Trauma Treatment in the Context of Domestic Violence: Implications for the DV Field

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Systematic Review of Trauma-Focused Interventions for DV Survivors

Introduction

Overview

- Context for the Review
- Highlights of the Review
- Implications for Treatment and Research
- Questions
Developing Evidence for Responding to the Effects of Trauma in the Context of DV

Goals

- Support the development of culturally relevant trauma treatment modalities that are acceptable and effective for survivors of DV
- Support the development and implementation of trauma-informed and trauma-specific practice appropriate for DV programs

CDC & IOM Evidence Framework

Best Available Research Evidence

Experiential Evidence/Best Clinical Experience

Contextual Evidence/Consistent with Patient Values

NCDVTMH Evidence-Building Initiative Trauma-Informed and Trauma-Specific Interventions for DV Survivors

- Conduct systematic review of EB trauma-focused interventions
- Identify additional treatment modalities that may be applicable to IPV survivors
- Identify meaningful outcomes through focus groups & interviews
- Identify core and unique elements
- Develop and pilot new outcome measures and evaluate promising models and programs
- Lay groundwork for more formal research
Why Focus Specifically on Trauma Treatment for Survivors of DV?

- DV survivors at higher risk for depression, PTSD, substance abuse, and suicidality
- DV survivors often experience multiple types of trauma (individual and collective)
- For some survivors, symptoms abate with safety and support. For others, they do not.
- Numerous interventions designed to reduce trauma-induced mental health symptoms
- Most trauma treatment models focus on past abuse

Yet, many DV survivors are still under threat of ongoing abuse or stalking

- Some evidence-based treatments for PTSD may be harmful in the context of ongoing abuse & complex trauma
- People experiencing current DV often excluded from trials
- Batterers often use trauma, mental health, and substance abuse issues to further control their partners including access to treatment

Trauma & DV Increased Risk for Coercive Control

- Batterers use MH & substance abuse issues to control their partners
  - Control of meds
  - Coerced overdose
  - Control of supply: Coerced use; Coerced illegal activities
  - Control of treatment
  - Undermining sanity, credibility, parenting & recovery
  - "She was out of control"

- Stigma, poverty, discrimination & institutionalization compound these risks

WHY DOES THIS WORK?

- Reports of abuse attributed to delusions
- Symptoms of trauma misdiagnosed as MI
- Assumptions that having a MI precludes good parenting
- Internalized stigma
For survivors of ongoing domestic violence, responding to trauma raises an additional set of concerns, particularly when the trauma is unremitting and symptoms also reflect a response to ongoing danger and coercive control.

Trauma in the Context of DV: Complex Picture

- Direct effects of perpetrator behavior
- Trauma-related effects
- Survival strategies
- Exacerbation of pre-existing MH & substance abuse conditions
- Active undermining of parenting, recovery and economic independence
- Role of cultural barriers & supports
- Role of stigma and provider, institutional, societal responses, ongoing discrimination/marginalization and limited overall resources

Evidence Review: Questions about Trauma Treatment for Survivors of DV

- What is the current state of evidence for trauma treatment in the context of DV?
- What is the state of evidence for culturally specific trauma-focused interventions for DV survivors?
- What do we know about the safety, efficacy and effectiveness of trauma treatment for survivors experiencing ongoing abuse?
Questions About Trauma Treatment for Survivors of DV

- What is different about trauma treatment in the context of DV?
- To what extent do existing trauma treatment modalities for DV survivors address the effects of multiple forms of trauma?
- To what extent do existing treatment modalities address outcomes that are most meaningful to survivors?

Evidence Review Process

- Identify non-pharmacological trauma-based interventions that:
  - Specifically focused on adult survivors of DV
  - Included comparison or control groups to examine treatment impact on mental health symptoms or well-being
  - Were written in English & published in peer-reviewed journals after 1999

- Articles were located through computerized journal databases and computerized registries of evidence-based practices
- Additional articles located through backwards search
- 6,668 articles initially identified
  - Many were duplicates or did not meet criteria
- 9 articles, referencing 8 distinct interventions, met the criteria for review
The Nine Studies

- Five described modifications of CBT (cognitive behavioral therapy) for IPV survivors
- One focused on low-income Black and Latina survivors who were seeking help for drug addiction
- One focused on Black survivors who were suicidal
- One targeted low-income survivors who were pregnant
- One addressed the mind-body connection in reducing trauma for IPV survivors

Evidence Review Highlights

Three Models

- Conducted in the US
- Addressed a range of issues relevant for DV survivors and programs
  - Women in DV shelter
  - Culturally specific intervention
  - Formerly battered women
- Involved survivors and/or advocates

