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COGNITIVE-BEHAVIORAL THERAPY FOR PATIENTS WITH PTSD AFTER EXPERIENCES OF INTIMATE PARTNER VIOLENCE – REVIEW OF THERAPY PROGRAMS

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Summary

About 30% of women around the world experience violence, which is a violation of fundamental human rights and is a major public health problem. The prevalence of post-traumatic stress disorder (PTSD) in those women varies between 45% and 84%. The aim of this article is to present various forms of psychological support for people experiencing violence, with particular emphasis on the work in the cognitive-behavioral current. The article discusses the theoretical assumptions, structure, and modules of the Cognitive Trauma Therapy for Battered Women (CTT-BW) by Kubany and presents modules on psycho-education about PTSD, strengthening stress management skills, assertive communication, coping with unwanted contacts with former partners, and identification of potential perpetrators. CTT-BW therapy is a short-term form of assistance, the effectiveness of which has been confirmed by research. In 94% of women participating in the 3-month programme according to its protocol, there was a reduction in anxiety, guilt, and shame and a significant increase in self-esteem.

Introduction

Violence is a socially significant problem that affects many women around the world. According to the World Health Organisation [1], nearly 30% of women are victims of violence (physical or sexual) by their partners. A study carried out by the European Union Agency for Fundamental Rights (FRA) [2] in 2014 indicates that in the European Union, 22% of women who are in relationships with men experience violence. There are many discrepancies between the data on the prevalence of violence in Poland. According to APPUE [2], approximately 3.5 million women in Poland have experienced violence (physical and/or sexual) at least once in

their lives. At the same time, according to the report of the Police Headquarters [3] covering the activities of the "Blue Card" procedure in 2015, there were 69,376 women suspected of being subjected to violence. These data indirectly confirm that many women do not admit to experiencing violence, which means that they are not supported by professionals.

There are many expressions of violence suffered by women. Its understanding in this article is most fully reflected by the term "intimate partner violence". It usually refers to male violence [4] and is defined as intimate behavior leading to potential or actual physical, emotional, sexual, or economic abuse [1].

Experiencing violence by the partner has many negative health consequences. Among them are injuries, sleep problems, affective disorders, anxiety, and suicidal behavior [5, 6]. Studies show that women experiencing violence are more often diagnosed with post-traumatic stress disorders (PTSD) than women in the general population. The prevalence of PTSD in this group varies between 45% and 84% [7].

Experiencing violence, post-traumatic stress syndrome and the feeling of guilt

Post-traumatic stress syndrome is a psychiatric disorder diagnosed in people who have experienced strongly traumatic events and have developed a specific pattern of thinking, feeling, and behavior as a result of these experiences. The most characteristic symptoms of post-traumatic stress disorder include, among others, repeated reliving of traumatic events, taking steps to avoid trauma-related stimuli, excessive stimulation, negative mood changes, and negative changes in the cognitive sphere [8]. Importantly, in DSM-IV of 1992, PTSD was classified as an anxiety disorder, whereas in DSM-V of 2013, it was included in the chapter on trauma and stress disorders. The diagnostic criteria for PTSD have been extended to include an established and distorted way of thinking about the causes or consequences of the traumatic event, leading to blaming oneself or others and a constant sense of guilt [8].

The inclusion of the above-mentioned symptoms in the clinical picture of post-traumatic stress disorder was the result of psychological studies conducted over many years. Kubany and co-workers have shown that guilt is a common problem in physically or sexually harmed women with PTSD. In a study carried out in the 1990s [9] among participants of a support group for maltreated women, it was noted that 49% of them experience moderate or high levels of guilt associated with the violence used against them. In the process of validation of the Trauma Related Guilt Inventory (TRGI) tool used to measure feelings of guilt, led by Kubany and colleagues in the first decade of the 21st century [10], it was noted that 75% of women experience moderate or high levels of guilt after experiencing violence. They developed [9] a

multidimensional guilt construct consisting of the emotional and the cognitive component. According to their assumptions, emotional guilt is associated with mental suffering. According to them, traumatic memories (*e.g.* prolonged experience of violence) are a source of distress and emotional pain due to their encoding in the language. Linguistic phrases related to guilt such as "something is wrong with me", "I am stupid" or "I am a bad mother" function as a conditioned stimulus with memories, images, and thoughts [10].

