Everlasting Pain: The Long-Term Effects of Physical and Emotional Abuse

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1 Introduction

This chapter will review the long-term effects of physical and emotional abuse and recovery for survivors of such violence and mistreatment. Physical abuse is causing someone physical harm, with or without a weapon. Emotional abuse erodes a person's sense of self-worth. Forms of emotional abuse include degradation, threatening, stalking, and isolating. Both forms of abuse are rampant in human trafficking. Lastly, intimate partner violence (IPV) is a perpetrator's pattern of behavior that may include various types of abuse, including physical injury, emotional harm, and sexual assault meant to isolate, intimidate, or otherwise coerce a romantic partner [1].

2 Long-Term Effects of Physical and Emotional Abuse

Throughout this chapter, the terms "victim" and "survivor" are used. The term "victim" refers to an individual who has experienced a recent assault. The term "survivor" refers to an individual who has begun to heal from the assault, both physically and psychologically [2].

2.1 Physical Abuse

Physical abuse includes punching, kicking, biting, choking, burning, shaking, and beating. Physical abuse may result in bodily injury, permanent damage, and death.

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Physical abuse is most frequently observed in relationships of trust, including between parents and children and between intimate partners. Individuals who experience physical abuse often feel helpless, isolated, and/or prone to the subsequent development of pathological conditions [3].

The most common form of adult physical abuse in the United States is intimate partner violence [3]. In the United States (U.S.), 32.4% of women and 28.3% of men report physical violence by an intimate partner. Moreover, about 1 in 3 women and nearly 1 in 6 men in the U.S. have experienced sexual violence during their lifetimes, and about 1 in 5 women and 1.5% of men have experienced rape or attempted rape [4]. In the U.S., women experience 4.8 million incidents of physical or sexual assault annually; however, the true prevalence of violence is unknown because many are afraid to share their experiences [1].

Research on physical abuse related to human trafficking is limited at this time; however, the limited evidence corroborates that victims of physical abuse related to human trafficking likely experience similar consequences of physical abuse related to IPV. These health consequences include anxiety, emotional numbness, memory loss, depression, post-traumatic stress disorder (PTSD), substance abuse, and eating disorders [5]. Many of the studies cited in this section reference IPV, but their conclusions can likely be applied to survivors of human trafficking.

2.1.1 Long-Term Physical Effects of Physical Abuse

Not only do survivors of physical abuse face short-term consequences, including physical injury, fear for safety, and acute stress, but they are also more likely to experience chronic physical health problems. In the National Intimate Partner and Sexual Violence Survey, men and women in the U.S. who report a history of physical or sexual violence by an intimate partner are more likely to report asthma, irritable bowel syndrome, frequent headaches, chronic pain, and difficulty sleeping compared to those without a similar history of sexual or physical violence [4].

Many victims of violence experience somatization or internalized stress. Somatization includes physical effects, which will be discussed here, and psychological effects, which will be discussed in the following section. Somatization may present as chronic headaches, sleep and appetite disturbances, palpitations, chronic pelvic pain, urinary frequency or urgency, irritable bowel syndrome, sexual dysfunction, abdominal symptoms, and recurrent vaginal infections [1]. It is important to screen all patients—but especially those with these chronic complaints—for a history of physical abuse or other violence.

Chronic pain. Chronic pain is common among survivors of physical abuse. Common complaints include abdominal pain, pelvic pain, headache, low back pain, and joint pain. In a study of 292 women who had separated from their abusive partners on average 20 months prior, more than one-third experienced high-disability pain. Those experiencing high-disability pain were more likely to have experienced child abuse, adult sexual assault, severe spousal abuse, lifetime abuse-related injuries, symptoms of depression and PTSD, history of suicide attempts, difficulty sleeping, and unemployment. High-disability pain was also associated with the use of medication in more than prescribed dosages [6]. Chronic pain persists long after

leaving abusive partners, so ongoing treatment of emotional and physical health is critical in the care for this population.

Traumatic brain injury. Sixty to 92 percent of female victims of physical abuse report traumatic brain injury (TBI). By applying the more conservative 60% estimate, there are 23,000,000 women in the U.S. living with a TBI from IPV. That is 37,000 times the number of National Football League players, but little research exists on TBI related to IPV [7]. A TBI results from repetitive blows to the head, and long-term sequelae include a decrease in memory, learning, and cognitive function; difficulty performing activities of daily living, which may make the victim more vulnerable and cause her to remain in her abusive environment; reduced ability to maintain employment; personality and behavioral changes; and increase in mental health problems, which will be addressed in a later section.

