

CALIFORNIA STATE UNIVERSITY, NORTHRIDGE

Alleviating Trauma: A Therapeutic Handbook for Therapists Treating Survivors of
Intimate Partner Violence

A graduate project submitted in partial fulfillment of the requirements
For the degree of Master of Science in Counseling,
Marriage Family Therapy

by

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DEDICATION

This graduate project is dedicated to, Justina McDonald, thank you for supporting me the past three years. My cousin Dawn, thank you for your kindness and generosity. I would also like to thank my incredible pets that have brought love and joy into my life. The two wonderful dogs, Dugout and Leche, I may have rescued you, but you saved me. The five amazing cats, and a special dedication to Moonie (Buddha-Cat) who we lost in November 2011. May you rest in peace and we will meet again in another life.

I would like to thank the entire staff at Peace Over Violence, these wonderful individuals have chosen to dedicate their lives to end violence against women and are the best team of people. I am blessed to have the opportunity to share a common goal with these folks.

Lastly, I would like to thank all the women who had the courage and strength to share their stories with me and had faith in their healing process at Peace Over Violence.

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ABSTRACT

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The purpose of this graduate project was to create a handbook for therapist to address the psychological consequences of intimate partner violence (IPV), specifically posttraumatic stress disorder (PTSD) in female survivors. The prevalence of IPV and violence against women continues. This project describes various cognitive behavioral treatment outcomes. The handbook was designed for therapist and includes combination five therapeutic components from evidence based trauma focused cognitive behavioral therapy (TF-CBT) and cognitive trauma therapy for battered women (CTT-BW). The handouts focused on alleviating symptoms of PTSD in women who have been battered. The handbook can be used in session as a therapeutic tool additionally handouts can be copied and utilized as homework assignments.

CHAPTER I

INTRODUCTION

The epidemic of domestic violence in our society is costly and has devastating health and mental health consequence (National Coalition Against Domestic Violence [NCADV], 2008). IPV is defined as physical, verbal, emotional abuse, sexual assault, including stalking, intimidation, or threats perpetrated by an intimate partner against another (NCADV, 2008). The epidemic is universal and prevalent in most communities (National Center for Injury Prevention & Control [NCIPC], 2012). However, environmental factors such as socioeconomic status may increase a women's risk of IPV and developing (Gil, Szanton, Taylor, Page, & Campbell, 2009). IPV is often accompanied by psychological abuse, use of power and control, and isolation. It results in physical injury, psychological trauma, and in some causes death (Center for Disease Control & Prevention [CDC], 2010). According to NCADV (2008) one in every four women will experience domestic violence in her lifetime.

IPV is the main cause of injuries to adults (Tjeden & Thoennes, 2000). Eighty-five percent of domestic violence victims are women and intimate partner violence is one of the most underreported crimes in the United States, but men are not excluded from being victims (NCIPC, 2012). Many of these survivors will suffer in silence and be plagued with physical and mental health issues (Pico-Alfonso, 2005). More alarming is the undiagnosed symptoms of PTSD and the risk of revictimization for males, females, and children (Foa et al., 2000). Children and elderly persons are also victims of IPV, however for the purpose of this paper only issue that pertains to female victims and female survivors. Due to the gruesome nature of violence against women, it is critical to

continue the awareness of violence against women in our society.

Historically, the struggle to end oppression and violence against women in the United States was fueled by political movement. Schechter (1982) explored how the feminist movement in the 1970's shed light on the issue of battered women. Through media exposure and icon, Gloria Steinman, the women's movement gained popularity and legitimacy across the United States (Tjaden, 2004). Herman (1997) noted that women, whom were tired of being raped and beaten, united and initiated the women's movement to end violence against women. The campaign helped create intervention and prevention programs across the United States to assist women and their children from being abused and traumatized. Women's shelters opened their doors and offered refuge to women and their children during that time. Many of these shelters remained operating and are utilized by women to this day.

Tjaden and Johnson (2000) studied the use of shelter facilities and community agencies that were utilized as safe places and provided personal space, and time to heal. In their sample female survivors credited the staff at shelters provided the community with crisis intervention and prevention programs for survivors of sexual assault and domestic violence. Some also provide a 24-hour crisis hotlines, housing, case management, and mental health care. Furthermore, Perez and Johnson (2008) noted how community shelters and non-profit agencies that advocate for awareness and social change have been the catalyst for public policy by implementing changes to the law and how victims are perceived in society.

Women who are victims of IPV are more likely to suffer from physical and psychological health issues. Battered women have higher rates of physical and mental

health issues (Perez & Johnson, 2008). IPV has a devastating financial impact on society due to cost of medical care, mental health services, and unemployment. In 2003, it was estimated at \$ 8.3 billion dollars (CDC, 2012). Golding (1999) reported women who are physically assaulted in America often visit emergency rooms as a direct result of IPV. The long-term effects of this epidemic on women's health and the well being of their children are detrimental to society. Women are at the greatest risk of homicide as a direct result of IPV (CDC, 2012). Foa et al. (2000) discovered that without the intervention of physicians, mental health professionals, or access to community resources women would most likely continue being abused. Community resources, such as domestic violence shelters and nonprofit organizations, offered intervention services that were critical in ending violence against women. Bell, Goodman, and Dutton (2009) reported interventions improved battered women's ability to access to safe shelter, case management, and counseling provided a safe place to heal and establish a sense of worth and value. Since the prevalence of violence against women is high, it is likely that doctors and mental health professionals will be challenged to deal with the effects of IPV, even if they are not associated with a DV shelter or agency. The symptoms of violence are beyond physical and more detrimental is the psychological pain battered women experience (Gleason, 1993). Victims are susceptible to developing posttraumatic stress disorder similar to combat veterans. The symptoms consist of feelings of anxiety, hyperarousal, depression, and helplessness (Crowell & Burgess, 1996).

Posttraumatic stress disorder is one of the most prevalent disorders in women survivors (Golding, 1999). Similarly, Jones, Hughes, and Unterstaller (2001) reported abused women diagnosed with PTSD had other psychological issues including other

traumatic stress, substance abuse, anxiety and depression disorders. When these symptoms remained untreated, it further endangered the survivor. For example, if women cannot function she may lose her job, which contributed to her returning to an unsafe situation due to financial dependence (Johnson & Zlotnick, 2009). Due to the high rate of victimization and revictimization (Follette et al., 1996) it is imperative to treat battered women specifically for symptoms of PTSD and related mental or physical health issues.

Statement of Problem

Domestic violence was once viewed as a family issue, but is now a social epidemic with negative ramifications. Battered women often suffer from psychological disorders such as depression and PTSD related to the IPV. They also experience shame, guilt, self-blame, and the stigma of being abused contributes to their reluctance in seeking help. Therapist need evidence based resources to help survivors of intimate partner violence.

Purpose

The purpose of this graduate project was to create a handbook for therapist to address the psychological consequences of IPV, specifically PTSD in female survivors. This project provides therapists with a handbook that includes five therapeutic components from evidence-based trauma focused cognitive behavioral therapy (TF-CBT) and cognitive trauma therapy for battered women (CTT-BW). The handouts were designed to alleviate symptoms of PTSD in battered women. The handbook can be used in session as a therapeutic tool or assigned as homework.

Terminology

1. Cognitive Therapy (CT) developed by Aaron T. Beck (1976) is an action-oriented form of psychosocial therapy that assumes that maladaptive, or faulty, thinking patterns cause maladaptive behavior and "negative" emotions. (Maladaptive behavior is behavior that is counter-productive or interferes with everyday living.) The treatment focuses on changing an individual's thoughts (cognitive patterns) in order to change his or her behavior and emotional state (Beck, 1976).
2. Cognitive Trauma Therapy for Battered Women (CTT-BW) includes elements adapted from cognitive behavioral therapy treatments for PTSD. These elements are psycho-education about PTSD, relaxation training, discussing trauma, and homework assignments. CTT interventions prevent revictimization (Kubany & Ralston, 2008).
3. Intimate partner violence (IPV) occurs between two people in a close relationship. This includes current or former spouses or dating partners. IPV can be a single episode of violence to ongoing battering (CDC, 2012).
4. Physical Violence is when a person hurts or threatens to hurt a partner by hitting, kicking, slapping, or any other type of physical force
5. Sexual violence is forcing a partner to take part in a sex act by forcing or coercion
6. Emotional abuse is threatening a partner or his or her possession or loved ones or harming a partner's sense of self-worth such as humiliation, intimidation, stalking, or isolation
7. Survivor is a term of empowerment meaning the individual was able to cope despite their life-threatening experiences
8. Victim is used by law enforcement agencies and the criminal justice system to

describe an individual who was harmed, injured, or killed as a result of a crime, accident or other event or action.

Summary

In order to understand the effects of domestic violence, it is necessary to examine the research that indicates the prevalence of psychological trauma in survivors of domestic violence. Including psychological trauma, specifically the diagnosis of posttraumatic stress disorder in female survivors of domestic violence and the effective therapeutic interventions. A review of cognitive behavioral therapy (CBT), evidence based trauma focused cognitive behavioral therapy (TF-CBT), cognitive trauma therapy treating battered women will be explored. The efficacy of treatment and techniques will finalize the project.

CHAPTER II

REVIEW OF LITERATURE

This chapter will begin with the definition of IPV, the types of abuse, and the cycle of violence. Then it will address the epidemic of IPV and the history of violence against women in our society. Next exploring the existence of psychopathology in battered women and the prevalence of trauma and post-traumatic stress disorder (PTSD) in battered women. Followed by reviewing health implications of PTSD and the symptoms that pertain to survivors of IPV. Finally, concluded with a summary of treatment components for trauma related PTSD and the efficacy of cognitive behavioral therapy, cognitive trauma therapy for battered women (CTT-BW), and evidence based trauma focused cognitive behavior therapy (TF-CBT).

Kuijpers, van der Knaap, Winkel, Pemberton, and Baldy (2010) explored the severity of IPV and the affects of mental and physical health in battered women. They concluded in their sample of 120 battered women, 60% met the criteria for PTSD. In addition exposure to IPV increased the rate of anxiety, depression hopelessness, low self-esteem, dissociation, numbing, and substance abuse. The severity of symptoms correlated with the amount of time they were in the relationship and how many years prior they experienced other types of violence. Posttraumatic stress disorder was linked to revictimization and the impact of the symptoms impaired their ability to establish safety.

Intimate Partner Violence

According to the CDC (2012) IPV is an attempt to establish power and control in an intimate relationship through use of violence and other forms of abuse. The abuse includes, but is not limited to physically, sexually, or psychologically violence, stalking,

threats, harassment, intimidation, financial abuse, destruction of property one's own property or partner's property, harming pets, using children as pawns and identity theft. The primary goals of the abuser are power and control regardless of gender since violence exist equally in homosexual and heterosexual relationships (Peterman & Dixon, 2003). Domestic violence and intimate partner violence is a term used interchangeably to describe violence against women, men, children, and elders, but the focus of this paper is violence that occurs between intimate partners and battered women.

Types of Abuse

Women may experience different types of abuse during a relationship with their intimate partner. According to NCADV (2008) the following types of abuse occur to women victimized by an intimate partner: physical, sexual, psychological, verbal abuse, and stalking.