The cognitive sense of guilt, on the other hand, is a component of dysfunctional beliefs, namely "wisdom after harm" (the certainty, after having experienced the negative event, that before it occurred, there was sufficient knowledge and resources to prevent it), sense of responsibility for negative events and lack of justification for one's own behavior (lack of action), and, consequently, sense of responsibility for the negative event and violation of values, and finally condemnation of one's own actions [11].

Popiel [12] drew attention to several cognitive distortions typical of guilt in women with PTSD experiencing violence, distinguished by Kubany, such as [11]: emotional justification, minimization/exaggeration, and selective attention. Emotional justification is the belief that feeling an emotion while thinking about something proves the truth of this thought. Minimization/exaggeration refers here to underestimating the benefits of the actions taken during the traumatic event and overestimating the role of small clues and intuitions about the possibility of other behavior during the event. Selective attention, in turn, is to focus only on the possible positive effects of actions that could have been taken during the traumatic event and that were not taken [12].

Kubany and Watson [7], while reviewing the literature, stated that the feeling of guilt felt by women experiencing violence may be related to *e.g.* a failed marriage, the effects of violence against children, or making decisions about the duration of the relationship or termination of the relationship [7]. In addition, feelings of guilt associated with traumatic memories (in this case experiencing violence) can lead to the suppression of these memories, which in turn hinders the process of spontaneous healing or natural extinction as a result of sufficiently long exposure [13]. In response to the symptoms of PTSD and frequent changes in the cognitive system due to guilt in people who have experienced violence, Kubany and his team developed a cognitive behavioral therapy program for people with PTSD following the experience of violence, Cognitive Trauma Therapy – Battered Women; CTT-BW.

The CTT-BW model and other forms of psychological support in the cognitive-behavioral trend for women experiencing violence

So far, many programs of psychological support for women experiencing violence have been described in international literature. These programs differ in terms of, among other things, the duration of the assistance; its intervention or therapeutic nature, the place of its implementation; the nature of the relationship between the perpetrator and the person experiencing violence, *e.g*. remaining in or leaving the relationship with the perpetrator [14]. There are therapeutic programs in the form of individual sessions, group meetings [15], couple therapy [16], or multi-family therapy [17].

Not all forms of therapy dedicated to people experiencing violence, implemented in different therapeutic approaches, include actions aimed at reducing symptoms of PTSD, which is a key aspect of this article. Based on the data presented in the meta-analysis of the results of effective PTSD therapies [18] and the conclusions presented in the review [19] of randomized controlled clinical trials on the efficacy of therapy for people with PTSD disorders, it has been demonstrated that first choice therapies should be cognitive behavioral therapy or Eye Movement Desensitization and Reprocessing (EMDR) therapy. Due to the lack of randomized control studies, there is not enough evidence for the effectiveness of psychodynamic therapy, systemic therapy, body-targeted therapy, or hypnotherapy [18].

In this article, a detailed analysis of the Cognitive Trauma Therapy Program for Battered Women with PTSD (CTT-BW) – in comparison to other therapeutic programs based on the assumptions of cognitive-behavioral psychotherapy – will be carried out. The effectiveness of the CTT-BW therapy program was confirmed by randomized studies conducted in a group of 125 women by the author of the program – Kubany and his colleagues in 2004 [10]. The study showed that 91% of women participating in the 3-month program according to its protocol no longer met the diagnostic criteria for PTSD. In addition, a reduction in anxiety, guilt, and shame was observed, as well as a significant increase in self-esteem [10]. Similar results in the significant reduction of PTSD, depression, and post-treatment anxiety were shown in replication studies in 2016 by Beck et al. [20] and in a study verifying the effectiveness of therapy also in the neurological aspect with the use of fMRI methods [21].

