A Traumatology Focus in Trauma Bonding

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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.

Consequentially, 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, sequalae, 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).

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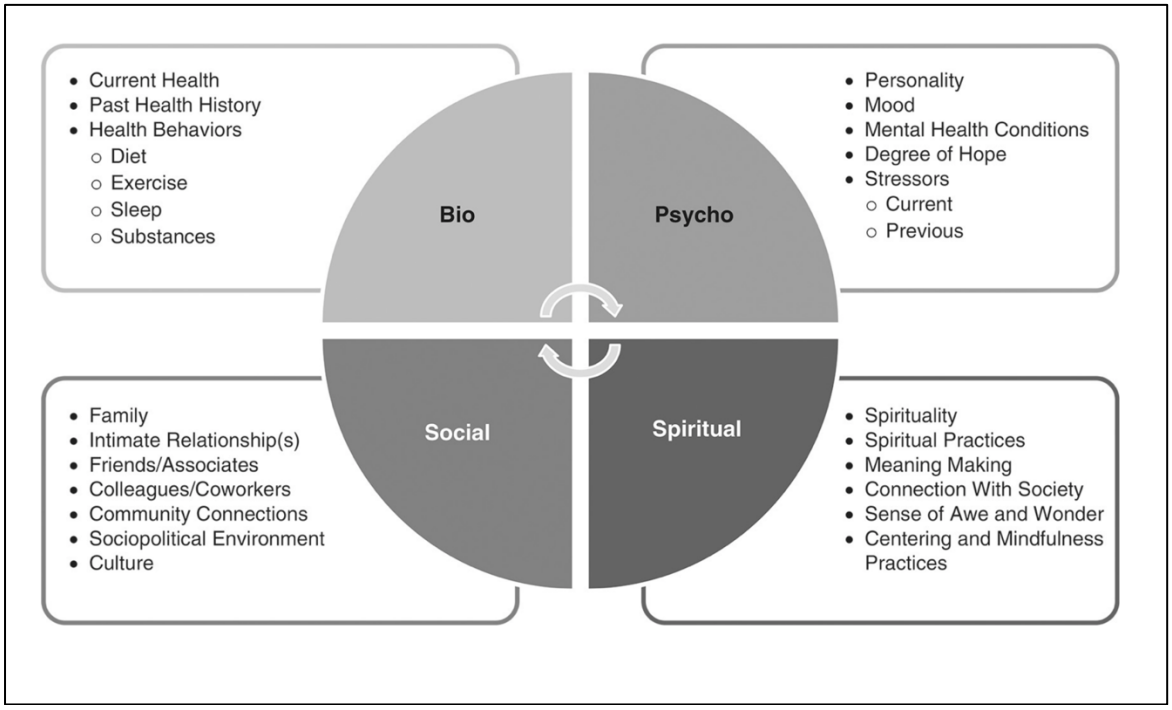
Addendum A

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

Addendum B

Biopsychosocial-Spiritual Model (Robinson & Taylor, 2017)



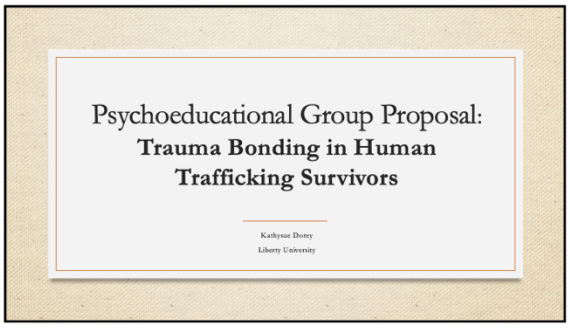
Addendum C

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

Addendum D

Proposed Transtheoretical Treatment Plan



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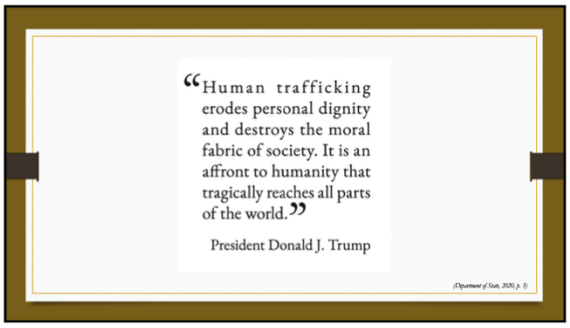