Physical Abuse. Physical abuse occurs in many forms such as slapping, biting, pushing, shoving, grabbing, punching, shaking, head banging, kicking, choking, throwing and damaging property. The abuser may use knives, guns, hot objects, cars and any other objects as lethal weapons. The threat of physical violence alone is sufficient to keep control over the individual as long as they are convinced that their life is in danger and they will be punished for disobeying (Walker, 2004). In some cases, men have held women hostage by chaining them to bedposts, locked in the house while they are gone, and kept under 24-hour surveillance at gunpoint in extreme cases (Walker, 2004).

Isolation is one of the main goals of the perpetrator. Some women have access to cars and telephones, but they are monitored in such ways as mileage tracking and cell phone bill usage, and denied access to family resources (Tjaden & Thoennes, 1998). Most women

over time learn to submit to this type of abuse rather than to face escalating abuse.

Although the escalation of abuse in many cases it is inevitable due to the increase of violence over time this is detrimental to their safety.

Sexual Abuse. Sexual abuse includes coerced or forced sexual activities with or without the use of physical violence (NCADV, 2008). The victim may be raped or have foreign objects inserted in the vagina or anus. Some women have been bound or handcuffed and raped by their partner. The majority of battered women reported they respond positively to sexual advances to avoid additional physical, sexual, and psychological abuse (Walker, 2004). By submitting to the perpetrator's sexual demands they may avoid further punishment and the submission is used to create harmony in the relationship despite the negative consequences. Campbell (2002) explored the types of coercion and violence battered women experienced which included mutilating of the genitals, stabbing their breasts, brutal anal rapes, raping them when they are ill, forced oral sex, punching their pregnant abdomen, and kicking them in the vagina. Furthermore, T.W. Leung, W.C. Leung, and Ho (2005) discovered battered women are forced to have sex with other people while the acts were photographed or video taped. Many battered women suffered vaginal infections and gynecological problems attributed to the rape.

Psychological Abuse. There are several definitions of psychological abuse. According to NCADV (2008) psychological abuse includes yelling, shaming, blaming, humiliation, isolation, and harassment. Similarly O'Leary (1999) defined psychological abuse as criticism and verbal aggression. Furthermore, the acts were intended to produce emotional harm or threat of harm and cause fear and low self-esteem (Murphy & Cascardio, 1999). The constant fear of abuse diminishes the women's sense of self worth

and can be more damaging than physical abuse due to long-term effects (Bell et al., 2008). Walker (2004) described psychological abuse as dominance and isolation. In which the abuser attempts to control that the victim spent time with, attempted to cut ties with friends and family members, listened to phones conversations, jealous of others, and used harassment. Types of harassment were sleep deprivation, and repeated sessions of intense questioning. Gas lighting is serious form of psychological abuse in which the abuser attempts to destroy another's perception of reality (Gass & Nichols, 1988). Stout (2002) characterizes gas lighting as a sociopathic trait in which the sociopath exploits others and denies doing wrong. Those who have victimized by their charm and convincing lies may doubt their own perceptions.

Verbal Abuse. Evans (2010) stated that most people recognize name-calling as verbal abuse. However verbal abuse takes many forms (Evans, 2010, p.21). In our culture it is hidden in putdowns, criticizing, manipulating, countering, topping, putting down, defeating, hard selling or intimidating (Evans, 2010, p.21). Verbal abuse may be overt or covert. Overt abuse such as angry outburst directed at partner or saying "You are too sensitive." Whereas covert abuse is described as "crazy making" and the victim is unable to recognize and deal with reality (Evans, 2010, p.23).

Stalking. Stalking is a serious and often life threatening crime and affects the victim, their family, friends and coworkers. In the United States 1.4 million women are stalked each year and 1 in 20 women will be stalked at least once in their lifetime. According to the National Center for Victims of Crime (NCVC, 2002) the legal definition varies state by state, but all states have some type of stalking law. Stalking is considered any kind of unwanted contact in which the victim feels afraid or is directly or indirectly threatened.

Stalking is generally any action that makes victims fear for their safety. Any person who harasses, follows, monitors, threatens, intimidates, or exhibits obsessive attention can be considered a stalker. Former partners or current partners, who are responsible for as many as 30% of all homicides against women, stalk many victims of IPV (FBI, 1998). Tjaden and Thoennes (2002) investigated how abusers utilized stalking to monitor and control their victims. The psychological impact on the victims included symptoms of anxiety, depression, hypervigilance, stress, and increased fear. The abuser appeared at the victim's work, school, or any place they frequently hung out. They may also call repeatedly and leave threaten messages, send mail or gifts.

Cycle of Violence

Bancroft (2002) describes the cycle of violence in three stages: the tension building phase, the eruption, and the "hearts and flowers" stage. The longer the relationship lasts the cycles shorten and the violence escalates. In the first phase the tension building occurs and usually there is only a threat of violence. The battered woman experiences an increased amount of tension, and the victims feel like they are walking on eggshells. During this phase, the batterer controls more and communication breaks down. In the second phase, the abuse incident occurs and the victim is traumatized. The batterer often blames the victim for their behavior for example: "If you would have been home on time then I would not get so pissed off and hit you." The victim feels helpless and trapped and they are often isolated from friends and family due to shame and guilt. In the third stage, there is a period of the batterer feeling remorse and being apologetic. The batterer uses manipulation and minimizes the violence. The victim experiences mixed emotions and feel responsible and guilty. There is reconciliation and

the batter makes promises to change, however they usually do not take responsibility for their actions or accountability for their behavior (Walker, 2004).

Patriarchy and Intimate Partner Violence

According to the feminist theory the major cause of IPV is the sexist, patriarchal nature of society, which treats women as male property (Brown, 1992). This can be seen in the legal system in which many states will charge assault against a stranger as a felony, but assault of one's wife is a misdemeanor (Herman, 1997). There is evidence that suggests patriarchal beliefs impact wife battering because patriarchy teaches oppression. Through entitlement, beliefs about power, being in charge and the authority in a person's life the abuser is influenced by societal patriarchy (Evans, 2010). Similarly, Brown (1992) argued that men who have patriarchal beliefs are more likely to adhere to strict gender roles and feel ownership of their wives. Therefore, they use physical violence to control and overpower them. Men that are vulnerable to patriarchal beliefs are those who have lost control over their own lives to poverty, substance abuse, and unemployment. Deprived of a sense of power, they tend to dominate and control their wives. Brush (2002) evaluated how women who worked experienced increased IPV. Their employment was seen as a threat and it affected the reoccurrence of physical violence. The study indicated that out of 167 welfare recipients interviewed, 40% reported an increase of physical abuse by their partners when they started working. Women who worked represented a threat to their partner's power and control and most women will quit their jobs out of shame and fear.

Intergenerational Violence and Affects on Children

According to NCADV (2008) violence is transmitted intergenerational when children witness violence between parents or caretakers. Although women are victims of domestic violence, children are victims of family violence (NCADV, 2008), which can have devastating implications for their future. Males, who viewed their mothers being battered are twice as likely to abuse their own partners and children as adults and 30 %-60 % of male perpetrators also abused their own children. Harris et al. (2007) reported that female children who were exposed to violence were 158 % more likely to be victimized by violence themselves than their peers from non-violent homes. Also the emotional impact of exposure to violence and trauma should be considered a public health issues due to the child's immediate long-term development. Long-term exposure to childhood trauma has also been linked to poverty (Cohen et al., 2006). Children exposed to intimate partner violence altered their neurobiological chemistry, deregulated their cognitive, social and affective processes (van der Kolk, 2001; Harris, Lieberman, & Marans, 2007).

When children are faced with a traumatic experience, they often feel helpless and immobilized. In an attempt to deal with danger the anticipation of trauma will cause a deregulation of cognitive and social functioning (Cohen et al., 2006). The underlying issue may not be properly addressed because they are labeled as behavior and discipline problems in child care and school settings (Puccia et al., 2012). Many times the children are overlooked and neglected by their own mothers who live in fear (Harris et al., 2007). Therefore, the children suffer the consequences and lack a sense of safety, shelter, and food. Although programs have been implemented to help traumatized children, they

lacked structural support. Liberman (2007) advised clinicians to implement an approach, which collaborates with other service systems including law enforcement, childcare, child protective agencies, and pediatric doctors. These agencies and services lacked comprehensive trauma focused interventions. Therefore, traumatized children who were victimized or witnessed violence need multiple support systems that collaborated together to help them heal and recover (Puccia et al., 2012). Instead, they were placed in foster care or juvenile systems and they fall through the cracks because these systems are independently operations that do not collaborate to with mental health professionals to address PTSD. Puccia et al. (2012) examined the efficacy of TF-CBT in domestic violence cases with children diagnosis with PTSD. Twenty-seven clients completed treatment and overall showed significant improvement of PTSD symptoms following TF-CBT treatment. Previously, Cohen, Mannarino, and Iyengar (2011) observed significant progress of hyperarousal and avoidance symptoms of PTSD in children who participated in community TF-CBT than children who did not in traditional child-centered therapy.

Physical and Mental Health

Battered women experienced an increase of medical issues, psychological distress, as well as reluctance to seek social support as a result of intimate partner violence (Browne, Salomon, & Bassuk, 1999). Physicians and mental health professionals are mandated reporters and trained to recognize signs or symptoms of domestic violence and child abuse. However, mental health professionals often misdiagnosed symptoms of PTSD as depression or anxiety, and physicians may be reluctant to investigate even if they are suspicious. IPV is the most underreported crime and many victims do not report IPV to doctors, police, family, or friends (CDC, 2012).

When physicians missed the opportunity to validate the patient's symptoms and provide treatment it jeopardized their safety, especially if their physician was only person they had a relationship where the abuser has no access to or association with (Yehuda, 2002).

Campbell et al. (2002) sampled 2,005 women who had been physically/sexually abused and compared their health to women who had never been abused. The Abuse Assessment Screen was used to identify those who had been abused, their general health was measured with the Medical Outcomes Study 36-shortform health survey, and the Miller Abuse Physical Symptoms and Injury Scale was used to measure abused specific health issues. The results indicated abused women had inferior health, overall 60% higher rate of physical health problems compared to those that were not victims of IPV. Women who were abused had a 50-70% increase in specific health problems like headache, back pain, digestive issues, and vaginal infections. Further investigation of the physical and mental health issues of battered women related to violence indicated that battered women who sought medical attention had injuries to their head, neck, face, thorax, breast, and abdomen. Fear and stress resulted in chronic health problems such as headaches and back pain. They more frequently suffered from gastrointestinal symptoms, loss of appetite, eating disorders, and irritable bowel syndrome. The most common gynecological issues due to forced sexual intercourse included sexual transmitted diseases, vaginal bleeding or infection, decrease sexual desire, and urinary tract infections. Forced sex also attributed to unintended pregnancy and HIV. Their co-morbid issues were substance abuse, previous arrest, unemployment, and most were uneducated.

Victims of IPV had a higher risk of developing psychological disorders such as depression disorders, anxiety disorders, and post-traumatic stress disorder (Roberts,

Lawrence, Williams, & Rapheal, 1998). The most common mental health effects included depression and posttraumatic stress disorder. Battered women suffered various mental health issues and had higher rates of mental health difficulties than non-victims (Jones et al., 2001). The association of IPV and PTSD was higher than that of childhood sexual assault (Campbell, 2002).