HOPE for Battered Women

- Eligibility: Survivors in Shelter; sub-threshold PTSD, no SMI, no recent suicidality or med changes, no concurrent individual therapy
- Development: With advocates and survivors; RCT
- Duration: 9-12 60-90 minute individual sessions, 2x/week
- Standard Elements: CBT to manage PTSD symptoms & triggers; no prolonged exposure (PE)
- Unique Elements: Prioritizes safety & empowerment; skills to reach personal goals; optional modules substance abuse & grief
- Findings: Significant improvement in depression severity, empowerment, social support & reabuse; some improvement in PTSD symptoms
- Engagement & Satisfaction: High: 63% attended 5; 26% all 12
- Limitations: Completion of treatment due to leaving shelter

Johnson & Zlotnick 2011
Grady Nia Project
Culturally Specific Intervention for Low-Income African American DV Survivors Who are Also Suicidal (RCT)

- Eligibility: 217 women DV past year; at least 1 suicide attempt
- Development: Concerns about high risk for suicidality and negative MH outcomes but reluctance to access MH services
- Standard Elements: Build skills and self-efficacy, increase social connectedness, access comprehensive MH care
- Unique Elements: Decrease trauma-related distress through gender-focused, Afrocentric empowering practices
- Findings: Both groups improved, no significant differences in depression, PTSD, psychological distress, suicidal ideation. There were treatment differences in impact of IPV on suicidality
- Engagement: 66% completed at least 7 sessions, average was 9; only 43% at post-assessment, 30% at 12 months
- Limitations: Modest findings, high attrition; complex lives

Kaslow et. al. 2010

Modified CBT for IPV Survivors: CBT-BW

- Eligibility: Survivors no longer being abused; had PTSD & Trauma-Related Guilt (TRG), no ETOH or SMI, ethnically diverse
- Development: With advocates and survivors; Can be delivered by non-clinicians; RCT
- Duration: 11 modules (up to 17 sessions), individual sessions
- Standard Elements: Psychoeducation, stress management, exposure
- Unique Elements: Trauma-related guilt, prior trauma, ongoing stressful contact with abuser, risk for revictimization
- Findings: Significant reductions in PTSD, depression, and guilt; increased self-esteem
- Engagement: 87% retention (average 9 sessions)
- Limitations: Eligibility (no current abuse)

Kubany et. al. 2003 & 2004

Cognitive Trauma Therapy for Formerly Battered Women with PTSD

National Center for PTSD
Honolulu, Hawaii
Unique Features

- Therapy developed with survivors & advocates working hand-in-hand with a trauma specialist psychologist
- Prior to this study, several years of work & research together, teaching each other
- Questionnaires and the instruments developed together
- Focus on safety and empowerment
- Survivors not treated as “sick”
- Partnership with survivors; 50:50 relationship

Study Personnel

- Principal Investigators
  - Elizabeth Hill, DNSc
  - Edward Kubany, PhD
  - Julie Owens, Survivor/Advocate
- 1 psychologist (trauma specialist)
- 3 experienced DV advocates
- 1 postdoctoral psychologist
- 2 doctoral level Army Nurse researchers
- Male and female therapists

Study Aims

- Train advocates to provide therapy according to protocol
- Conduct a controlled clinical trial to demonstrate the efficacy of a trauma therapy for alleviating PTSD & depression and elevating self-esteem
- Focus on eliminating Trauma-related Guilt

First randomized clinical trial for formerly battered women with PTSD
CTT-BW Trauma Therapy

- Structured, highly educational program based on principles of learning
- Consists of 8 to 10 sessions, 1.5 hours each.
- Includes trauma history exploration, PTSD education, stress management, exposure to reminders of abuse and abuser, self-monitoring of negative self-talk, cognitive therapy for guilt, and modules on self-advocacy, assertiveness, and how to identify potential perpetrators
- Focus on self-healing; therapist as coach

Study Design

- 120 battered women
- At least 18 years old
- Receiving services from an agency or provider that provides services for battered women
- Not cohabited with abusive partner for at least 30 days

The Survivors

- Ages 18 to 70 (mean age was 42)
- White, Asian, Pacific Islander, American Indian & 17 of mixed ethnicity
- Last abuse averaged 5 years prior
- Abusive relationships averaged 6+ years
- Averaged 9 different types of trauma on the Traumatic Life Events Questionnaire (out of a possible 21)
Therapy Methods

- Eight sessions (two sessions per week)
- Quite structured
- Very educationally oriented
- Strong focus on recognizing and dealing with guilt aspects of PTSD
- Homework
- Tapes

Intensive Therapist Training

- A workshop on CTT-BW
- Reading the procedural manual
- Listening to numerous audiotapes of sessions
- Viewing EK conducting CTT-BW via closed circuit TV, followed by debriefings
- Modeling and role-playing practice of CTT-BW procedures
- Conducting CTT-BW with two clients
- Regular supervision and as needed consultation
- 55 page manual and workbook

Trauma-Related Guilt

An unpleasant feeling, plus the belief that one should have thought, felt, or acted differently.