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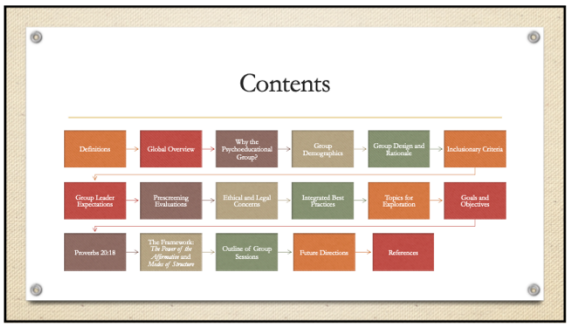

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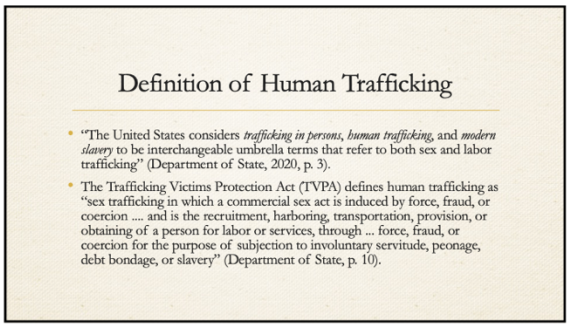

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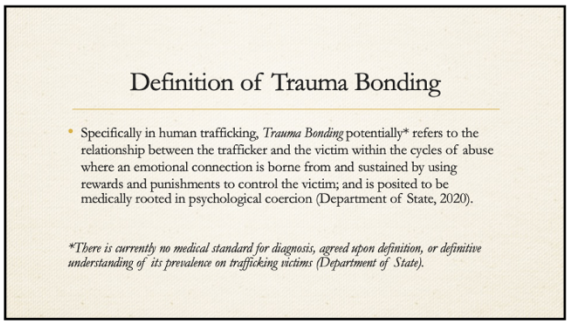

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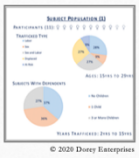
Addendum D (continued)

Proposed Transtheoretical Treatment Plan

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).



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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 (Furr, 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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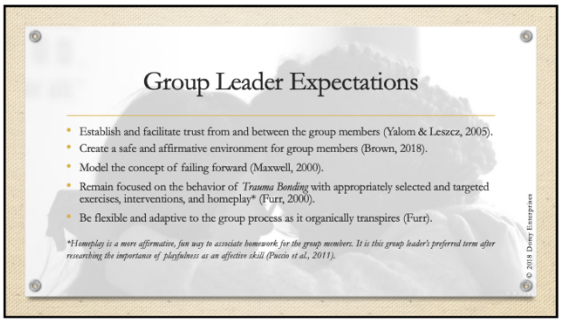
Addendum D (continued)

Proposed Transtheoretical Treatment Plan



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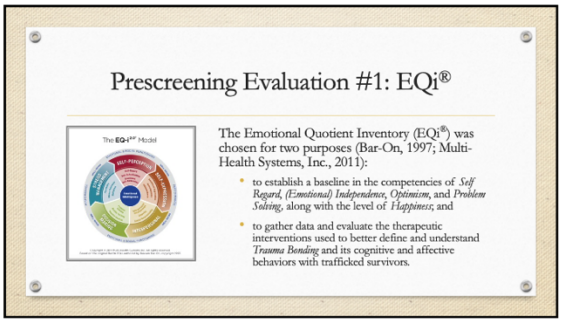