Perez and Johnson (2008) purposed that the severity of IPV correlated to the severity of PTSD symptoms and compromised the women's future safety. Symptoms of PTSD in battered women impacted their experience of future violence, which inhibited their ability to utilize outside resources. This played a major role in being revictimized and in their ability to establish safety. It is imperative that treatment is focused on PTSD symptoms so battered women learn to alleviate symptoms and utilize available resources to end the cycle of violence.

Violence with Same-Sex Couples

The actual number of IPV in gay, lesbian, bisexual relationships is unknown, Tjaden, Thoennes, and Allison (1999), analyzed the prevalence of IPV in same-sex relationships. The numbers are similar to heterosexual incidents of IPV, but bisexual individuals experienced higher rates of IPV. In a homophobic society, same-sex IPV is disregarded because homosexual victims are not granted equal legal protection (Jablow, 2000), despite the same number of incidents reported in same-sex relationships as heterosexuals (Messinger, 2011). S.M. Seelau and E.P. Seelau (2005) hypothesized perception of heterosexual IPV and same sex IPV conformed to gender role stereotypes. Several perceptions of gender stereotypes were consistent with previous research based on male power, aggression, and physical ability to inflict harm. Heterosexual IPV was

perceived harshly because female victims were viewed as more vulnerable than male partners. Participants viewed male abusers as a greater threat to females. Violence in same-sex relationships was considered less severe because of the perception of gender-role stereotypes, not menacing enough for any type of intervention due to perceived lack of stability and the stereotyped that same-sex violence is less severe in homosexual relationships. Furthermore, gays, lesbians, and bisexuals experienced internalized homophobia that perpetuated the lack of reporting IPV and seeking outside interventions or resources (Messinger, 2011). Similarly due to societal homophobia, homosexual victims felt it was their responsibility to protect the abusive partner based on ignorance of IPV and homophobia (Peterman & Dixon, 2003). Gay, lesbians, and bisexuals stay in the relationship based on fear, shame, guilt, hope, pride, financial dependence, low self-worth, ignorance, and children (Ferris et al., 1997). The types of abuse are similar although lesbians reported they were more often victims of psychological and verbal abuse (Peterman & Dixon, 2003). It has been estimated that gay men experience higher rates of IPV than in same sex relationship because both partners are capable of being abusers and gay men are not less violent (Peterman & Dixon, 2003). However, Renzetti (1992) stated mutual battering is a myth used to minimize violence in same-sex relationships. Intimate partner violence occurs in all relationships, social class levels, educational levels, and cultural backgrounds (Peterman & Dixon, 2003).

Environmental Factors & Minorities

According to Gill et al. (2009) living in poverty or residing in inner cities increased the risk of experiencing IPV and developing PTSD. A sample of 250 battered women who experienced poverty and resided in urban communities participated; 86%

were African American, 14% Caucasian, and 4% other. These women were four times more likely to develop PTSD due to environmental factors. PTSD was associated with IPV, chronic fatigue, chronic pain, and they had twice the number of clinical visits per year compared to women without a history of IPV and PTSD. Therefore, IPV and PTSD were common in low-income urban women who sought medical services. A previous study, Breslau et al. (1998) reported socioeconomic status and residing in urban communities attributed to PTSD. African American women living in poverty reported experiencing PTSD based on the chronic stress of living in poverty, risk of being assaulted, experiencing trauma in childhood, lack of quality housing, and racism (Breslau et al, 2009).

Latinas, especially immigrants are vulnerable and the potential of IPV increases based on the abuser using this to their advantage (Vidales, 2010). Many abusers threatened and manipulated them into staying by using their immigration status against them. Vidales (2010) presented various barriers, which contributed to minority IPV. In the sample, language, cultural, structural, and institutional barriers were predictors of IPV. Latina women, who did not speak English fluently, did not seek help. The Latino emphasis on family, and collectivism kept the women from leaving. Women in the study also reported poverty interfered with their ability to leave.

Posttraumatic Stress Disorder

History of Posttraumatic Stress Disorder

Vietnam veterans returned to the United States in the late 1970's with psychiatric issues (van der Kolk et al., 2005). Many of them returned exhibited abnormal behavior and it was treated as "battle fatigue or gross stress." Based on Abram Kardiner

(1941) clinical description of symptoms he called “war neuroses” a new diagnoses, posttraumatic stress disorder (PTSD) was created. Kardiner was a psychiatrist who redefined Freud’s definition of hysteria. He believed patients developed hypervigilance and sensitivity to temperature, pain, and sudden tactile stimuli. Kardiner described the symptoms in *The Traumatic Neuroses of War* (1941), as those who startled easily, were irritable, and impatient. He hypothesized that individuals who remained on constant alert and anticipated return of trauma agitated “cognitive homeostasis” and harmony.

In 1980, the American Psychiatric Association (APA) included in the diagnosis of post traumatic stress disorder as a legitimate diagnostic category in *Diagnostic and Statistical Manual of Mental Disorder* (3rd ed.; DSM-III; American Psychiatric Association, [APA], 1980). The change filled the gap between public health knowledge and shed light on the mental impact of trauma (McNally, 2003). Herman (1997) explained that men who suffered from battle fatigue formed “rap groups,” personal meetings with their peers, where they shared traumatic experiences of war. The rap groups provided solace and awareness about the effects of war. Through their efforts, the vets were able to get the attention of American psychiatrists.

Since the men were able to legitimize posttraumatic stress disorder as a psychological disorder, which resulted from the war, it helped shed light on the trauma of rape and ramifications of violence against women. Prior to theory of posttraumatic stress disorder battered women and survivors of sexual assault were diagnosed with rape trauma syndrome (van der Kolk et al., 2005). The American anti-war movement created opportunity for the birth of the women’s movement and women organized for equality. Women gathered across the country raising conscious awareness of violence against

women. The movement exposed the issue of rape and created awareness about intimate partner violence. Walker (1984) created the battered women's syndrome which captured the trauma symptoms not included in PTSD, such as the effects of the victims sense of safety, self worth, trust, revictimization, and the loss sense of self. The women's movement made women's issues visible and battered women's shelters opened their doors to the millions of women who had suffered in silence from rape, incest, and intimate partner violence. Through their ongoing efforts, feminists achieved the recognition of mental health professionals and the psychological symptoms of trauma seen in rape, incest, and domestic violence survivors were essentially the same as those seen in war vets not as war trauma, and could be classified as PTSD.

Posttraumatic Stress Disorder Diagnosis

Since then, the American Psychiatric Association (APA) has continued to revise and update the definition of PTSD. According to the current version of the *Diagnostic and Statistical Manual of Mental Disorders* (4th ed., text rev.; *DSM-IV-TR*; American Psychiatric Association, [APA], 2000) Posttraumatic Stress Disorder (PTSD) is characterized by three categories; the first is reexperiencing the traumatic event, the second consists of avoidance and numbing, and the third is includes hyperarousal, insomnia, and hypervigilance. The diagnostic criterion is listed as followed: Criterion A (p. 467) "following exposure to an extreme traumatic stressor involving direct personal exposure of an event that involved actual or threatened death or serious injury or other threat to one's physical integrity; or witnessing an event that involves death, injury, or a threat to the physical integrity of another person; or learning about an unexpected or violent death, serious harm, or threat of death or injury experienced by a family member

or other close associate. The person's response to the event must involve intense fear, hopelessness, or horror (in children, the response must involve disorganized or agitated behavior).”

The characteristic symptoms resulting from the exposure to the extreme trauma include persistent reexperiencing of the traumatic event (APA, 2000). The persistent avoidance of the stimuli associated with the trauma and numbing of general responsiveness (APA, 2000) and persistent symptoms of increased arousal (APA, 2000). These symptoms must be present for more than a month. Disturbances must cause clinically significant distress or impairment in social, occupational, or other important areas of functioning (APA, 2000).

Posttraumatic stress disorder is diagnosed as acute if duration of symptoms is less than three months and chronic if duration of symptoms are three months or more, or delayed onset symptoms appear six months after the traumatic event. Traumatic events include, but are not limited to military combat, violent personal assault, sexual assault, domestic violence, being kidnapped, taken hostage, terrorist attacks, torture, incarceration as a prisoner of war or in a concentration camp, natural or manmade disasters, server car accidents, or being diagnosed with a life-threatening illness (APA, 2000). Symptoms usually begin within three months after the trauma, but these symptoms may be latent for years before they appear (APA, 2000). These symptoms included intrusive thoughts, nightmares, flashbacks, and psychological distress when exposed to reminders of event, intense physiological reaction in response to the reminders of event (APA, 2000). People with PTSD avoid or numb out by evading thoughts or feelings associated with the event, avoiding people or places, experiencing memory issues, feeling detached, restricted

affect, and hopelessness (Crosby, 2008). It is common for the person to experience symptoms of increased arousal such as insomnia or difficulty staying asleep, rage, difficulty concentrating, hyperactive vigilance, anxiety, and being easily startled (Crosby, 2008).

Psychobiology of Posttraumatic Stress Disorder

Van der Kolk (2001) reviewed various studies about the psychobiology of PTSD. With the assistance of technology such as position emission tomography (PET), single photon emission computed tomography (SPECT) and event –related potential (ERP) neurologists have been able to exam how trauma affects certain structures of the brain. The structures of the brain and phenomena of trauma were illustrated through research with patients diagnosed with PTSD. The individuals receive information from the environment through sensory inputs. The brain analyses this input with different structures of the brain, operating on both instinctive and acquired knowledge about the environment, body, and the brain. Complex brain functions are used to regulate the hypothalamus and the brain stem.

Most individuals with PTSD have difficulty transmitting discriminatory function and suffer from intrusive memories, numbing, and hyperarousal (van der Kolk, 2001). The specific brain structures associated with the physiology of PTSD are the parietal lobes, which assimilates information between different cortical association area; the amygdala, which assesses information for emotional meaning and is activated when people are exposed to reminders of trauma; and the hippocampus, which maps and categorizes experiences and in traumatized people is decreased in size. The other structures involved in emotional and cognitive mapping of experiences are the corpus

callosum, which transfers information between both hemispheres, and a decrease in size has been found in adults abused as children (van der Kolk, 2001). The other structure affected, the cingulated gyrus, acts as an amplifier and a filter to incorporate emotional and cognitive components of the mind. Finally, the prefrontal cortex, which functions as a problem solving, learning, and complex stimulus discrimination. The frontal cortex of people with PTSD is less active when exposed to reminders of the trauma (van der Kolk, 2001).

Symptoms of Posttraumatic Stress Disorder in Battered Women

Jones et al. (2001) analyzed the correlation of intimate partner violence and posttraumatic stress disorder. They discovered it was common for battered women to experience symptoms of PTSD and its associated features, but were often misdiagnosed and treated for depression. The treatment for depression was ineffective and perpetuated the symptoms of PTSD. Lindemann (1994) explored cognitive coping processes of traumatized individuals who compensated for their constant state of hyperarousal by shutting down in two ways: on a behavioral level, by avoiding stimuli that triggered memories of trauma, and on a psychobiological level through emotional numbing. Recently, van der Kolk (2001) studied memory and discovered individuals with PTSD suffered from hyperamnesia, hyperactivity, to stimuli and reexperiencing with numbing, avoidance, and amnesia. The symptoms contribute to female revictimization due to development of PTSD symptoms and the empirical data exposed the complex responses to trauma. Although there are various symptoms of PTSD, intrusive thoughts, flashbacks, nightmares, avoidance and numbing, and hyperarousal, are the most pervasive symptoms linked to intimate partner violence (Johnson, Zlotnick, & Perez, 2011).