Gastrointestinal disorders. Women who have experienced IPV are more likely to have diagnosed gastrointestinal (GI) disorders including peptic ulcer disease, irritable bowel syndrome, gastroesophageal reflux, indigestion, diarrhea, and constipation. Patients seen in a gastroenterology clinic for GI complaints who had a history of childhood or adult abuse were significantly more likely to have GI surgeries compared to patients without such abuse history. Psychological and physiologic mechanisms related to chronic stress are likely responsible for increases in GI symptoms among survivors of IPV [6].

Chronic disease. Past or present IPV is also associated with developing or exacerbating chronic diseases, including asthma, stroke, hypertension, hypercholesterolemia, myocardial infarction, and cardiovascular disease [8]. Chronic and acute stress activates autonomic, neuroendocrine, immune, and cardiovascular systems; this may increase the likelihood of developing or exacerbating cardiovascular disease [6]. It is also essential to consider the social context in which IPV occurs. Poor self-esteem and lack of social support have long-lasting health consequences. In addition, survivors of IPV are more likely to smoke, which is associated with poorer outcomes related to chronic disease management [8].

2.1.2 Long-Term Psychological Effects of Physical Abuse

Individuals who experience physical abuse are at greater risk of developing mental health issues, including PTSD, depression, anxiety, substance use disorders, and suicide [2].

Post-traumatic stress disorder. Somatization, or internalized stress, may develop into PTSD. PTSD may be associated with depression, anxiety, and suicide [1]. Survivors of physical abuse and intimate partner violence are likely to experience PTSD. PTSD is a disorder that may result when an individual lives through or witnesses an event in which they believe there is a threat to their safety. Symptoms include but are not limited to painful recollections, flashbacks, recurrent dreams or nightmares, avoidance of activities or places, emotional numbing, chronic physiological arousal, and difficulty sleeping [9]. PTSD prevalence predictions range from 31 to 84.4% of IPV survivors [10].

In 2018, the World Health Organization proposed a new diagnosis called complex post-traumatic stress disorder (CPTSD), which includes criteria for PTSD as

well as symptoms of disturbance of self-organization. In a study of 162 female IPV survivors, 39.5% met the diagnostic criteria for complex PTSD, and 17.9% met the diagnostic criteria for PTSD. The main variable related to experiencing CPTSD, in contrast to PTSD, was expressive suppression, which is an effort to conceal, inhibit, or reduce emotional expression [11].

Depression and anxiety. Experiencing physical violence increases the risk for developing depression and anxiety. Individuals in abusive relationships commonly experience depressed moods, poor sleep, inability to concentrate, and feelings of hopelessness [6]. Moreover, one meta-analysis found that women with pre-existing depression were more likely to be victims of IPV [12]. Not only does physical abuse affect mental health, but mental health factors can cause some women to be more vulnerable to violence than others.

One longitudinal study ($n = 1529$) found a relationship between IPV at 21 years of age and new cases of major depression disorder at 30 years of age; however, IPV did not predict the onset of a new anxiety disorder [13]. IPV did, though, have a robust association with more severe anxiety disorders in women with a previous anxiety diagnosis. Individuals with a previous anxiety diagnosis may show a stronger response to interpersonal stressors, engage in negative self-evaluation, and experience intensified and prolonged negative emotions; therefore, individuals with anxiety may be more vulnerable to perpetrators of the cycle of abuse, and those with anxiety will likely experience worse anxiety symptoms because of physical abuse.

Alcohol and substance abuse. Women experiencing IPV are nearly six times as likely to have a substance abuse diagnosis [6]. Conversely, women diagnosed with alcohol or substance abuse are more vulnerable to IPV. Among women at a methadone maintenance clinic, nearly half had experienced IPV in the past month, and nearly 20% had experienced severe violence or injury by an intimate partner in the previous 6 months [6]. One potential theory is that victims abuse alcohol and substances as a poor coping strategy for violence. Another theory is that women who are dependent on substances are more likely to be in relationships with men who are similarly dependent on substances, and substance abuse and IPV perpetration are strongly linked. It is important for a clinician to screen for abuse and substance abuse together [6].