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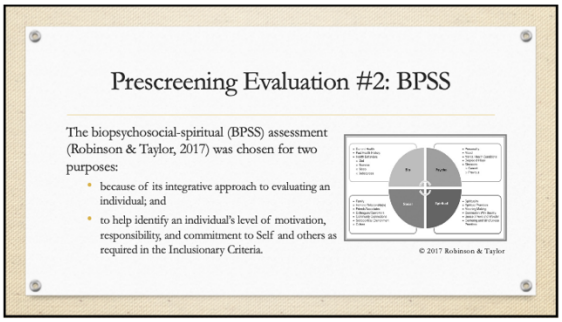

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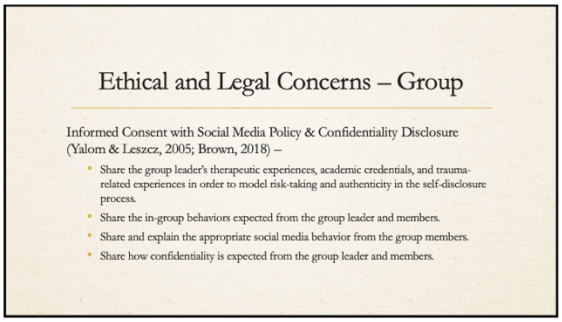

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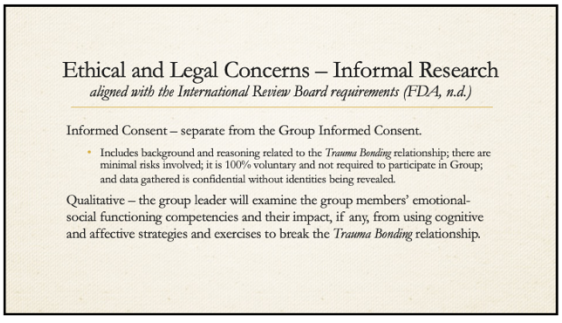

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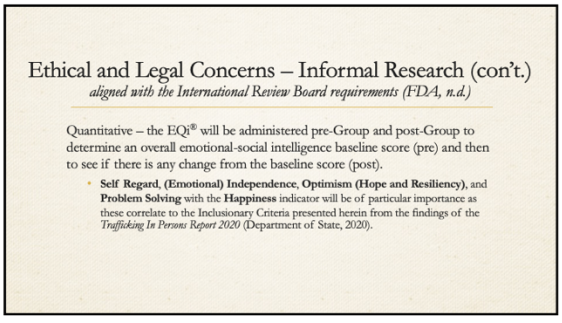

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Addendum D (continued)

Proposed Transtheoretical Treatment Plan

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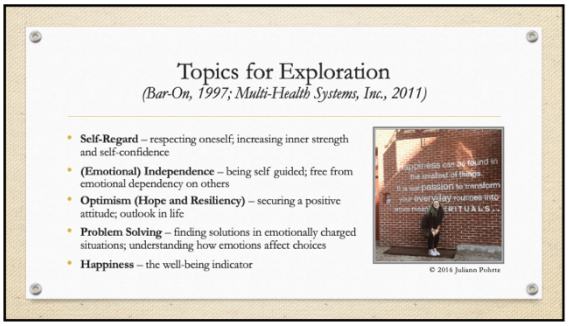

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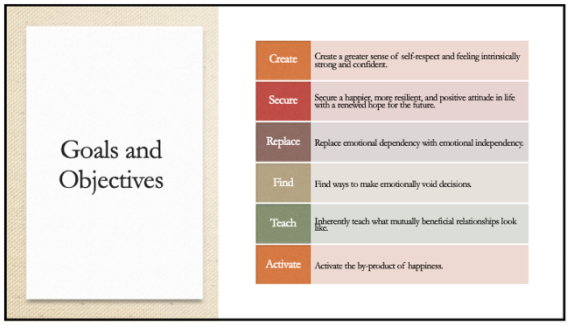