Trauma Related Shame and Guilt

Trauma related guilt and shame hinders survivors' cognitive and emotional development (Golding, 1999). Combined, PTSD and trauma related shame and guilt are detrimental to the survivor's safety, mental and physical health. Beck et al. (2011) explored the association of shame and guilt among women victims of intimate partner violence. The women in the study reported higher levels of shame associated with greater levels of emotional and verbal abuse; this was associated with elevated levels of PTSD. In terms of guilt, the women reported guilt related cognitions and guilt-related distress. Using a series of moderation analyses they examined whether exposure to specific forms of psychological abuse were associated with shame and guilt. The results indicated that high levels of both emotional and verbal abuse along with domination and isolation interacted with high levels of shame in association with PTSD. These results suggest that interventions designed to address shame and guilt can be useful in treatment when dealing with women suffering from violence and control from intimate partners.

These findings were consistent with Lewis (1971) who measured how shame and guilt played a powerful role in individuals who had experienced trauma. He described shame as an individual's internal negative evaluation where they have deemed themselves as "unworthy" or "a bad person." Guilt is described an internal negative evaluation of an action for example; a person will feel like they should have known better. Battered women struggle with both shame and guilt because they feel like since they should have known better and left the abuser they deserved to be abused. Therefore it is common to observe both shame and guilt in survivors especially after they are no

longer in the relationship.

Learned Helplessness and Lack of Affect Regulation

Learned helplessness is based on the model of emotional learning (Kubany & Ralston, 2008). The model of emotional learning was originally tested and demonstrated on animals, and applied to human behavior (Pavlov, 1932). Emotional learning is based on the theory of repeatedly pairing or associating something that is neutral with something that evokes positive or negative feeling without prior learning. In time the neutral event will also evoke positive or negative feelings. Then it is associated with fear and avoided. The natural desire is to seek relief. Relief reinforces because most people in physical or emotional pain will do anything to alleviate the pain. However, the relief is temporary especially in an abusive relationship. Survivors tend to learn how to gain immediate gratification (Kubany & Ralston, 2008) and this leads to constant escape and avoidance behaviors that cause symptoms of PTSD.

Additionally, battered women with symptoms of PTSD are unable to leave and seek help due to increased stress. Battered women have difficulty regulating when they feel overwhelmed and this interferes with personal relationships due to increased physiological arousal (van der Kolk, 1988). The levels of hormones necessary to manage stress are deteriorated due to chronic hypersensitivity, low levels of serotonin, and high cortisol levels (van der Kolk, 1988). In addition, hormonal imbalance in trauma survivors affects the individual's ability to regulate the intensity of emotions such as anger, and anxiety. Traumatized people often perceive most interactions as traumatic and feel revictimized since they are unable to regulate (van der Kolk, 1988). Stress can manifest itself somatically and reactions include panic attacks, rage, and anxiety (van der Kolk,

1988).

Depression

Abused women adopt coping strategies to evade further abuse or minimize the mental and physical pain. Trauma survivors cope using denial, minimization, and repression (Golding, 1999). Victims of IPV are more likely to express symptoms of depression, emotional numbing and avoidance (Vidales, 2010). Depressive symptoms were the primary reason survivors of IPV sought help from a health profession (McCauley et al., 1995). Campbell, Kub, and Rose (1996) and Campbell, Kub, Belknap, and Templin (1997) discovered that 39% to 43% had moderate to severe symptoms of depression. Campbell and Soeken (1999) researched women's response to abuse over a 3-year period. The outcome revealed physical and mental health improved once the female ended the relationship. Terminating the abusive relationship resulted in less depression, improved self-esteem, and self-care. Similarly, Yehuda (2002) reviewed concepts of PTSD and medical doctors deem symptoms as easily identifiable, but because depression and other anxiety disorders have similar characteristics, the diagnosis is missed unless specific questions are asked about the traumatic event. Frequently, battered women will visit the emergency room. Campbell (2002) estimated 12-17%, of these visits were a direct result of IPV, but injuries were presented as accidents. Doctors are unwilling to investigate and often the patient will not offer to disclose the information (Campbell 2002). Especially when the case involves shame, or secrecy such as rape where any disclosure might mean an invasive examination, non-adherence might manifest as an avoidance tactic.

Zlotnick, Johnson, and Kohn (2006) compared depression symptoms, lower life

satisfaction, lower self-esteem, and functional impairment with survivors of IPV to those who had never experienced abuse. They found that survivors of IPV reported higher levels of depression, low self-esteem, less life satisfaction, and more functional impairments. Additionally, battered women exposed to prolonged periods of psychological abuse risk developing major depressive disorder whether or not they stayed in the relationship.

Numbing and Avoidance

Winkel et al. (2003) suggested that victims with cognitive coping issues, due to their previous victimization, experienced more psychological problems when confronted with a new victimization because prior incidents make them vulnerable and they are at a greater risk. According to Krause, Kaltman, Goodman, and Dulton (2006) emotional numbing symptoms of PTSD are associated with a higher risk of continued abuse. The findings indicated that IPV victims might numb during a dangerous situation, reducing their ability to appropriately assess a situation as unsafe and escape. Van der Kolk (2001) identified numbing as the most significant PTSD symptom, and people who suffer from intrusive thoughts remained in a state of feeling unmotivated and dead to the world. PTSD symptoms of numbing from outside stimuli and part of the patients' everyday functioning is intrusive. The emotional numbing interferes with resolving trauma in therapy because there is an absence of the ability to imagine a future, which blocks the capacity to discover new solutions. The high correlation of symptoms of PTSD in victims of domestic violence is grounds to create effective interventions that address PTSD to prevent further trauma.

Kubany (1998) found that 48% of battered women in shelters met the diagnostic

criteria for PTSD. Kubany, Hill, and Owens (2003) studied the efficacy of CTT-BW with 37 ethnically diverse formally battered participants. The immediate CTT-BW group showed no significant difference the group who received delayed onset CTT-BW. The participants in both groups expressed significant symptoms of PTSD and depression based on Beck Depression Inventory and CAPS scores (Kubany et al., 2003). Battered women enrolled in CTT-BW no longer met the criteria for PTSD numbing and avoidance at a three-month follow up and 6 month follow up. Additionally, 94% no longer met the criteria for depression, guilt, shame, and had experienced significant increase in their self-esteem (Kubany et al., 2003). Kubany et al. (2004) followed previous research with a larger sample size of 125 formally battered women. Using the same technique of randomly assigning participants into two groups immediate and delayed onset treatment there was significant decrease in symptoms of PTSD and depression in battered women. Improvements post CTT-BW at three month revealed 89% did not meet the criteria for PTSD and six month follow up 59% no longer meet the criteria for PTSD. Similar, Kubany and Watson (2000) identified the unique needs of battered women with PTSD. Battered women have guilt and shame issues, they have experienced repeated traumas, they remain enmeshed with their former abusers, and many are at risk for revictimization.

Dissociation

Van der Kolk and Fisler (1996) reported individuals who learned to cope with stress by dissociation most likely would do so in response to trivial stressors and it impedes their ability to face challenges. Many survivors of trauma developed bulimia, self-mutilation, and borderline personality disorder (Kuijpers et al., 2011). In acute cases of dissociation some people suffer from dissociative identity disorder. Previously, van der

Kolk et al. (1996) studied the affects trauma had on memory functions. The four categories of memory affected are traumatic amnesia, dissociative processes, sensormotor organization, and memory impairment. Traumatic amnesia occurs in traumatized individuals in which all or parts of the event will be lost, but in some cases will later return. It can last for weeks, months, or years (van der Kolk, 1996). Memory impairment makes it is difficult for patients to account for the memory gaps and to recall and construct an accurate reality due to continued dissociation. Dissociation is the compartmentalized experience of trauma stored in memory as sensory perceptions or affective states. These sensormotor perceptions or affective states are stored as visual images, olfactory, auditory, or kinetic sensations (van der Kolk, 1996).

Hyperarousal

Hyperarousal is a common symptom in those who have survived combat, rape, kidnapping, spouse abuse, accidents, natural disasters, incest, and sexual abuse (van der Kolk, 1988). It plays a major role in avoidance and escape behavior in people with PTSD (van der Kolk, 1988). Recently van der Kolk (2001) noted that only a percentage of people will develop symptoms of hyperarousal and they compensate by shutting down on a behavioral level, avoiding stimuli, and by emotional numbing. Symptoms of hyperarousal include sleeplessness, hyper valiance, and irritability (Jones et al., 2001).

Assessment of Posttraumatic Stress Disorder in Battered Women

The most common measures are designed to assess for PTSD symptom severity, depression, and trauma history. PTSD Symptom Severity Scale Interview ([PSS-I] Foa, Riggs, Dancu, & Rothbaum, 1993) is used to indicate the presence of PTSD. Another screening measurement is Clinician Administered PTSD Scale ([CAPS] Blake et al.,

1990). CAPS, is a structured interview for assessing symptoms of PTSD according to the criteria in the DSM-IV-TR (APA, 2000).

Depression

The Beck Inventory ([BDI] Beck, et al., 1961) is a 21-item self-report which measured characteristic attitudes and symptoms of depression with established reliability and validity.

Trauma History

The Traumatic Life Events Questionnaire (TLEQ; Kubany et al., 2000) assessed exposure to 21 potential traumatic events such as fear, hopelessness, horror, and helplessness, to determine if the event was a traumatic stressor. TLEQ items were developed from multiple sources to enhance the validity across important traumatic events.

Overview of Cognitive Behavioral Therapy

This section provides an overview of Cognitive behavioral therapies and their historical development. Then it includes a description of the efficacy of treating posttraumatic stress disorder through the lens of cognitive behavioral therapies. Finally a review of the cognitive behavioral therapies used to develop the manual and the basic principles of perception, thoughts, emotions, and behavior.

History and Development of Cognitive Behavioral Therapies

Behavior therapy was developed in the 1950's as a clinical method used to treat a variety of psychological disorders and utilized to treat a broad range of the population (Banduara, 1977). The major areas of established include: classical conditioning, operant conditioning, social learning and cognitive behavioral therapy. The therapeutic approach

was based on classical and operant conditioning (Wilson, 2000). In the 1960s Cognitive behavioral therapy (CBT) was developed as a hybrid of cognitive therapy and behavioral therapy. CBT is a form of psychotherapy that focuses on treating maladaptive patterns of cognition, behaviors, and emotions. CBT has been effective in treating a variety of psychological disorders such as mood disorders, anxiety disorders, substance abuse, PTSD, and psychotic disorders. Albert Bandura, Albert Ellis, and Aaron Beck, Ivan Pavlov, and Albert Skinner, were the most influential founders of behavior therapy and cognitive behavior therapy.