The CTT-BW program is based on methods of cognitive behavioral therapy in the field of belief restructuring with particular emphasis on guilt. It also includes exposure techniques recommended for work with PTSD, assertiveness training, and relaxation methods. The HOPE (Helping to Overcome PTSD Through Empowerment) program is an important therapeutic model dedicated to people experiencing violence, also in the cognitive-behavioral therapy

current [22]. However, it focuses mainly on providing security, support, and emotional stability for both women and their children in shelters for people experiencing violence. The CTT-BW program, on the other hand, is being implemented for women who are no longer in a violent relationship and the last act of violence was at least one month before the start of the therapy. The HOPE program, like the CTT-BW, uses techniques of cognitive restructuring and behavioral control. Unlike the CTT-BW, work in the PTSD area is carried out through psycho-education, relaxation, but no exposure techniques are used. This is justified by the difficult circumstances faced by people in the shelter who have experienced violence in the recent past and are at risk of returning to the perpetrator [22].

Narrative exposure therapy (NET) is an evidence-based short-term treatment to reduce the symptoms resulting from traumatic experiences [23]. NET is based on cognitive behavioral therapy but differs from other exposure-based PTSD therapies, such as the Foa program [24] or CTT-BW, as it focuses on a series of traumatic events rather than a single event. Another aspect that distinguishes this method is that it takes into account all good and enhancing events and experiences of emotional resources in a woman's life, which perfectly reflect the multi-faceted, complex and chronic nature of intimate partner violence (IPV)-based relationships [25]. A particularly important aspect of NET therapy is the fact that its effectiveness has been demonstrated in a group of women who were in a relationship with a violent person during the therapy [25]. This is an important response to a situation that professionals often confront when working with people who experience violence. As NET researchers stress, therapeutic interventions in the context of ongoing domestic violence can reduce the amount of violence and increase the motivation of women to seek further help.

An important approach in working with people with PTSD disorders is EMDR therapy. Studies have shown its effectiveness in reducing the symptoms of PTSD in people experiencing violence [26], as well as people after sexual assault [27]. This therapy is included in the so-called third wave of cognitive-behavioral therapy. Studies have shown a significant decrease in the symptoms of PTSD due to the EMDR method in people experiencing violence. However, there are currently no reports of a comprehensive EMDR therapy program dedicated to people experiencing violence, including additional aspects related to violence, *e.g*. the contact with partners or feelings of guilt beyond the symptoms of PTSD.

Dialectical Behavior Therapy for Women Victims of Domestic Abuse is a 12-session program focusing on emotional problems resulting from experiencing violence [28]. In this model, group therapy is carried out. A particularly important aspect is to learn how to regulate emotions, train interpersonal skills, and mindfulness methods. The protocol was created on the

basis of Marshy Linehan's therapy program for people with borderline personality disorders. Indirectly, it takes into account the specific working methods that reduce the symptoms of PTSD. This model has undergone the least amount of empirical verification.

Another example of assistance for women experiencing violence is crisis intervention and preventive crisis intervention programs. The IPS (Interpersonal Problem Solving Model) uses *e.g*. cognitive-behavioral techniques such as cognitive restructuring and behavioral control [29]. In a crisis situation, the emotional aspect dominates over the cognitive aspect, therefore, before the application of the IPS program, it is suggested to prepare a given person for the possibility of a possible crisis and to teach them how to cope with it [29], or even to create entire educational and intervention programs [30].

Cognitive Trauma Therapy for Battered Women with PTSD (CTT-BW)

Cognitive Trauma Therapy for Battered Women with PTSD – CTT-BW is carried out according to Kubany's protocol [7] and consists of three modules: (a) psycho-education for post-traumatic stress disorder, (b) strengthening the ability to cope with stress (including relaxation training), and (c) talking about trauma. In addition, the CTT-BW shall include specific procedures: (a) assessment and correction of irrational guilt beliefs and (b) reduction of self-incrimination and shame. In addition, the CTT-BW uses modules on issues that may complicate the healing process. They focus on self-manifesting/increasing one's own abilities and include (a) psycho-education in the area of cognitive and behavioral strategies, (b) developing assertive communication skills, (c) dealing with unwanted contacts with former partners, and (d) ways to identify potential perpetrators and avoid revictimization [7].