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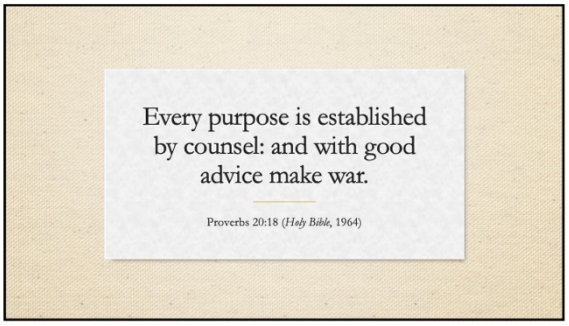

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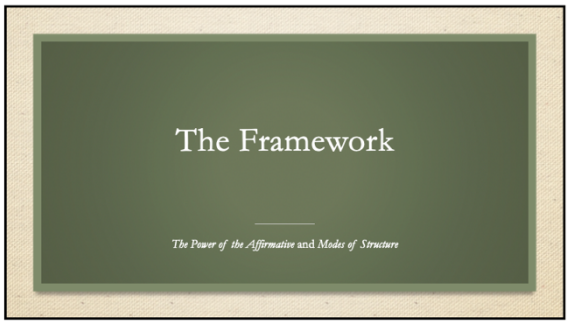

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Addendum D (continued)

Proposed Transtheoretical Treatment Plan

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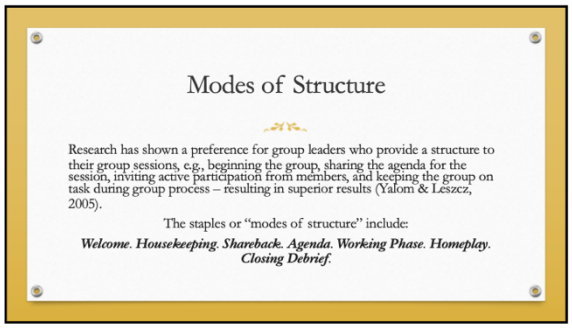

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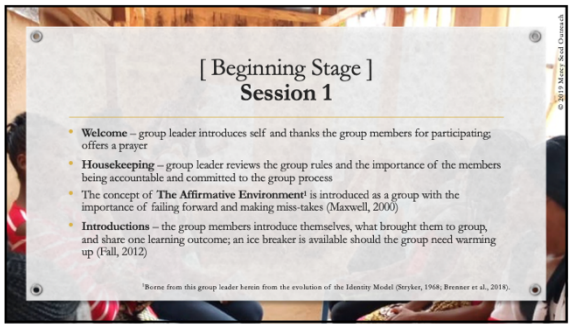

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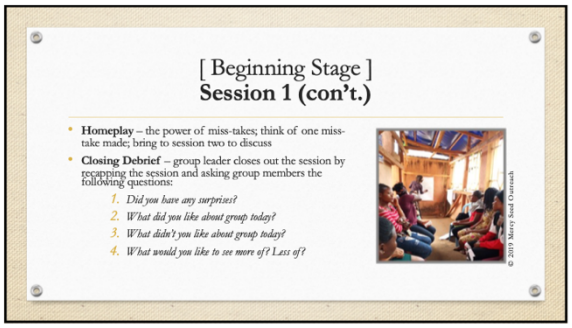

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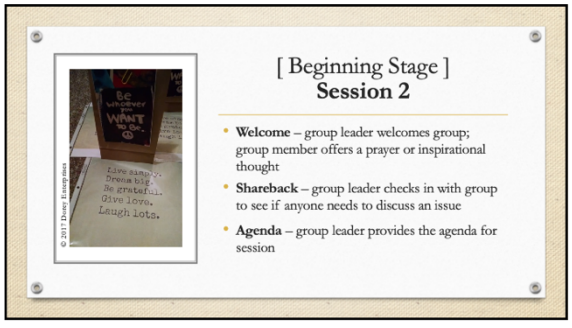