- Bandura (1977) developed social learning theory. The theory is a combination of operant conditioning and classical conditioning with observed learning. The belief that we are behavior is based on the environment and outside stimuli. Bandura believed individuals are capable of changing their behavior.
- Ellis (1962) developed the A-B-C theory of emotions used to analyze irrational thinking. He theorized that individuals that A= activating event, B = Beliefs about A, based on the meaning of the event, C= Emotional and behavioral consequence based on the belief. Most individual will connect A to C, the activating event to the emotional and behavioral consequence. The missing piece is B, the belief, which is incorporated by the individual.
- Beck (1976) developed Cognitive therapy known for its effective treatment of depression. Beck's theory was based on the way people feel and behave was based on perceptions of their experience. Cognitive therapy emphasizes changing negative thoughts and beliefs. The goal is to change core beliefs through automatic thoughts and reconstruct maladaptive beliefs.

- Pavlov (1932) developed operant and classical conditioning based on his work with dogs. Classical conditioning refers to what happens prior to learning that creates a response pairing. Operant conditioning is a type of learning in which behavior is influenced by a reward and positive and negative reinforcement.
- Skinner (1953) based his work on operant conditioning to shape and modify human behavior. Through his research with cats he discovered forms of punishment and reinforcement. The desired behavior can either be reinforced through reward or extinguished through punishment. The ways in which to reward and punish are as follows: positive reinforcement, negative reinforcement, positive punishment, and negative punishment.

Trauma Focused Cognitive Behavioral Therapy

Trauma Focused Cognitive Behavioral Therapy (TF-CBT) is a component based treatment model and combines, CBT principles, including attachment, developmental neurobiology, family, empowerment, and humanistic theoretical models to meet the needs of sexually abuse children and their parents (Cohen, Mannarino, & Deblinger, 2006). The primary goals are: reducing symptoms of PTSD, a change in children's maladaptive beliefs about the trauma, support and skills for parents to use with their own issues about the trauma, and skill to help parents support their children (Cohen, Mannarino, & Deblinger, 2006). TF-CBT is a short-term treatment approach designed to work in as few as 12 sessions. Depending on the need of the client more sessions can be provided for a longer period of time. TF-CBT was designed to treat children, however the components can be used with adult survivors. Additionally TF-CBT addresses behavior problems, sexualized behaviors, trauma related shame, interpersonal trust, social

competence.

The core values are summarized as follows: components based, respectful of cultural values, adaptable and flexible, family focused, therapeutic relationship is central, self-efficacy is emphasized ([CRAFTS] Cohen, Mannarino, & Deblinger, 2006). TF-CBT core components are psychoeducation and parenting skills, relaxation, affective modulation, cognitive coping and processing, trauma narrative, in vivo mastery of trauma reminders, conjoint child-parent sessions, enhancing future safety and development ([PRACTICE] Cohen, Mannarino, & Deblinger, 1996). TF-CBT components are based on a set of skills that progressively build on previous skills. It is not a ridged session-to-session treatment approach.

Additional clinical considerations when working with trauma survivors includes other service needs such as safety planning, placement, housing, and transportation. Often trauma survivors have comorbid issues such as substance abuse, alcoholism, or suicidal thoughts. Intermittent suicidal thoughts are experienced by survivors with a history of trauma, however acute suicidal intentions require the involvement of other providers. Serious substance abuse requires additional intervention from drug or alcohol treatment centers.

TF-CBT is based on a strong therapeutic relationship. It emphasizes developing trust, acceptance, empathy, the therapist models how to restore trust, self-esteem, and optimism in traumatized individuals. The long-term goal of TF-CBT is self-efficacy, self-regulation of affect and behavior. The individual should be able to sustain their strengths and skills after therapy.

Cognitive Trauma Therapy for Battered Women

Cognitive trauma therapy for battered women (CTT-BW) is an intervention designed to treat women with history of physical and sexual abuse and to treat PTSD in battered women (Kubany et al., 2003). CTT-BW includes the following preexisting CBT components: psychoeducation, relaxation, trauma narrative, exposure, self-awareness of negative thoughts and beliefs (Kubany & Watson, 2003). However, specialized components for battered women include: assessing and correcting irrational guilt related beliefs and reducing negative self-talk related to shame and guilt (Kubany & Manke, 1995).

Efficacy of Cognitive Behavioral Therapies and Trauma Survivors

Domestic violence is pervasive in our society and research indicates that female survivors suffer from PTSD. Cognitive behavioral therapy is an effective intervention in reducing PTSD symptoms (Johnson & Zlotnick, 2006). Recently Iverson et al. (2011) explored the use of CBT and reduction of risk for future trauma in victims of IPV who had developed symptoms of PTSD and depression. They predicted that emotional numbing symptoms impede the survivor's ability to respond or detect the risk of danger based on previous research that suggested emotional numbing was the only PTSD symptom cluster that significantly predicted IPV revictimization, (Kruse et al., 2006). The results were consistent with previous research; however, at the six-month mark those who received CBT therapy had fewer symptoms of PTSD and depression, which correlated with a decrease in revictimization. Iverson et al., (2011) suggested some survivors needed long-term psychotherapy to address comorbid issues such as substance abuse.

In addition Iverson, Shenk, and Fruzzetti (2009) focused on the chronic emotional deregulation in female survivor of IPV. The objective was to utilize dialectical behavioral therapy (DBT) a type of comprehensive CBT, in a 12-session group therapy. The core skill of DBT is mindfulness and self-validation, which are important skills for female survivors of intimate partner violence due to their inability to describe and articulate their emotions (Linehan, 1993). The outcome of the group showed significant improvements of depression, hopelessness, psychiatric distress and increase social adjustment. However, the DBT group had limitations. The participants in group therapy lacked a diverse sample because participants were low-income Caucasian females. And it lacked a control group. Therefore it was unclear whether outcomes were due to other factors like socioeconomic status, ethnicity, culture norms, group cohesion, or therapeutic alliance.

Common Techniques for Use with Battered Women

The techniques for the handbook were picked from TF-CBT and CTT-BW. Each technique has been empirically researched and clients exposed to these have shown significant improvements and alleviated symptoms PTSD (Cohen, Mannarino, & Deblinger, 2006; Kubany & Ralston, 2008).

Psychoeducation

The goal of the Psychoeducation component is to help normalize and validate the client's trauma reactions and symptoms, offer accurate information about trauma and trauma reactions. Myth busting is also an important part of psychoeducation. Normalizing and validating can motivate the client to engage in exercises, which will eventually alleviate symptoms of PTSD (Kubany & Ralston, 2008).

Relaxation

Focused breathing helps the client explore how stress manifests in the body and mind. Through focused breathing they learn to alleviate stress and tension in therapy by following simple instructions. Once they have mastered the techniques they can practice on their own (Cohen, Mannarino, & Deblinger, 2006).

Affect Expression and Modulation

This component eliminates pessimistic thoughts, shame, guilt, and anger as a result of trauma (Cohen, Mannarino, & Deblinger, 2006). Clients practice and learn how to manage affective states and self-soothe when they are feeling distressed. Clients counter affective states with an appropriate intervention to modulate the affects by creating a list of several different possible self-soothing activities.

Cognitive Distortions

This intervention helps explore thoughts that are inaccurate and unhelpful (Cohen, Mannarino, & Deblinger, 2006). The client learns about the cognitive triangle and how thoughts, feelings and behaviors are connected. The goal is to teach the client to think positively in order to feel and behave differently.

Negative Self-Talk

The objective of this component is to motivate the client to break habits of negative self-talk by monitoring their thoughts on a weekly basis. The self-monitoring assignment should be photocopied and a verbal commitment should be made to comply. The therapist should explain how negative self-talk is detrimental to the client's emotional health and progress in therapy (Kubany & Ralston, 2008).

Trauma Narrative

Having the client write a narrative of traumatic events deals with avoidance symptoms of PTSD (Kubany & Ralston, 2008). It helps the client overcome their fears by exposing them to non-threatening reminders of these events in a safe environment (Cohen, Mannarino, & Deblinger, 2006).

Summary

Women who are exposed to trauma are susceptible to psychological and physical health issues. The excessive rate of domestic violence and prevalence in society has created awareness about impact of IPV and consequences of violence. It has also appealed to mental health professionals and physicians who have generated research. Empirical evidence proposes that cognitive behavioral therapy is effective with survivors of trauma. Cognitive behavioral therapy can help female survivors of domestic violence alleviate symptoms of PTSD when utilized in individual and group counseling.

CHAPTER III Implications

Introduction

Cognitive therapy is a therapeutic intervention used with survivor of IPV (Kubany et al., 2008). The creation of the handbook was inspired by the need for an effective treatment model for therapists treating battered women. The techniques presented are based on TF-CBT and CTT-BW. The handbook includes an outline of TF-CBT and key components of trauma therapy. A combination of five TF-CBT components and several CTT-BW components for battered women were selected and used to create the handbook.

Development of Project

The project was developed using cognitive therapy literature: *Treating PTSD in Battered Women* (Kubany & Ralston, 2008), American Psychiatric Association *Diagnostic and statistical manual of mental disorders*, 4th ed., text rev., *Treating trauma and traumatic grief in children and adolescents* (Cohen, Mannarino, & Deblinger, 2006), *Abused women and survivor therapy: A practical guide for the psychotherapist* (Walker, 1994), *Healing the trauma of domestic violence: A workbook for women* (Kubany, McCaig, & Laconsay, 2004).

Intended Audience

These techniques are intended for therapist to use with females seeking therapy at agencies like Peace over Violence, formally the Los Angeles Commission on Assault Against Women. For 40 years, Peace Over Violence, a private non-profit agency, has a history of providing intervention and prevention services related to sexual assault and domestic violence. The uses of these techniques are effective with survivors whom meet

the following criteria: the survivor is no longer in the abusive relationship does not live with the abuser, and they are committed to completing a minimum of 10 sessions of individual therapy (Kubany & Ralston, 2008).

Personal Qualifications

The handbook can be used by a mental health professional such as a marriage family therapist, or other licensed mental health professionals.

Environment and Equipment

The therapeutic environment should be a well-lit room with comfortable furniture and free of clutter. The space should be calm, quiet, and relaxing. The room should be clean and the temperature should accommodate the client's needs. The therapist should make sure they have a designated room reserved or make sure no one interrupts during the session. This includes turning off all electronic devices before each session and they are to remain off during the session. It is important to have an analog or digital clock in the room to keep track of time. The room should always have at least one box of Kleenex tissue to offer to clients when necessary. Try to keep outside noise to a minimum especially in hallways and from adjacent rooms. The noise machine will help drown out noise and provide additional privacy.

Formative Evaluation

Project was presented to interns Peace Over Violence, during a one-on-one consultation with MFT students and LCSW students from UCLA and USC in March 2012. These individuals interned at Peace Over Violence in the past year. Additionally one student from Art Center College of Design was asked to evaluate the handbook. They were asked to critic the design, organization, effectiveness, if they would use the

handbook, and areas of improvement.

Project Outline

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CHAPTER IV

Formative Evaluation

This project was presented and reviewed by three trainees as part of formative evaluation.

- March 2011, the treatment handbook was presented and reviewed by an MFT intern at Peace Over Violence. In general comments addressed the design, organization, and flow of the handbook. The reviewer found it user friendly and practical
- March 2011, the treatment handbook was presented and reviewed by an LCSW intern at Peace Over Violence. In general comments addressed handouts and organization of the handbook. The reviewer suggested replacing a specific technique and revising the contents of the handouts because they were difficult to comprehend.
- April 2012, the treatment handbook was presented to an Art Center student to test the flow and easiness. In general the student with no psychology background or prior knowledge of cognitive behavioral therapy was able to read and follow the components of TF-CBT. They found the handouts simple and useful. They suggested removing some items from the affect modulation handout because it seemed arrogant.