Suicide. Physical abuse is a risk factor for suicide. A study of formerly abused women experiencing chronic pain found that 31% had attempted suicide. Physically abused women are nearly eight times more likely to attempt suicide than non-abused women, and HIV-positive physically abused women are 13 times more likely to attempt suicide than HIV-negative, non-abused women [6]. The National Violent Death Reporting System found that intimate partner problems were a precipitating factor for 32% of male and 27% of female suicides [6].

2.1.3 Recovering from Physical Abuse

It is important to emphasize that a preventative approach toward reducing violence in the community is more valuable than the community's reaction to acts of violence. As various forms of abuse abound, it is imperative to clinically address the treatment

of survivors following physical abuse. This section will address both prevention of physical abuse and how to support survivors.

Prevention. Physical abuse is not the victim's fault, so prevention must be geared toward perpetrators. Risk factors for perpetrating physical abuse include low self-esteem, low education or income, depression, antisocial personality traits, conduct problems, suicide attempts, lack of nonviolent problem-solving skills, belief in strict gender roles (e.g., male dominance in relationships), history of physical or emotional abuse in childhood, unhealthy family relationships, and interactions, witnessing violence between parents, history of experiencing physical discipline as a child, living in a community with high poverty rates and limited educational and economic opportunities, weak community sanctions against IPV, gender inequality in the society, societal income inequality, and cultural norms that support aggression [14]. Protective factors against perpetrating physical abuse include strong social networks, positive social relationships, neighborhood connectedness, coordination of resources and services, safe housing, medical care and mental health service access, and access to economic and financial help.

Physical abuse is preventable. To prevent abuse, we must understand and address the factors that put people at risk. Promoting healthy, respectful, nonviolent relationships, and community will reduce the occurrence of physical abuse. The Centers for Disease Control and Prevention (CDC) has developed a resource titled "Preventing Intimate Partner Violence Across the Lifespan," which addresses various prevention strategies to help communities utilize evidence-based techniques to impact individual behaviors and modify larger risk factors [15] (see Table 1).

Table 1 Preventing IPV: a CDC resource

Strategy	Approach
Teach safe and healthy relationship skills	• Social-emotional learning programs for youth • Healthy relationship programs for couples
Engage influential adults and peers	• Men and boys are allies in prevention • Bystander empowerment and education • Family-based programs
Disrupt the developmental pathways toward partner violence	• Early childhood home visitation • Preschool enrichment with family engagement • Parenting skill and family relationship programs • Treatment for at-risk children, youth, and families
Create protective environments	• Improve school climate and safety • Improve organizational policies and workplace climate • Modify the physical and social environments of neighborhoods
Strengthen economic supports for families	• Strengthen household financial security • Strengthen work-family supports
Support survivors to increase safety and lessen harms	• Victim-centered services • Housing programs • First responder and civil legal protections • Patient-centered approaches • Treatment and support for survivors of IPV, including teen dating violence

Initial steps. The first step a victim of violence will take to break the violent pattern is to tell someone of the abuse, so telling someone they trust—whether a medical provider, social worker, or friend—is a momentous step. When a client discloses physical abuse, the clinician should first acknowledge the trauma and assess the victim and any children's immediate safety. Risk factors for homicide include previous acts of violence, estrangement from a partner, threats to life, threats with a weapon, previous strangulation, and partner access to a firearm [1]. It is also important to discuss the person's feelings, whether they be relief or shame, and emphasize that no one deserves to be abused. Being abused is never the victim's fault.

Next, assess their desire and readiness to leave or remain in their current situation. For those wanting to leave an abusive relationship, clinicians may help them make a plan, but their best resource is a local domestic violence agency. The National Domestic Violence Hotline and other hotlines (see Table 2) can help with legal assistance, shelter, counseling services, and connection to other resources. A plan may include seeking medical care for injuries, keeping any evidence of physical abuse, reporting the abuse legally, contacting the local shelter for domestic violence victims, and gathering monetary fund's [16].

Short-term recovery. The 2013 World Health Organization guidelines concluded that there is not yet sufficient evidence to support interventions for IPV that will improve health outcomes, except for women who have spent at least one night in a shelter or for pregnant women experiencing IPV. This does not mean that all interventions are ineffective, but quality research in this field is difficult due to patient safety concerns and difficulty with follow-up.