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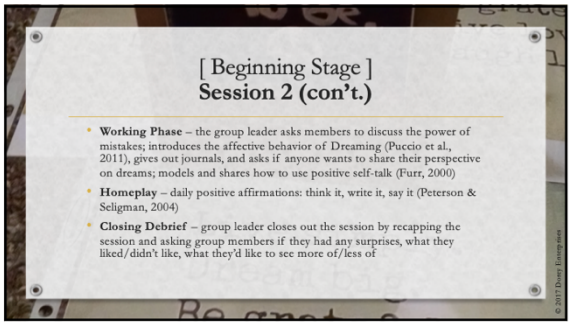

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Addendum D (continued)

Proposed Transtheoretical Treatment Plan

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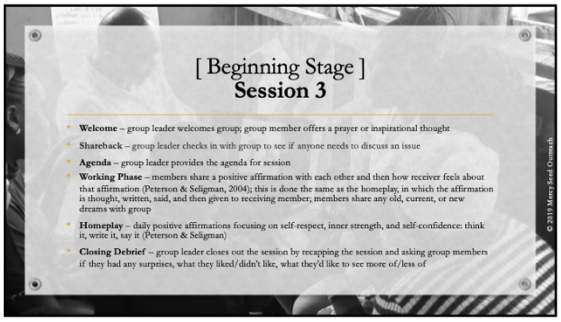

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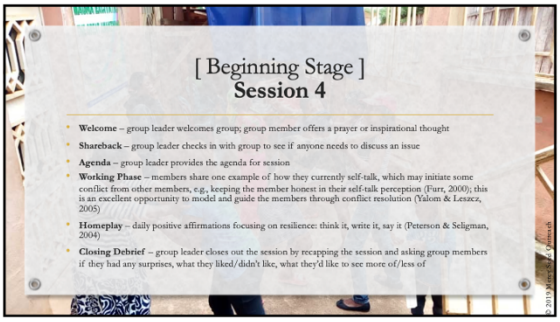

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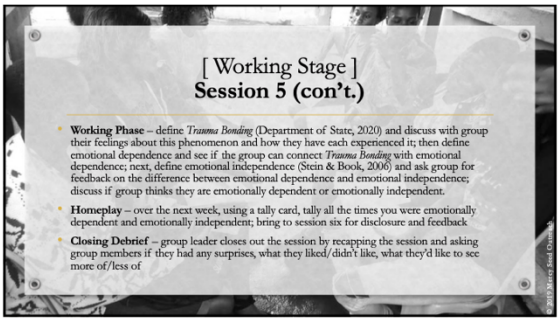

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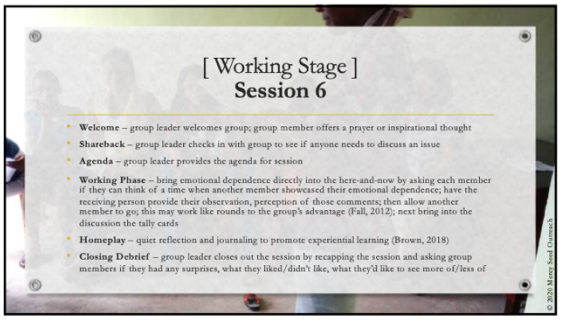

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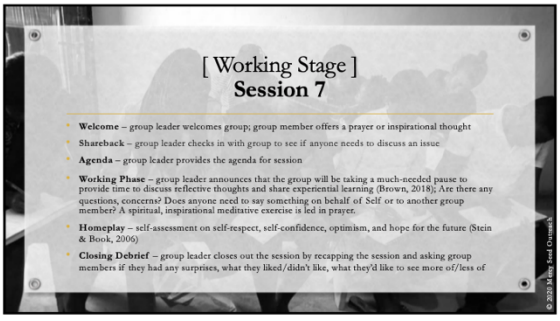

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Addendum D (continued)