Next chapter will discuss the implications of feedback received to improve and implement treatment in the future. It will also address recommendations and conclusion.

CHAPTER V

DISCUSSION

The purpose of this graduate project was to create a handbook for therapist to address the psychological consequences of intimate partner violence (IPV), specifically posttraumatic stress disorder (PTSD) in female survivors. This project provided the therapist with a handbook that included a combination five therapeutic components from evidence based trauma focused cognitive behavioral therapy (TF-CBT) and cognitive trauma therapy for battered women (CTT-BW). The handouts focused on alleviating symptoms of PTSD in women who have been battered. The handbook can be used in session as a therapeutic tool additionally handouts can be copied and utilized as homework assignments.

Recommendation

In this section we discuss the recommendation for implementation this curriculum and recommendations for future research. The handbook was based on empirical research and evidence based trauma therapy. The techniques have been studied with children and adolescents, however; it was modified to treat symptoms of PTSD in adults. Cognitive trauma therapy has been efficacious in treating and alleviating symptoms of PTSD in female survivors.

Recommendations for Implementation

It is strongly recommended that the therapists have knowledge and experience working with survivors of intimate partner violence. Understanding cognitive behavioral therapy is strongly encouraged as well as basic knowledge or TF-CBT. The handbook can only be used successfully with a trained clinician who understands the unique needs

of battered women. Battered women have to overcome many challenges in recovery. The therapist should be sensitive and empathic to their needs.

Recommendation for Future Program Development

The next version of treatment will include a Spanish translation. Minority victims often experience language barriers and have limited access to resources (Vidales 2010). Peace Over Violence serves a large number of the Latino population in Los Angeles. It is important to psychoeducation and provides adequate resources to that community.

The next version of the handbook will include a section on treating same-sex partner violence. Most same-sex couple's violence is overlooked where lesbian and bisexual victims are ashamed to disclose their sexual orientation. This further complicates psychological issues and magnifies shame (Messinger, 2011).

Recommendation for Future Research

In the future research will be conducted for evaluating effectiveness of the curriculum.

Conclusion

Intimate partner violence affects women and their children. Violence against women is rampant in all communities has negative long-term ramifications for everyone involved. To prevent partner abuse it is imperative to utilize early interventions such as teen violence awareness. Since the issues are so pervasive all families should have access to therapeutic services such as family and couples therapy to help deal with stress and conflict. Although there are existing batter treatment programs they intervene after the fact and the abuser usually has a long history of violence. Even shelters and community agencies get involved after the damage has been done. Harsher punishments for battering

and child neglect may be a solution, but seems to have created a criminal system that entraps the poor, the uneducated, and stifles real change. Social change takes time and until all violence is unacceptable prevention is a plausible solution. Prevention can influence both females and males to deal with conflict in a non-violent manner through mutual respect, non-violence communication, and empowerment.

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Appendix A

A Handbook for Therapists Treating Survivors of Intimate Partner Violence

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Introduction

Leaving an abusive relationship is a crucial decision a survivor will make and seeking help takes a tremendous amount of courage. There will be many hurdles in the journey of healing and self- discovery. Collaborating with a therapist is often part of the healing process. More important, is learning how to trust again and establishing a safe and trusting relationship with the therapist. In therapy and through cognitive behavioral techniques, the survivor can learn to overcome symptoms of PTSD and begin to rebuild her life and thrive. A competent therapist will have empathy and create a non-judgmental therapeutic environment where survivors feel empowered because most battered women have experienced trauma or multiple traumas which have taken a toll on their self worth and self-esteem. It will be counterproductive if you come across as judgmental, victim blame, or attempt to control. The survivor is free to make decisions and discover the person who was hampered by abuse, trauma, and ultimately symptoms of PTSD.

This handbook includes a combination of five techniques from trauma focused cognitive behavioral therapy (TF-CBT) and cognitive trauma therapy for battered women (CTT-BW) used to alleviate symptoms of PTSD. The handbook has been divided into three sections: the first sections introduces TF-CBT and CTT-BW, while the second and third sections describes specific trauma focused components of each model. Although these components were created to build on one another, the techniques can be used throughout various sessions in therapy. Because personal healing and growth varies depending on the individual it is important to use each technique appropriately and when

the client is ready. This is not a session-by-session treatment workbook and there is flexibility with the introduction of each component. Some components may take more than one session to comprehend and practice before it is mastered. The conclusion of the handbook will include additional training and resources on TF-CBT and CTT-BW.

Section 1: Information for the Therapist

Trauma focused cognitive behavioral therapy (TF-CBT) is an evidence based treatment model which is based on a hybrid of various psychotherapies. TF-CBT, integrates trauma interventions, cognitive behavioral principles, including attachment, developmental neurobiology, family, empowerment, and humanistic theoretical model to meet the needs of traumatized children and their parents (Cohen, Mannarino, & Deblinger, 2006). However, the treatment model has been adapted to treat adult survivors of intimate partner violence. TF-CBT address symptoms of PTSD, depression, and anxiety usually within ten sessions, each session is about fifty minutes. Components based are a set of skills that progressively build on previous skills. It is not a ridged session-to-session treatment approach. These components should be provided in a way that meets the need of the individual. The treatment model places an emphasis on showing respect for the individual, family, cultural values, religion, sexual orientation, and community. The therapist should work with the individual to implement TF-CBT components to suit their needs. Therefore your creativity, flexibility, and ability to adapt treatment case by case will create a successful TF-CBT model. A therapist who experiments with creativity and clinical judgment will determine how the components are utilized. It is important to develop trust, acceptance, and empathy. A competent therapist models how to restore trust, self-esteem, and optimism in a traumatized individual. The

long- term goal of TF-CBT is self-efficacy, self-regulation of affect and behavior. The individual should be able to sustain their strengths and skills after therapy. The TF-CBT components used for this project are psychoeducation, relaxation, affect expression and modulation, trauma narrative, cognitive distortions, and enhancing future safety. Since the treatment model was adapted for battered women the author selected specific components that have been used to treat PTSD in adults.

Cognitive trauma therapy for battered women (CTT-BW) is based on a psychoeducational learning model which that targets specific symptoms of PTSD in battered women. CTT-BW treatment model emphasis is on self-advocacy and therefore it is only appropriate for women or men who are no longer in an abusive relationship (Kubany & Ralston, 2008). Clinicians interested in conducting CTT-BW need to have previous expertise and knowledge pertinent to intimate partner violence. Similar to the therapeutic qualities listed in TF-CBT, it is imperative that the therapist has experience and is comfortable dealing with trauma. Also having the capacity and preparation to manage the healing process and challenges of working with battered women. Those who have experienced trauma have a history of multiple traumas. CTT-BW therapist are mentors, and advocates, these qualities are not acquired through formal education. Having the capacity to listen and bare witness to this type of pain will include allowing the client to process intense emotions in session, being comfortable with silence, being in the moment, and not having the “answer” to fix the client. CTT-BW is based on fifteen components: beginning treatment, negative self-talk, stress management, relaxation, trauma history, education about PTSD, exposure homework, learned helplessness, trauma related guilt, assertiveness training, managing “supposed to” beliefs, managing mistrust,

identifying potential abusers and managing unwanted contacts with former abusers. The components usually take between one to two sessions with each session is approximately fifty-five minutes. Cognitive trauma therapy has resulted in reduction of PTSD, depression, guilt, shame, and increases self-esteem (Kubany & Ralston, 2008).

Section 2: Trauma Therapy Overview

The purpose of the initial session is to establish rapport, safety, obtain history of partner abuse, and create goals. The first session is usually ninety minutes. As the therapist, provide an overview of the therapeutic approach and discuss key principles of therapy that will be addressed. Therapists who are genuine, empathic, and non-judgmental build rapport with clients quickly. These qualities promote safety and trust, especially with those who have suffered from multiple traumas. The initial session may be the first time the client discloses their abuse. Therefore maintaining confidentiality is critical to establishing a therapeutic relationship. The purpose of creating long-term and short-term goals facilitates the client's sense of accomplishment. The client can reflect on their establishment of milestones of progress and growth.

Key Principles of Trauma Therapy

The key principles in trauma therapy have a significant role and with the client (Walker, 1994). The following key principles are safety, empowerment, validation, and emphasis on strengths, psycho-education, understanding oppression, and making own decisions:

Safety & Empowerment.

Safety planning is important to establish immediately in therapy (Kubany & Ralston, 2008). Develop an escape plan with the survivor by addressing the following:

- Figuring out escape routes out of the house in case doors are blocked.
- Encourage her to keep an extra set of house and car keys hidden somewhere safe so she can leave quickly.
- The following information should be stowed away and accessible: drivers license, social security cards, copies of essential legal papers for herself and children, immigration papers, medical insurance, public assistance ID, birth certificates, marriage license, school/vaccination papers, bank records, credit cards, etc.
- Keep a packed bag with spare clothes and money, medicine, diapers, formula, toys, and emergency food.
- Tell someone you trust about your situation and your plan.
- Hide or destroy anything that might give your batterer a clue to where you might be going or that you are planning on leaving. Remember to delete browsing history on computers and deactivate social media sites, etc.
- Choose a safe time to leave when you know your abuser is at work or out for the night. Never return to the home alone and call the local police to escort you. This is called a “civil standby.”
- Long-term law enforcement intervention may be implemented by obtaining a restraining order. However, discuss possible retaliation and that she is aware it might make the situation worse due to retaliation. Therapy includes relationship with family, friends, and significant others.

Validation

Validating the client’s feelings, thoughts, and choices are critical to the recovery process (Kubany & Ralston, 2008). Evade victim blaming with attentiveness to words or

phrases that come across as judgmental and insensitive. Provide validating messages such as “You don’t deserve to be treated that way. There is no excuse for domestic violence.”

Emphasis on Strengths.

It is important to place emphasis on their strengths rather than their deficits. When the opportunity arises, the therapist can identify those strengths and bring awareness of positive qualities and attributes the client may not be aware due to PTSD (Kubany & Ralston, 2008).

Psychoeducation

Utilized in therapy to teach new coping skills. The therapist can encourage the client to continue her education, get a better job or change careers, or take up parenting classes, and self defense (Kubany & Ralston, 2008).

Oppression Through a Multicultural Lens

Survivors encompass a variety of cultures, sexual orientations, gender, race, class, education levels, and disabilities. A therapist that is sensitive and aware of oppression the client experiences will help the client adapt new strategies (Kubany & Ralston, 2008).

Personal Decisions and Support

Many battered women may not be able to immediately leave their abuser. The goal is to support her decisions and discuss the consequences if she stays in the relationship. Through psychoeducation and support the client can make an informed decision. When the therapist attempts to push the client, it will recreate power and control experienced in the abusive relationship (Kubany & Ralston, 2008).

Trauma History

Once goals have been established ask the survivor about their history of intimate

partner violence. Below is a list of questions you can ask the client:

- Tell me about the problems you are having?
- Where you physically or sexually abused as a child? Did you witness violence growing up?
- Tell me about past or present intimate partner violence?
- How long did it last and when did the abuse begin?
- Who abused you?
- Tell me about them?
- How did you meet and how did it end?