- Measured by scores on the Trauma Related Guilt Inventory
Some sources of DV-Related Guilt

- Guilt about not seeing the “signs” of the batterer’s potential for violence
- Guilt about not having left sooner
- Guilt about how the children were impacted
- Guilt about believing they could change their partner
- Guilt about problems the children are experiencing as adults
- Guilt about disclosing very personal information to the batterer which he later “used against me”
- Violating her “moral code”; letting him change her

A Causal Model – the Role of Guilt & Anger in the Development and Persistence of PTSD

Some specific “thinking errors” can lead to faulty conclusions about:

- Preventability “I should have known”
- Justification “I chose it”
- Causal Responsibility “I caused it”
- Wrongdoing “I did wrong”
Finding the Trauma-Related Guilt Issues

- To what extent do you think you should have known better and could have prevented or avoided the outcome?
- How justified was what you did?
- How personally responsible were you for causing what happened? Percent?
- Did you violate personal standards of right and wrong?

Session Contents

- Session 1: PTSD/anxiety education & avoidance-busting education
- Session 2: Structured relaxation; instructions
- Session 3: Guilt assessment & education
- Sessions 4-7: Analyze each guilt issue 1-by-1 (e.g. grief/loss)
- Session 8: Tools for identifying potential abusers; decision-making; coping; role-play responding to abuser and others

Mean Pre-Post Therapy Changes in Scores of 115 Women Who Completed CTT-BW

- 77% reduction in PTSD symptoms
- 81% reduction in depression
- 78% reduction in trauma-related guilt
- 77% increase in self-esteem
- White and ethnic minority women benefited equally from CTT-BW
- Similar treatment outcomes were obtained by male and female therapists
- Similar treatment outcomes were obtained by therapists with different levels of education and training
- Gains were maintained at 3- and 6-month follow-ups

### Final Project Findings

150 started; 118 completed

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<tr>
<th></th>
<th>Post-Therapy</th>
<th>3-Month 90%</th>
<th>6-Month 82%</th>
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<tbody>
<tr>
<td>No PTSD at Post-Therapy &amp; Follow-Up</td>
<td>(104/115) 90%</td>
<td>(69/79) 90%</td>
<td>(42/51) 82%</td>
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- “The treatment has dramatically changed the way I think and feel about the abuse experience.”
- “Before this therapy, I did not believe it was possible to be happy, function effectively, or to live without constant fear.”
- “Working through issues of guilt... removed such an enormous load. I could physically feel its removal.”
- “I am forever grateful to all who have invested their time... to help in this fight against PTSD.”
I  m  plications?  

- Completed in 1 month
- Goes beyond the support group/helps survivors get “unstuck”
- Advocates can do it just as well as clinicians
- Prepares survivors to face abuser(s) if/when necessary

Limitations?

- Intense training required
- Guilt piece very complex
- Clinical supervision helps
- Team support/debriefing helps
- Strong reactions possible
- Survivor therapists must be well healed
- 1:1; not for group use

- Healing the Trauma of Domestic Violence: A Workbook for Women- a New Harbinger Self-Help Workbook (Kubany, McCaa)
- Treating PTSD in Battered Women: A Step-by-Step Manual for Therapists and Counselors (Kubany, Ralston)

What did we learn?

What else do we need to consider?
Evidence Review Summary

**Strengths**
- Treatment protocols developed in collaboration with advocates and sometimes survivors
- Some interventions can be delivered by non-clinicians
- Adaptations enhanced accessibility & addressed survivor-defined needs
- Symptom reduction may reduce revictimization/reabuse

**Limitations**
- Sample sizes were small; Women with greater co-morbidity and/or experiencing current abuse sometimes excluded
- Retention rates varied widely (over 90% for 3 studies, lower for others 55%-68%) and not random
- Adaptations may have contributed to weaker clinical results
- No tests of complex trauma models for DV survivors

Implications

- Treatments need to be accessible as well as effective
  - Need to identify elements essential to treatment outcomes while modifying interventions to enhance participation
  - Need to identify survivors’ goals and priorities and tailor treatment accordingly while factoring in safety
- Treatments need to be culturally relevant
  - Need research on a wider range of culturally specific approaches to trauma recovery
- Treatments need to address both safety and recovery as well as symptom reduction
- Treatments need to be inclusive of survivors with more complex needs
Complex Trauma

- Aftermath of severe, prolonged interpersonal trauma; inversely related to age of first trauma
- More complex array of trauma effects (including effects on providers that must also be attended to), and more meaningful array of outcomes
- Includes PTSD symptoms plus effects on:
  - Emotion regulation
  - Feelings about oneself
  - Relationships with others
  - Meaning and beliefs
  - Attention and consciousness (dissociation)