Proposed Transtheoretical Treatment Plan

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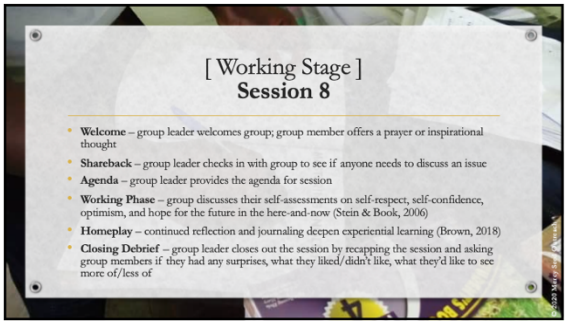

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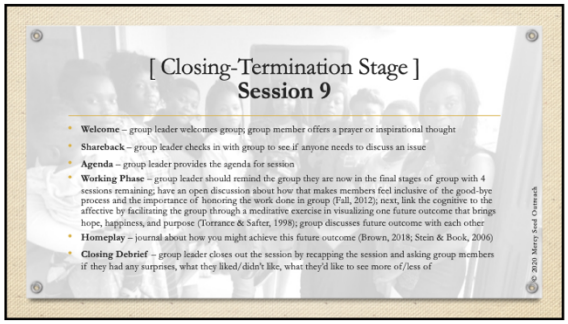

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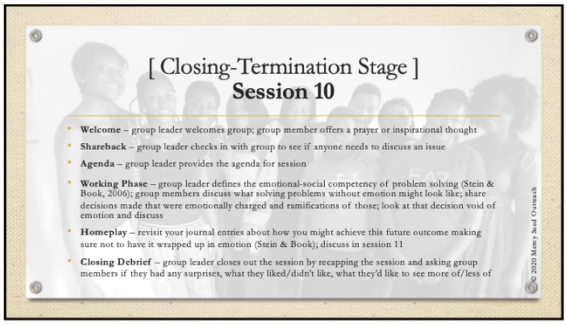

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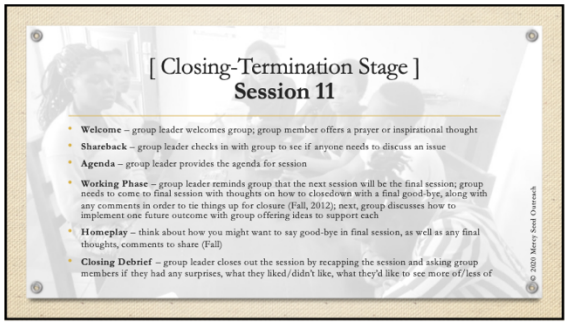

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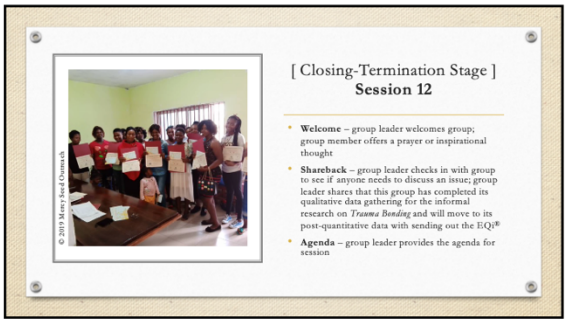

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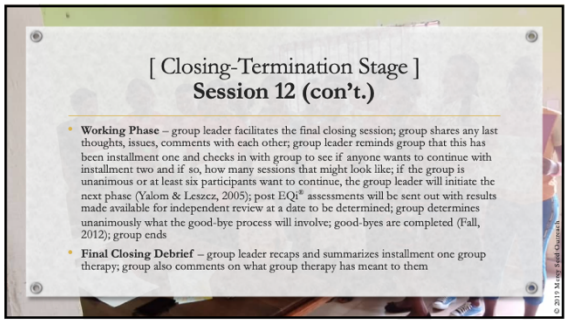

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Addendum D (continued)