A Cochrane review analyzed the effectiveness of advocacy interventions for survivors of domestic violence in healthcare settings, domestic violence shelters, and community centers. Advocacy, or active support by trained people, may help individuals make safety plans, deal with abuse, and access community resources [17]. Counseling the survivor at the time of their disclosure of abuse may strengthen their self-worth and provide ongoing support. Counseling may also allow the clinician to assess the degree of danger for survivors and their children and help them develop a safety plan. Attempting to or leaving a relationship with a perpetrator often increases the risk of injury, so providers should not encourage their patients to leave a relationship but should instead support their patients in their decisions. If a patient would like to leave their abuser, healthcare workers should aid in developing a safety plan and connecting to community resources [17]. The Cochrane review

Table 2 Hotlines for victims of abuse

Child Abuse Hotline	1-800-4-A-CHILD (800 422 4453)
National Domestic Violence Hotline	1-800-799-7233
Missing and Exploited Children Hotline	1-800-843-5678
Rape, Abuse, Incest, National Network (RAINN)	1-800-656-HOPE (1-800-656-4673)
Sexual Abuse - Stop It Now!	1-888-PREVENT
National Human Trafficking Hotline	1-888-373-7888
Suicide and Crisis Lifeline	988

showed that intensive advocacy might reduce physical abuse 1–2 years after the intervention, but there was no evidence that advocacy reduced physical, emotional, and sexual abuse in the long term or that advocacy benefitted survivors' mental health [17]. This does not mean that advocacy efforts are ineffective, however; rather, these vulnerable individuals require longer-term follow-up and mental health care.

Evidence-based treatments for survivors of physical abuse and IPV may be lacking, but clinicians should familiarize themselves with local resources for referral. These may include hospital programs, community hotlines, shelters, support groups, legal aid, and social welfare services. Governmental web-based resources include:

- www.futureswithoutviolence.org/
- www.ncadv.org/learn-more/resources
- www.womenshealth.gov/relationships-and-safety/get-help
- www.cdc.gov/ViolencePrevention/intimatepartnerviolence/index.html
- Other web-based resources are available (see Table 3)

Long-term recovery. In a study reporting the perspectives of adult female IPV victims in a Midwestern community domestic violence shelter, 83.5% indicated that IPV worsened their health, and 53.5% reported unmet healthcare needs. About 80% of unmet care was related to mental health care needs [18]. Because of this clear gap

Table 3 Web-based resources for victims of abuse

Organization	Description	URL
Women's Law	Non-profit organization that supports all victims of abuse, regardless of sexual orientation or gender, providing education, tips, and a state-by-state list of resources for victims and families.	https://www.womenslaw.org/find-help
Health Insurance and Mental Health Services	Overview of how to navigate insurance coverage for mental health resources.	https://www.mentalhealth.gov/get-help/health-insurance
Substance Abuse and Mental Health Services Administration (SAHMSA)	Locates services for various forms of mental health or substance abuse treatment.	https://www.samhsa.gov/find-treatment
National Human Trafficking Hotline	Connects victims and survivors with resources to get to a safe place. Accepts tips for suspected cases of human trafficking.	https://humantraffickinghotline.org/
Office on Trafficking in Persons (OTIP)	Connects victims and case workers with additional resources, including federal assistance. Also, includes information on how to assist foreign nationals.	https://www.acf.hhs.gov/otip/victim-assistance

in care, the following section will address mental health care for survivors of physical abuse.

The World Health Organization recommends that women who have experienced IPV and have a mental health diagnosis should receive evidence-based mental health treatments. A Cochrane review (n = 5517 women) demonstrated that psychological therapies—including cognitive behavioral therapy (CBT), third-wave CBT (e.g., acceptance and commitment therapy and mindfulness), behavior therapy (e.g., problem-focused), humanistic therapy (e.g., grief work), integrative therapy (e.g., motivational interviewing), and systemic therapies (e.g., narrative therapy)—effectively reduced depression and anxiety symptoms; however, therapy did not improve other outcomes including PTSD, social support, re-exposure to IPV, and safety planning. IPV survivors require a team-based, individualized, and trauma-informed approach to tailor treatment to each individual's needs. Therapy may help with mental health symptoms, but survivors must first feel safe and supported by their social network, community, and society to make holistic progress [19].

