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

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**

- **Stigma, poverty, discrimination & institutionalization compound these risks**

- 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"

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

Evidence Review Process

- 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

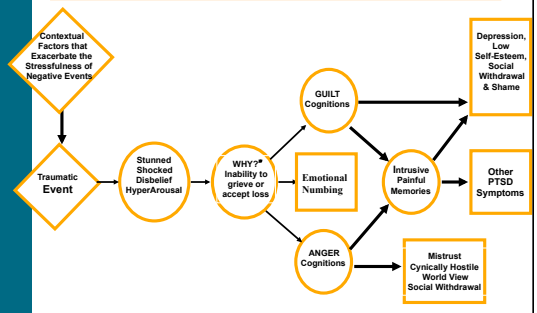
An unpleasant feeling, plus the belief that one should have *thought, felt, or acted* differently.

- 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**

No PTSD at Post-Therapy & Follow-Up

Post-Therapy	**3-Month**	**6-Month**
(104/115) **90%**	(69/79) **90%**	(42/51) **82%**

- "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."

Implications? Limitations?

- 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
- 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

- **Cognitive Trauma Therapy for Battered Women With PTSD (CTT-BW)** (Kubany, Hill, Owens, et. al.) Journal of Consulting and Clinical Psychology Feb 2004, Vol 72, Num 1
- **Healing the Trauma of Domestic Violence: A Workbook for Women**- a New Harbinger Self-Help Workbook (Kubany, McCaig)
- **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

- Trauma-focused treatments designed for IPV survivors hold promise for reducing at least some symptoms over time
- A number of studies demonstrated that treatment improved women's PTSD and/or depression symptoms if they completed treatment
- Some maintained improvement over time
- Interventions varied, so premature to determine specific components (group, individual, number of sessions, content) that are essential for all, beneficial for some or irrelevant
- Racial and ethnic diversity was a strength

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

Warshaw 2001, Courtois 1999, Courtois and Ford 2009

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**

Dutton 2001, Walker 2001, Kubany 2005, Bloom 2000, Warshaw et al 2009

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

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:

http://www.nationalcenterdvtraumamh.org/publications-products/ncdvtmh-review-of-trauma-specific-treatment-in-the-context-of-domestic-violence/

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