Proposed Transtheoretical Treatment Plan

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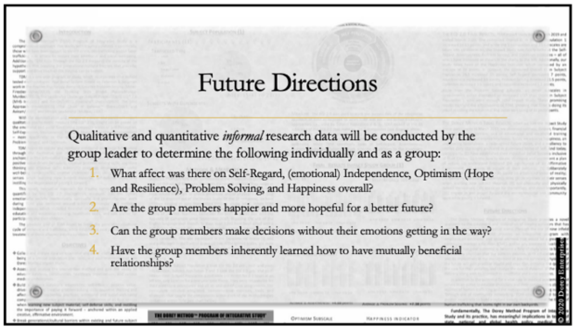

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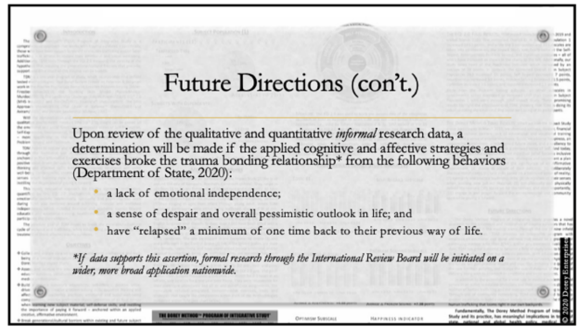

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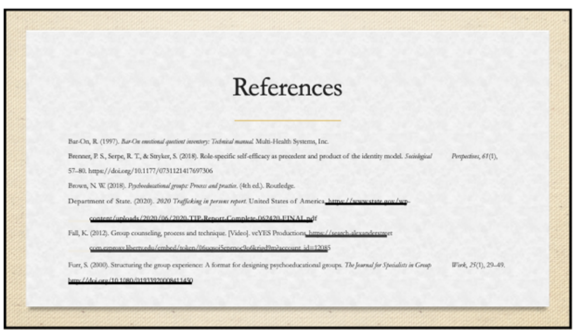

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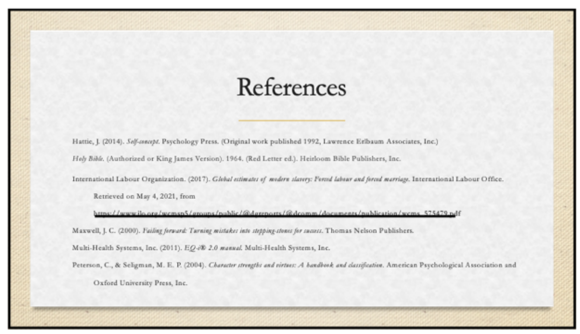

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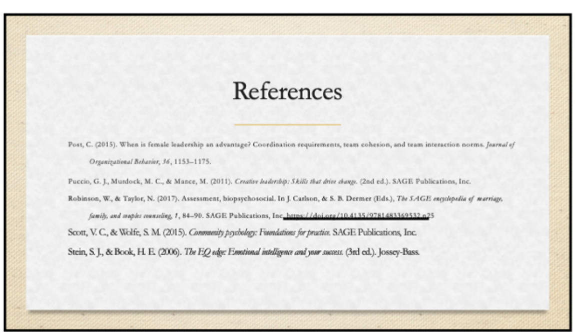

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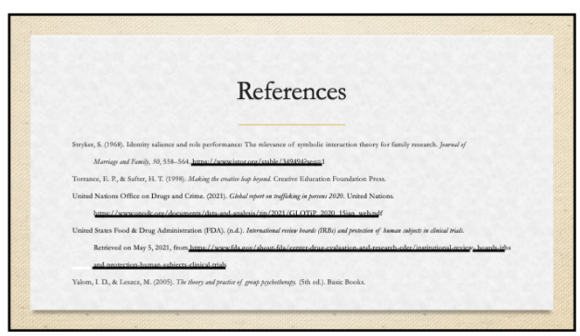

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