The objective is to identify other trauma related issues and give the client the opportunity to disclose their experience of intimate partner violence (Kubany & Ralston, 2008). The following sections will focus on psychoeducation and five techniques, which alleviate symptoms of PTSD.

Section 3: Psychoeducation

Psychoeducation is a core intervention of cognitive therapy including TF-CBT (Cohen, Mannarino, & Dellinger, 2006) and CTT-BW (Kubany & Ralston, 2008). It is used to normalize the client's experience of traumatic events and their response to those events. During the initially session present the factsheet on IPV (refer to handout). It includes information about intimate partner violence, the frequency of IPV and the definition of power and control. These kinds of fact sheets not only dispel myths about IPV, but also provide facts about the effects of IPV. Take a few minutes to read the TF-CBT/CTT-BW handout with the client and include the following: The individual might be having significant PTSD or trauma related symptoms, research suggests that early

intervention prevents long-term difficulties, review PTSD symptoms from the clinical assessment if possible, the only way to significantly deal with trauma is by talking directly and openly, the components are implemented at the client's pace. Explain how you will be working in collaboration with the client. Use a multicultural approach and be open to learning their cultural rituals, religion, and family norms. A thorough understanding and comprehension of the diagnostic criteria for PTSD is essential before you discuss the diagnosis in session. Refer to the current edition of the American Psychiatric Association (APA) Diagnostic and Statistical Manual Fourth Edition Text Revision (DSM-IV-TR, 2000). In session have a copy of the PTSD handout for both you and the client so you can read along with the client. When presenting the client with the PTSD Questionnaire normalize the symptoms by explaining PTSD is a normal reaction to extreme stress and most women who have been in an abusive relationship often experience PTSD. Reassuring the client the difficulties they struggle with are caused by what happened to them, not because of anything about them.

Materials: IPV Factsheet Handout, TF-CBT/CTT-BW Model of Treatment Handout, Psychoeducation PTSD Handout, and PTSD Questionnaire.

Section 4: Therapeutic Techniques

There are numerous evidence based cognitive behavioral therapy techniques that have been utilized to treat PTSD in survivor of trauma. To treat battered women who have sought help from clinicians the following are five techniques picked from TF-CBT and CTT-BW. These have been empirically researched and clients exposed to these have shown significant improvements and alleviated symptoms PTSD (Cohen, Mannarino, & Deblinger, 2006; Kubany & Ralstion, 2008). These techniques are relaxation; affect

regulation and modulation, cognitive distortion triangle, negative self-talk, and trauma narrative. Each technique includes a set of instructions for the clinicians, a list of materials, and handouts with instructions for the client located after the techniques.

Technique # 1: Relaxation

Utilize this component to teach the client focused breathing which helps reduce somatic manifestations of stress. (Cohen, Mannarino, & Deblinger, 2008). Focused breathing consists of (1) taking 1-3 deep breaths and slowing exhaling; (2) thinking “relax” before each exhalation; and (3) scanning their body for tension and attempting to relax as much as possible as they breath out. In session practice begins with a few trials in a comfortable chair. Begin the session you plan on practicing relaxation by explaining the manifestations of stress such as increased heart rate, hypervigilance, startle response, irritability, panic attacks, anger and rage, agitation, insomnia, and restlessness. Then explain why these manifestations are problematic especially for survivors with PTSD. Finally practice focused breathing in session with the client and provide the handout as reference so they can continue to practice at home (Cohen, Mannarino, & Deblinger, 2008). The handout is step-by-step instruction to focused breathing for the client.

Material: Focused Breathing Handout

Technique # 2: Affective Expression and Modulation

As you help the client process issues related to PTSD symptoms begin by helping the client identify feelings. Clarification about the expectation to only feel positive emotions is unrealistic because most likely they will experience an array of emotions, especially in the beginning of treatment. Then explain “wrong” feelings do not exist in therapy and our purpose is to learn how to manage overwhelming emotions (Kubany,

McCaig, & Laconsay, 2004). Next help them create their own list of several different ways they can self-soothe when they are starting to feel distressed or they can practice from the samples listed on the handout. Material: Affect Modulation Handout

Technique #3 Cognitive Triangle

During the session in which this is implemented ask the client to identify how they felt during and after the abusive relationship. Then explain the connection between thoughts, feelings, and behavior. Next illustrate the cognitive triangle, using the handout as a visual aid. Finally, help them identify their own negative thought, feelings, and behaviors. Awareness will generate change and she can finish by creating positive thoughts that are accurate (Cohen, Mannarino, & Deblinger, 2006). Materials: Cognitive Triangle Handout

Technique # 4 Negative Self-Talk

The goal is challenging clients' negative self-talk and their lack of self-advocacy (Cohen, Mannarino, & Deblinger, 2006). Battered women have difficulty with the styles of functioning that are related to a lack of self-advocacy. The lack of self-advocacy creates low self-esteem, depression, and their needs not being met (Kubany, McCaig, & Laconsay, 2004). The styles of functioning are listed below

- Placing other people's needs before their own
- Passiveness and tolerance of disrespect
- Making decisions based on "supposed to"
- Inability to deal with hostility

The goal is to encourage the client to break the habit of negative self-talk by committing to the negative self-talk monitoring form as a homework assignment. Explain

how and why negative self-talk is counterproductive emotionally and mentally. Provide copies of the negative self-talk monitoring form homework handout and look it over with them. Follow up with the non-negative thinking technique. Focus on the client's strengths. In session explore the following questions with the client:

- “Does putting yourself down motivate you to try harder or make you feel worse?”
- “Putting yourself down lowers your self-esteem. Why would you want to lower your self-esteem?”

Then explain the importance of giving them the respect and they deserve from other people by respecting themselves. Encourage and reinforce the following examples of positive statements. Validate the client's strength and courage for seeking help and their commitment to therapy. This will inspire hope, and impact their view of themselves.

Material: Negative Self-Talk Monitoring Form

Technique #5 Trauma Narrative

Therapist: The goal of trauma narrative is deal with avoidance related to PTSD. Trauma narrative improves psychological and physical health as while as integrate thoughts and feelings into a meaningful experience by desensitizing the individual. Assign trauma narrative as homework and in the following session have them read it out loud to you. It is important that you help them identify feelings and process their stories immediately after they share. Through their trauma narrative they will be able to differentiate negative thoughts and reminders from negative emotions such as fear, shame, rage, terror, and helplessness (Cohen, Mannarino, and Deblinger, 2006).

Materials: Trauma Narrative Handout

Section 5: Handouts for Clients

IPV Factsheet Handout

Intimate partner violence (IPV) is an attempt to establish power and control in an intimate relationship through use of violence and other forms of abuse. The abuse includes, but is not limited to physically, sexually, or psychologically violence.

- Physical abuse is when a person hits or attempts hurt their partner by kicking, slapping or any type of physical force.
- Sexual violence is forcing a partner to have sex without their consent.
- Threats of physical or sexual violence include verbal, gestures, weapons, or other means or intent to harm.
- Emotional abuse is threatening a partner or their possessions or loved ones, or their sense of self-worth. Examples are verbal abuse, stalking, intimidation, financial abuse; destruction of property one's own property or partner's property, harming pets, using children as pawns and identity theft.
- Power and control is the primary goals of the abuser are power and control regardless of gender since violence exist equally in homosexual and heterosexual relationships the frequency of IPV

IPV is a serious problem in the United States:

- 3 in 10 females and 1 in 10 men in the U.S. have experienced some form of abuse by and intimate partner related to IPV
- In 2007, IPV resulted in 2,340 deaths and of those deaths 70% were females.
- The cost of IPV in 2003 was estimated at \$8.3 billion due to medical care, lost time at work, and mental health services

Effects of IPV

- Physical injuries including cuts, bruises, broken bones, internal bleeding, miscarriages, and death
- IPV is linked to post traumatic stress disorder (PTSD)
- IPV is linked to alcohol and substance abuse

Risk Factors for abusive tendencies

- History of violence or aggression
- Witnessing or being abused as a child
- Alcoholism or abusing drugs

*Excerpted from CDC (2012) IPV factsheet understanding intimate partner violence

TF-CBT & CTT-BW Model of Treatment Handout

Take a few minutes to read TF-CBT and CTT-BW treatment model. Please ask questions and express any concerns.

TF-CBT is a short-term psychotherapy composed of various components

- Components that we will utilize together are psychoeducation, relaxation and stress management, affective expression and modulation, negative self-talk, cognitive coping, trauma narrative.
- TF-CBT reduces intrusive thoughts and memories, avoidance and emotional numbing, physical reaction to hyperarousal, difficulty concentrating, or irritability.
- In addition improvements in depression, anxiety, trauma related shame and guilt, interpersonal trust, and relationships.
- Handouts will be utilized in session or assigned as homework
- In this handbook many of the exercises correspond to homework assignments. Clients who do their homework are far more likely to recover from PTSD and we strongly encourage you to make the effort to complete all exercise.

*Excerpted from Cohen, Mannarino, and Deblinger (2006), Kubany & Ralston (2008).

Posttraumatic Stress Disorder: Symptoms of Posttraumatic Stress Disorder
(American Psychiatric Association, 2000)

The following symptoms are normal and common reactions to highly stressful or traumatic events—events that evoke intense fear, helplessness, or horror. PTSD symptoms are characterized into three clusters: reexperiencing, avoidance and numbing, hyperarousal.

A. Trauma stressor: the individual has been exposed to a traumatic event in which both of the following were present:

- The person experienced, witnessed, or was confronted with an event or events that invoked actual or threatened death or serious injury, or a threat to the physical integrity of self or others.
- The individual's response involved intense fear, helplessness, or horror.

B. Reexperiencing

- Unwanted thoughts about the event when nothing has happened to remind you
- Distressing dreams or nightmares about the event
- Suddenly reliving the event, experiencing flashbacks of the event or acting or feeling like it was actually happening again
- Distress when reminded of the event
- Physical reactions when reminded of the event such as sweaty palms, rapid heart beating, pounding heart, dry mouth, nervous stomach, or tense muscles

C. Avoidance and Numbing

- Efforts to avoid thoughts or feelings that remind you of the event
- Efforts to avoid activities, people, or places that remind you of the event

- Inability to recall important parts of what happened
- Loss of interest in important activities, such as your job, hobbies, sports, and social activities
- Feeling detached or cut-off from others around you
- Feeling emotionally numb-unable to feel tenderness, loving feelings, joy, or unable to cry
- Thinking your future will be cut short in some way for example no expectations of a career, a serious relationship, or children, or expectation of a premature death

D. Hyperarousal

- Trouble falling asleep
- Difficulty concentrating
- Irritability or outbursts of anger
- Being alert, watchful, or on guard, for example looking around you, checking out noises, or checking to see if doors and windows are locked
- Being jumpy or startled by sudden sounds or movements
- Feeling guilt related to the event or feeling upset because you should have thought, felt, or acted differently
- Feeling anger related to event or feeling upset because you think someone else should have thought, felt, or acted differently
- Grief, sorrow, or feelings of loss in regard to loved ones, belongings, identity, self worth, faith in god, or human nature, optimism, loss of control, loss of innocence, or loss of time

E. Duration of the disturbance, symptoms in cluster B, C; D is more than 1 month.

F. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

*Excerpted from Kubany and Ralston (2008) Treating PTSD in battered women.