Harris et al., 2001, Cloitre et al., 2009

Complex Trauma

- More comprehensive framework for understanding and responding to the effects of chronic abuse
- More flexible multi-modal treatment approach
- May be more useful particularly for DV survivors whose experiences of abuse have been more prolonged and severe

Warshaw et al., 2009

Trauma Recovery or Trauma Symptom Reduction? Complex Trauma Treatments

- Combine emerging data on the neurobiology of trauma with:
  - Attention to physical and emotional safety
  - Developmental relational perspectives
  - Cognitive-behavioral techniques for managing dysregulated affect states
  - Skill-building strategies to address developmental disruptions
  - Emphasis on empowerment and social context
Phased Approach

- **Building Alliances:**
  - The quality of the therapeutic relationship

- **Co-creating Safety and Stability:**
  - Physical and emotional; DV safety planning; skill building; affect regulation and interpersonal skill development

- **Working Through Trauma:**
  - Acknowledgment, re-experiencing, grieving, acceptance, integration
  - Not abreaction

- **Reconnecting and Rebuilding:**
  - Cultivating self- and relational-development


Facilitating Choice Making and Empowerment

- Knowledge
- Problem-solving skills
- Self-nurturing
- Increasing socio-economic resources
- Challenging assumptions and cognitions about violence; attributions of responsibility
- Increasing independent living skills
- Increasing coping skills to deal with effects of victimization

Dutton 2001

Long-term Recovery from Trauma & DV

- **Experiencing feelings**
  - Modulating affect and states of arousal
  - Gaining control over dissociation
  - Grieving irreparable losses
  - Reducing guilt and shame
  - Coming to terms with anger
  - Lessening need for avoidance

- **Re-establishing trust and connections**
- **Making sense of experience**
- **Re-integrating aspects of self**
- **Reconnecting and rebuilding**

Trauma in the Context of Domestic Violence

What else do we need to keep in mind?

Trauma, DV & Social Context: Expanding the Frame

- PTSD
  - Trauma is not “post”
  - Appropriate response to ongoing danger & coercive control
- Complex Trauma
  - Reenactment vs. re-entrapment
- Cultural, historical & insidious trauma
  - Social, political, systemic retraumatization
  - Traumatic trigger vs. revictimization

An Integrated Approach to Safety

- Mental Health Context
  - Self-harm, harm to others
- Trauma Context
  - Retraumatization
  - Potentially risky coping strategies
- Domestic Violence Context
  - Ongoing danger from partner; coercive control
  - Revictimization by other people and systems

© National Center on Domestic Violence, Trauma & Mental Health 2009
Expanding Clinical Perspectives: Reframing Symptoms and Disorders

Biomedical phenomenon
Response to the trauma of abuse
Response to social realities of entrapment, isolation, & danger & broader social, political, economic context

Trauma Treatment in the Context of DV: Issues to Keep in Mind

§ IPV dynamics and safety concerns
  • Perpetrator accountability & coercive control; psychological safety

§ Decrease fear & isolation:
  • Information, options, referrals to DV programs, support networks, National DV Hotline: 1-800-799-SAFE (7233)

§ Information and access to resources on trauma and DV

§ Therapeutic alliance: Interactions that counteract experience of abuse
  • Respect, collaboration, empowerment & choice
  • Attention to our own responses

DV Safety Planning: Issues Specific to Trauma Treatment

§ Physical, Emotional, Sexual Safety
  • Withholding medication, sleep deprivation
  • Coerced treatment, custody threats
  • Control of finances, guardianship; Advance Directives
  • Medication: Control, choice, impact on safety
  • Anticipate trauma triggers; distinguish from necessary vigilance
  • Adapt to cognitive abilities and ability to process information during crisis
Trauma Treatment in the Context of DV

- Culture and context
- Skills & resources:
  - Problem solving, economic independence
  - Cognitive and emotional skill development
- Coping with impact of victimization:
  - Contextualized trauma treatment: Build on strengths and supports
- Build alliances around parenting
- Documentation

Implications for Research & Practice: Incorporating a Culture, DV & Trauma Lens

- Core elements of trauma treatment with attention to physical and emotional safety, ongoing risk and other DV-specific issues
- Exploration of the applicability of complex trauma treatment approaches for DV survivors and/or specific subsets of survivors
- Culturally specific approaches (not just making treatments culturally relevant but also looking at philosophically different approaches)
- Ensure treatment and treatment environment are culture, DV- and trauma-informed
- Partnerships with DV advocates & survivors

The Full Report

A Systematic Review of Trauma-Focused Interventions for Domestic Violence Survivors [C. Warshaw, C.M. Sullivan, E.A. Rivera, 2013] can be downloaded from:
