https://www.jstor.org/stable/3524026>

Torresano, E. P., & Seltzer, H. T. (1998). *Making the creative leap beyond*. Creative Education Foundation Press.

United Nations Office on Drugs and Crime. (2021). *Global report on trafficking in persons 2020*. United Nations.

<https://www.unodc.org/documents/trafficking-in-persons/2021/04/20210420/20210420.htm>

United States Food & Drug Administration (FDA). (n.d.). *International review board (IRB) and protection of human subjects in clinical trials*. Retrieved on May 5, 2021, from <https://www.fda.gov/oc/ohrt/irb-international-review-board-protection-human-subjects-clinical-trials>

Valian, I. D., & Luzzati, M. (2005). *The theory and practice of group psychology* (5th ed.). Basic Books.

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