PTSD Questionnaire

The following twenty questions about PTSD symptoms are to determine if you have PTSD. Please answer each question by circling yes or no. If your answer is yes, provide a brief example of the situation in the space provided.

1. Do you have unwanted thoughts about the abuse? Yes No
2. Do you have nightmares? Yes No
3. Do you have flashbacks or relive the abuse? Yes No
4. Do you feel distressed or upset when reminded of the abuse? Yes No
5. Do you avoid thoughts or feelings that will remind you of the abuse? Yes No
6. When reminded of the abuse do you have a physical reaction such as heart pounding, or palms sweating? Yes No
7. Do you avoid people, places, and activities that will remind you of the abuse?
Yes No
8. Are you unable to remember parts or events related in the abuse? Yes No
9. Lost interest in hobbies, social activities, or work? Yes No
10. Do you feel detached from others? Yes No
11. Do you feel emotionally numb? Yes No
12. Do you think you will die prematurely? Yes No
13. Do you have difficulty falling asleep or staying asleep? Yes No
14. Are you angry, moody, or irritable? Yes No
15. Do you have difficulty concentrating? Yes No
16. Are you anxious or startled easily? Yes No
17. Do you blame your self for the abuse? Yes No

18. Do you feel guilty and think you should have acted, thought, or felt differently? Yes No

19. Are you hyper alert? Yes No

20. Do you experience grief, sorrow, or loss related to the abuse? Yes No

The above are symptoms of PTSD and are grouped into three primary PTSD clusters. Question 1 to 5 refers to the reexperiencing symptoms cluster. Questions 6 to 12 refer to the numbing and avoidance symptoms. Question 13 to 17 refers to the hyperarousal symptom cluster. A diagnosis is based on a person experiencing symptoms from each of these clusters. Specifically, to have PTSD, a person must have at least one reexperiencing symptom, three numbing or avoidance symptom, and at least two hyperarousal symptom. To estimate whether you have PTSD determine the following:

1. Write the number of yes answers to questions 1 to 5: _____
2. Write the number of yes answers to questions 6 to 12: _____
3. Write the number of yes answers to questions 13 to 17: _____

It is likely you may have PTSD if you indicated the following:

1. At least one reexperiencing symptom (question 1-5)
2. At least three numbing or avoidance symptoms (question 6 to 12) and
3. At least two hyperarousal symptom (question 13 to 17).

If you numbers do not add up to 1, 3, and 2, you may still be experiencing PTSD to some degree and only a trained mental health professional can formally diagnosis you or anyone else as having PTSD.

Focused Breathing Handout

Duration: 20-30 seconds, about 20 minutes a day

Instructions: Find a comfortable position in your chair or you can lie down when you practice at home.

1. Take several slow, deep breaths, thinking to you “inhale” as you breath in and “relax” as you breath out. Your breathing should be slow and comfortable, letting the air in and out slowly. Breathe in deeply so your lower abdomen expands during inhalation and reduces when you exhale. This is known as belly breathing.
2. Direct their attention on the breathing and as you breath out let go of as much muscle tension as you can. Try relaxing your jaw and face muscles as you breath out.
3. Practice this form of breathing in safe situations for example while you are in the waiting room, standing in line, in rush hour traffic, on the verge of road rage.
4. Practice daily initially in calm situations to master the techniques and then in stressful situations such as on a stressful phone call, etc.

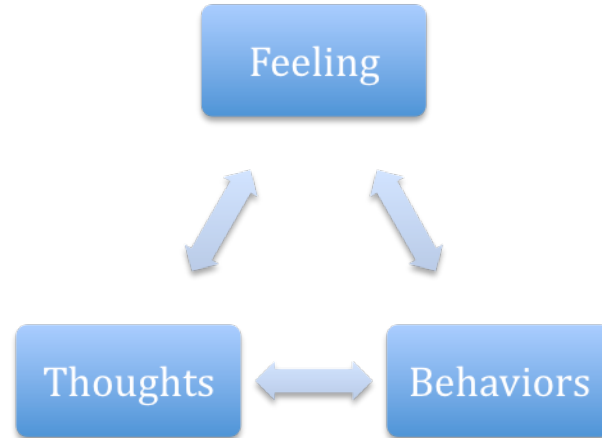
*Excerpted from Cohen, Mannarino, and Deblinger (2006)

Affect Modulation: Ways to Feel Better When You Feel Stressed

- Stop what you are doing, close your eyes and take 10 deep breaths
- Visualize yourself in your “safe place”
- Go somewhere quiet and read
- Listen to music
- Pray, meditate, or repeat your mantra
- Listen or read something humorous
- Run in place for 3 minutes or stretch
- Call a friend who will understand you listen without giving advice
- Journal
- Take a hot shower or warm bath
- Get a massage
- Dance
- Use post-its to leave positive messages around for yourself
- Silently say ten good things about yourself
- Tell someone you love him/her
- Play with or walk your dog
- Draw
- Do something nice for someone else

*Excerpted from Cohen, Mannarino, and Deblinger (2006)

Cognitive Triangle Handout



Cognitive coping is used to challenge pessimistic thoughts. The term cognitive coping refers to a variety of interventions in which clients explore their personal thoughts that are inaccurate and hinders growth. The goal of the cognitive triangle exercise is correcting negative thinking by identifying inaccurate reoccurring thoughts and learning how to enhance happiness by creating an optimistic perspective on life. This can be accomplished through awareness of negative thoughts and creating positive thoughts. Pessimistic thoughts are reinforced with traumatic events because individuals attempt to make sense of traumatic events through life experience and basic knowledge. Therefore it is difficult for trauma survivors to think positive and feel optimistic.

Instructions: When you feel upset about something, write down the situation and how it makes you feel. Then “track back” to what you thought was about the situation that made you think that way. Was that thought (1) accurate and (2) helpful? Create alternative thoughts in this situation and write down how they will make you feel and whether they are accurate and helpful. Identify new, helpful thoughts, think about what you would say to close friend in a similar situation if he/she shared the distressing

thought(s).

1. Identify a situation: _____
2. Identify the thought: _____
3. Behavior: _____
4. New thought: _____
5. New feeling: _____
6. New behavior: _____

These are examples of pessimistic thoughts:

- “ I can only be happy if I am in a relationship.”
- “ I’m old no one will love me and I will die alone.”
- “Things like this always happen to me.”
- “ I am too fat and ugly”
- “Other women have better relationships then me because they don’t talk back.”

Possible coping statements to challenge these:

- “Lots of things make me happy; I will try and do one fun thing today.”
- “I’m amazing and age has nothing to do with how vibrant and youthful I feel; it is too soon to think about loving someone else.”
- “I will take care of body and mind through exercise and eating healthy; I am committed to a healthier lifestyle. I am beautiful.”
- “I have the right to express how I feel and if I don’t like something; a mutual relationship is important to me.”

Negative Self-Talk Handout

The way you talk to yourself and the specific words you use when you speak and think impact your recovery. Certain words and phrases interfere with a survivor's ability to overcome PTSD. Negative self-talk is a habit and being aware of how often you use negative words and phrases will create awareness. When you are aware and conscious of negative self-talk you can correct thoughts and speech. This will improve your emotional well being and create happiness. The self-talk monitoring form will teach you to keep track of four categories of negative self -talk in your thoughts and speech, to help break this destructive habit.

Instructions: Put your name and dates you will monitor yourself on the top of the form. The first section is the four categories of negative self-talk. The second section the week is broken up into time blocks. The first time in each day that you catch yourself saying or thinking a category in 2 statement, write the number "2" in the time block when the habit occurred. Example: called myself stupid at 1pm Monday, then I write "2" in Monday column 8am-noon. Record only the first instance of a category within each time block. This makes it easy and simple rather than records every single occurrence of negative self-talk. In the third section there are spaces provided for you to write examples of your negative self-talk. Write down verbatim the first time each day that you engage in each category. Carry this sheet around with you at all times so you immediately write down the numbers. Waiting until later defeats the purpose of this exercise. If you do not engage in negative self-talk you do not have to write anything down.

Once you have completed an entire week of monitoring your negative self-talk on a separate sheet of blank paper write positive counter statements to your negative

thoughts. These are examples of positive statements: I have lived through one of the most difficult experiences and that takes a lot of courage, I am a good person, I am intelligent, lovable, and beautiful, I can find things to be happy about and will practice finding one happy thing about my life everyday, I love myself, my feelings are real and valid, I matter and I am important, I am worthy of love and respect.

Self-Monitoring Form

Your Name: _____ Dates: From _____ to _____

Phrases of Concern:

1= “should, I should have, I could have, why?”

2= Self put downs or your entire personality or character (I’m stupid, I’m inadequate)

3= “I feel” statements ending with words that are not emotions (I feel obligated, overwhelmed, sorry for)

4 = Apologies

*Excerpted from Kubany, McCaig, and Laconsay (2004)

Date:							
	Mon	Tues	Wed	Thurs	Fri	Sat	Sun
8pm-noon							
Noon-4pm							
4pm-8am							
Midnight-8am							
Monday Phrases:							
1:00							
2:00							
3:00							
Tuesday Phrases:							
1:00							
2:00							
3:00							
Wednesday Phrases:							
1:00							
2:00							
3:00							
Thursday Phrases:							
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Friday Phrases:							
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2:00							
3:00							
Saturday Phrases:							
1:00							
2:00							
3:00							
Sunday Phrases:							
1:00							
2:00							
3:00							

Trauma Narrative Handout

Instructions: The goal of creating a trauma narrative is to desensitize you to the trauma reminders through the repetition of reading, writing, and elaboration of your story. The more you practice this technique physical and hyperarousal to reminders will decrease. In addition it will decrease the need to avoid reminders and improve PTSD symptoms and restore normal functioning. Furthermore, you will be encouraged to share personal thoughts and feelings about your experiences to help discovery underlying patterns of dysfunctional thoughts and beliefs. Write your experience of the abusive relationship, including past trauma. Please write about sexual, physical, emotional, and verbal abuse. Include how this has affected you. Then write a section about your recovery. It is important to include your thoughts and feeling about the traumatic event in your story.

Conclusion

This handbook was created from a hybrid of cognitive behavioral therapy. Trauma focused cognitive behavioral therapy and cognitive trauma therapy for battered women has been used to treat PTSD with both children and adults who experienced or witnessed intimate partner violence (Cohen, Mannarino, & Deblinger, 2006; Kubany & Ralston, 2008). Intimate partner violence is pervasive in our society and most female survivors suffer from symptoms of posttraumatic stress disorder (Kessler et al., 1995). The techniques provided were created to treat symptoms of PTSD in women who are out of the abusive relationship. However, there are components of CTT-BW that address the consequences and implications of staying in an abusive relationship. A survivor seeking help should never be turned away because she is still with the abuser (Kubany & Ralston, 2008).

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Appendix B

Evaluation Form

Do you like the design of the handbook?

Do you think the handbook is organized and easy to use?

Do you think the handbook is beneficial for clients?

Would you use the handbook in session?

On a scale of 1-10 please rate the effectiveness of the handbook:

1 (not effective) _____ (5 somewhat) _____ (10 very effective)

Please suggest improvements