2.2 Emotional Abuse

The prevalence of emotional abuse remains elusive, largely because it is difficult to define, making it difficult to identify and report. Unlike physical abuse, emotional abuse leaves no visible mark that can be quantified. In fact, the long-term effects of abuse are only recently being researched and somewhat understood. Even in the current research, the long-term effects of emotional abuse in adulthood remain minimal, as most research is focused on the emotional abuse of children or adolescents. What is known is that emotional abuse wreaks emotional and psychological havoc upon the recipient throughout their lifetime.

Emotional abuse. Emotional abuse encompasses a wide variety of behaviors and patterns that vary amongst abusers. Though difficult to define, emotional abuse is easily recognized by objective third parties—following the adage "you'll know it when you see it." Though there is a push to define emotional abuse for diagnostic or legal purposes, there is also resistance based on the fear that defining emotional abuse may impose limitations, leaving outlying victims unprotected [20]. Attempts at defining emotional abuse often result in simply describing the outcome of emotional abuse, such as "damage to the child's psychological development and emerging personal identity" or "the child's behavior is disturbed or their development impaired" [21].

Instead of focusing on defining emotional abuse, experts rely primarily on distinguishing patterns. Emotional abuse can be largely recognized as repetitive behaviors demonstrating an inappropriate emotional interaction or response from the abuser [21]. Emotional abuse may entail intimidation, threatening, or emotional with-holding. The abuser may blame and inflict excessive punishment for menial offenses. Victims of emotional abuse endure deprecating speech, insults, and rejection from the abuser. Victims are often isolated from external social networks as the abuser may interfere with the victims' external relationships, limiting contact

or transportation. Emotional abuse of a child may include assigning inappropriate responsibilities and tasks. Exposing children to explicit adult behaviors or exposing an adult to unwanted explicit behaviors is a form of emotional abuse [20]. It is important to note that though any individual may occasionally demonstrate any of these or similar behaviors, emotional abuse is characterized by a pattern of repetition—inflicting such behaviors on another individual repeatedly [21].

2.2.1 Long-Term Effects of Emotional Abuse

Emotional abuse has the potential for detrimental long-term effects. Emotional abuse may lead to psychological or mental health problems and chronic disease, which may severely impair the victim's ability to develop healthy, lasting relationships. These effects may be seen in childhood or adulthood, though there are some slight differences when the victim suffers emotional abuse as a child that should be taken into consideration.

Psychological. Victims of emotional abuse struggle to establish a self-identity, often holding on to poor self-perception, self-worth, and self-esteem. Emotional abuse survivors possess inadequate coping mechanisms for periods of distress, resulting in depression, anxiety, and isolation. Poor mental health in this population commonly manifests in higher rates of self-harm, substance use disorder, eating disorders, and high-risk behaviors [22]. Women who endure emotional abuse are more likely to suffer from depression and low self-esteem. A history of emotional abuse contributes to feelings of loneliness and self-despair. Anxiety and emotional numbness may be signs of emotional abuse [5].

Physical. Emotional abuse may lead to long-term physical effects. It has been hypothesized that emotional abuse is related to the development of chronic fatigue and fibromyalgia [23]. Eating disorders developed secondary to the effects of emotional abuse may lead to physical harm, such as nutrient deficiencies, anemias, bone demineralization, and irregular menstruation in women [5]. Victims often experience sleep disturbances, such as insomnia, that affect their overall mental and physical health. Emotional abuse may precipitate chronic pain of a psychosomatic origin, disrupting their ability to work, care for a family, or engage in regular physical activity [5].

Relational. Those who have endured emotional abuse often find it difficult to create and maintain healthy relationships [22]. Victims of emotional abuse experience higher rates of interpersonal conflict in subsequent relationships [24]. Emotional abuse increases the likelihood of revictimization, or exposure to subsequent traumatic events, more so than physical or sexual abuse. This perpetuates a cycle of recurrent emotionally abusive experiences [25]. In fact, emotional abuse has been found to be a reliable predictor of intimate partner violence in affected women, leading to further victimization of physical abuse, emotional abuse, sexual abuse, coercion, or controlling behaviors [26].