In the authors' research, the CTT-BW protocol was applied to women who (a) had not been in contact with the perpetrator of the violence for at least 30 days and had no intention to return to the perpetrator, (b) had not been persecuted or experienced physical or sexual violence for at least 30 days, (c) met the diagnostic criteria for PTSD resulting from partner abuse, (d) had moderate feelings of guilt linked to abuse (as measured by the TRGI questionnaire), (e) did not abuse alcohol or drugs at the time of the trial, (f) did not suffer from schizophrenia or bipolar disorder.

Women participating in the study were not obliged to stop using other therapeutic services, *e.g*. support groups or prescribed drugs [10].

Cognitive Trauma Therapy for Battered Women [7] is conducted in the form of individual meetings. The protocol consists of 8 to 11 sessions, with the majority of female clients being offered two sessions per week lasting 90 minutes each [7].

The most important goal of the first session of the CTT-BW is to start the process of establishing a safe therapeutic relationship. The therapist conducts an interview with the client about the history of abuse by her partner and asks her about other important traumatic experiences. She is also familiarized with the theory and structure of Cognitive Trauma Therapy for Battered Women [7].

The aim of the next three sessions of the CTT-BW is to detail the history of the client's traumatic experiences (if this has not happened during the first session). The therapist also conducts psycho-education on post-traumatic stress disorder, and then tasks homework based on exposure (*e.g*. looking at photos and imagining the partner, watching films about domestic violence). The therapist also devotes time to justify the rightness of using this homework [7].

An important goal of the second to fourth session is psycho-education about learned helplessness. The therapist strengthens the solution-oriented attitude of the client as opposed to the obstacle-oriented attitude, conducts psycho-education on the strategy of coping with stress, and conducts progressive muscles relaxation according to Jacobson [7].

Another aim of these therapy sessions is to do cognitive work in the area of negative beliefs about oneself. The therapist discusses the mechanism of talking to oneself in a negative way and sets homework tasks for monitoring the content that appears during the internal monologue [7].

The next two to four sessions are devoted to Cognitive Therapy for Trauma-Related Guilt (CT-TRG). At the beginning of their work, the therapist conducts psycho-education on cognitive deformities resulting from trauma, then assesses with the client the rationality of her beliefs, and considers alternative explanations. The client is treated not only for the guilt associated with experiencing violence but also for the guilt associated with other traumas of the client [7].

Sessions 8-11 are devoted by the therapist to assertiveness training. The therapist actively cooperates with the client in differentiating between assertive and aggressive speech and discusses with her strategies for assertive coping in response to verbal hostility and reactions to unwanted telephone calls or direct contact with a former partner. They also discuss the subject of identification of potential perpetrators [7].

The last area of therapeutic work is psycho-education in the area of self-expression strategies (*e.g*. making the realization of one's own needs a priority, defending one's rights, or not tolerating disrespect) [7].

Summary

There are many forms of psychological support for women experiencing violence. One of them is Cognitive Trauma Therapy for Battered Women (CTT-BW). The proposed protocol of this therapy is inspired by PTSD therapy based on prolonged exposure according to Edna Foa [24]. It also includes an extensive model of cognitive work on guilt (referring to recent changes in the diagnostic criteria of PTSD placed in DSM-5). In addition, the CTT-BW therapy protocol contains strategies for coping with stress and draws attention to the aspect of the relations with the perpetrator after the end of violence, as well as to self-expression strategies.

CTT-BW therapy, rich in many cognitive and behavioral issues, can, therefore, be considered as a comprehensive support program for women who have experienced violence. Its effectiveness has been confirmed by randomized studies. In addition to its complexity and effectiveness, the CTT-BW also has the advantage that it is short-term. Its duration of 8-11 sessions, 90 minutes each, may be beneficial for clients expecting rapid results from therapy (which appear on condition that they are involved in the work on themselves and motivated to go through the entire support program), although it may be a considerable challenge for the therapist to carry out a therapy in such a short time, which is supposed to lead to permanent changes in the client's cognitive system.