2.2.2 Effects of Childhood Emotional Abuse

Emotional abuse in childhood has been linked to various mental health disorders well into adolescence and adulthood. Mental health disorders known to be associated

with *any* form of childhood abuse include anxiety, depression, bipolar disorder, various eating and personality disorders, post-traumatic stress disorder, and revictimization. Emotional abuse specifically has been found to be strongly correlated with the increasing severity of post-traumatic stress disorder when endured in childhood [25].

Studies have shown that childhood emotional abuse is independently related to the development of emotional dysregulation and depressive symptoms compared to physical or sexual abuse [24]. This is important to consider when evaluating behavioral or learning problems or when establishing a new home with a new caregiver. Children who suffer from emotional abuse seem to show increased rates of substance use disorders in adulthood [24]. However, it is important to consider that a child often suffers from multiple forms of maltreatment resulting in overlapping long-term effects.

2.2.3 Recovering from Emotional Abuse

First Steps. Unlike physical abuse, where visible wounds heal relatively quickly, emotional abuse often takes years of active rehabilitation to achieve recovery. Before recovery from emotional abuse takes place, the victim needs to be removed from the reach of the abuser. This requires recognizing and disclosing the abuse, which is a hard first step for many victims. Emotional abuse tends to develop slowly, becoming more severe over time. This can make it difficult for the victim to see the abuse as they endure it daily. Once the victim does recognize the abuse, leaving the abuser may be further complicated by child custody, lack of housing, lack of independent finances, lack of education, or lack of employment opportunities. As mentioned previously, victims of emotional abuse experience feelings of low self-worth. Low self-esteem may cause them to believe they are incapable of a life independent of the abuser or even that they deserve the abuse they suffer. Victims of emotional abuse may show signs of Stockholm Syndrome—an unhealthy emotional attachment to the abuser [27]. A desire to withhold information about the abuse is common, often due to feelings of shame or wanting to protect the abuser. This can be especially challenging and lead to additional barriers to recovery because recovery requires honesty and transparency from the victim. However, when supporting victims of emotional abuse, it is important to validate these feelings and desires. Normalizing these emotions will aid in decreasing embarrassment and facilitating a trusting relationship [28]. Because leaving an emotionally abusive situation can be so difficult, victims of emotional abuse may need support from an outside source, such as a primary care provider, religious leader, mental health specialist, peer support group, or simply a good friend or family member. Normalizing asking for help and creating a safe space for a victim to turn when the time comes can be an excellent starting point for anyone encountering a suspected victim of emotional abuse.

Therapies. The primary goal when aiding in emotional abuse recovery is to rebuild a sense of self, develop healthy relationships, and create healthy coping strategies for strong emotions. This is most commonly achieved through various methods of psychotherapy [22]. Research shows that adults who have suffered

maltreatment as children and currently suffer from mental health disorders, such as depression, anxiety, or post-traumatic stress disorder, benefit more from psychotherapy than medication [29]. There are multiple modalities of psychotherapy that may be beneficial to a recovering victim of emotional abuse. Eye Movement Desensitization and Reprocessing (EMDR) therapy has specifically been shown to assist in resolving memories of adverse events, such as memories of severe emotional abuse [30]. Component-based psychotherapy (CBP) was developed solely to support victims of emotional abuse resulting in complex post-traumatic stress disorder (CPTSD). This method of psychotherapy addresses four components of emotional trauma—relational, self-regulation, dissociative self, and narrative construction of self [3, 31]. Other forms of therapy beneficial to victims of emotional abuse include group therapy, individual therapy, cognitive behavioral therapy, and somatic therapy [27].

Supporting Children. Experiencing emotional abuse as a child can lead to an especially challenging recovery. Childhood is when relationship roles are defined, attachments are formed, communication skills are developed, and skills for emotional regulation are learned. Recovery starts with placing the child in a safe environment away from the abuser. Safe placement can be a barrier as there are many considerations to be made, such as whether to place the child with extended family, how/if to keep siblings together, and how to support the new caregiver or adopter. Children from an emotionally unstable environment often come with severe emotional dysregulation. Preparing the new caregiver for this anticipated barrier through education and promotion of self-care is essential to success. Role-modeling healthy emotional regulation by the new caregiver is an important aspect to the path to recovery. It is advised to refrain from labeling children with a severe history of emotional abuse with any form of behavioral disorder. Commonly, these children will present similarly to other children with attention hyperactivity disorder (ADHD), autism, attachment disorders, anxiety, depression, or PTSD. However, mislabeling children recovering from emotional trauma may lead to self-fulfilling prophecies, as it may be easier for these children to adapt to the label than to an emotionally recovered state. Children recovering from emotional abuse should have a supportive care team, including a case manager, behavioral health specialist, and pediatrician [20].

Supporting Victims of Human Trafficking. Hope is an essential element when aiding human trafficking victims in their recovery from emotional abuse. In a recovery setting, victims of human trafficking feel as though they are in a state of limbo—scarred by their past and unsure of their future. Unsurety leads to feelings of worry and anxiety—worry about where they will live, how they will generate an income, or whether anyone cares about them or want them. A study conducted by Viergever et al. found that replacing feelings of hope*less*ness with hope*ful*ness gives victims direction. Victims benefit by developing a sense of competence in a skill or area. Competence can be achieved with small projects or learning activities, such as learning a language, learning to bake, or taking an art class. Recovering victims also benefits from feeling relatable to others. This can be facilitated through group activities with other victims of abuse and further provides opportunities for

emotional support. Developing autonomy allows victims to envision another future. A sense of autonomy may come from opening a bank account or developing a trade skill that could potentially generate income. Creating a sense of purpose lights up a pathway for recovering victims to move forward [32].

3 Summary

Physical and emotional abuse are significant contributors to the trauma experienced by victims of human trafficking and intimate partner violence. Physical abuse is preventable with education, identification of risk factors, and promotion of healthy relationships. Though the effects of physical abuse may be seen long after the abuse has occurred, acute injuries occurring from physical abuse are usually treatable. Long-term physical effects of physical abuse include somatization, chronic pain, traumatic brain injury, gastrointestinal disorders, and chronic disease. Psychological sequelae may include PTSD, depression, anxiety, substance use disorders, and suicide. When supporting a victim of physical abuse, the first step is to perform a safety assessment, followed by referring to appropriate community resources to create a safety plan. After treatment of any physical injuries, the next consideration should be a mental health evaluation, as mental health is the most common unmet healthcare need following physical abuse. Evidence-based mental health therapies for physical abuse recovery include CBT, behavior therapy, humanistic therapy, integrative therapy, and systemic therapies.

Emotional abuse is difficult to define, but it includes emotionally degrading behaviors committed against another individual and is characterized by a pattern of repetition. Long-term effects of emotional abuse include emotional instability, mental health disorders, chronic health conditions, and difficulty maintaining healthy relationships. Emotional abuse suffered in childhood is correlated with increased rates of post-traumatic stress disorder, emotional dysregulation, and behavioral problems into adolescence and adulthood. Recovery from emotional abuse requires recognition of the abuse by the victim, which is not always easy. Recovering from emotionally abusive relationships can take years and most often requires various forms of mental health support, including psychotherapy. Supporting child victims of emotional abuse can be difficult as severe emotional dysregulation and attachment problems often create challenges for the child and the new caregiver.

Supporting victims of abuse requires a hopeful environment. Clinicians need to take an empathetic approach, understanding that leaving a physically or emotionally abusive situation presents various challenges for the victim to overcome. Recognition of the long-term impacts of both physical and emotional abuse better prepares clinicians to provide the support required for recovery. The role of clinicians when encountering abuse is to identify, treat, and refer victims when appropriate. Clinicians should become familiar with local, state, and federal resources available to victims.

Discussion Questions

- Name three long-term physical and three long-term psychological effects of physical abuse.
- Your 28-year-old patient is here for her annual physical exam. She reports she is a survivor of human trafficking and discloses a history of related physical abuse that occurred 5 years ago. She reports feeling safe now and denies any ongoing abuse. She endorses a history of depression but is otherwise healthy. However, she complains of chronic headaches, insomnia, and random abdominal pain with no associated cause over the last 5 years. What might your patient be experiencing? How do you proceed?
- What actions may be considered emotional abuse? What key elements need to be present to call it emotional abuse?
- You are taking a social history on a new patient. She reports not having a driver's license because her partner can take her wherever she needs to go. She reports no socializing beyond work or home. She doesn't make eye contact and often makes self-degrading comments. What questions do you have for this patient? What resources would you provide her?

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