Analyzing previous reports from research verifying the effectiveness of the CTT-BW therapy program, it is worth pointing out the challenges and potential limitations of the model that the therapists and researchers are facing. As Beck and others [20] note, it is not certain whether the CTT-BW program would be effective in the case of men experiencing partner violence. The CTT-BW therapy was empirically verified in a group of women after experiences of violence. When analyzing the therapy program, it can be assumed that some components of the program would be universal regardless of gender, *e.g*. psycho-education and work in the area of PTSD symptoms, assertive communication, and work techniques, *i.e*. cognitive restructuring, relaxation. The cognitive content analyzed in this work, *e.g*. concerning guilt and the use of help by men, would be most worth deliberating, due to the cultural nature of beliefs perpetuating certain patterns of women and men as a person experiencing violence or as a parent.

So far, measurements of therapy effectiveness have been carried out in a relatively short period of time from the end of therapy - from 3 to 6 months. In subsequent studies, it would be worthwhile to verify the results after a longer period of time. Moreover, the current effectiveness of therapy has been tested in academic centers, and it would be interesting to carry out another study in aid institutions [20].

Despite the above limitations, it is worth stressing that the CTT-BW program is a recommendable, evidence-based treatment program for women after experiences of violence, with symptoms of PTSD. This program could also be used in Poland, which corresponds to the intention of its authors that the model should be applicable in different systems of assistance and in different cultural contexts. Certainly, it would be worthwhile to undertake research, training and publication activities in Poland. It should be emphasized that the therapy protocol can be implemented by people working in aid institutions without specialist, long-term psychotherapeutic training, which may potentially be associated with reaching a greater number of people in need of support [10].

References

1. Global and regional estimates of violence against women: Prevalence and health effects of intimate partner violence and non-partner sexual violence. Geneva: WHO. 2013.
2. Violence against women: Study at the European Union level - The results of the study at a glance. European Union Agency for Fundamental Rights (FRA), Vienna 2014.
3. Information on the implementation by the Police organizational units in 2015 of the "Blue Card" procedure and initiatives taken in the field of counteracting domestic violence. Prevention and Traffic Office of the Police Headquarters. 2015.
4. Soldevilla J, Feixas G, Varlotta N, Cirici R. Characteristics of the construct systems of women victims of intimate partner violence. J. Constr. Psychol. 2014; 27(2): 105–119. doi: 10.1080/10720537.2014.879521.
5. Devries K, Mark J, Bacchus L, Child J, Falder G, Petzold M et al. Intimate partner violence and incident depressive symptoms and suicide attempts: A systematic review of longitudinal studies. PLoS. Med. 2013; 10(5): e1001439. doi: 10.1371/journal.pmed.1001439.
6. Koziol-McLain J, Vandal A, Nada-Raja S, Wilson D, Glass N, Eden K et al. A web-based intervention for abused women: the New Zealand safe randomized controlled trial protocol. BMC Public Health. 2015; 15: 1-8. doi: 10.1186/s12889-015-1395-0.
7. Kubany E, Watson S. Cognitive trauma therapy for formerly battered women with PTSD: Conceptual bases and treatment outlines. Cogn. Behav. Pract. 2002; 9(2): 111–127. doi: 10.1016/S1077-7229(02)80005-0.
8. Morrison J. DSM-5 bez tajemnic. Praktyczny przewodnik dla klinicystów. Kraków: Wydawnictwo Uniwersytetu Jagiellońskiego; 2016.
9. Kubany E, Haynes S, Abueg F, Brennan J, Manke F, Stahura C. Development and validation of the Trauma–Related Guilt Inventory (TRGI). Psychol. Assessment. 1996; 8(4): 428–444. doi: 10.1037/1040-3590.8.4.428.
10. Kubany ES, Hill EE, Owens JA, Iannce-Spencer C, McCaig MA, Tremayne KJ. Cognitive trauma therapy for battered women with PTSD (CTT-BW). J. Consult. Clin. Psychol. 2004; 72: 3–18.
11. Kubany ES. The Trauma Related Guilt Inventory (TRGI). Assessing and treating PTSD manual. Los Angeles: Western Psychological Services; 2004.
12. Popiel A. Terapia poznawcza poczucia winy związanego z traumą u osób z PTSD. Psychiatr. Pol. 2014; 48(3): 615–625.
13. Rohrbaugh M, Riccio D, Arthur A. Paradoxical enhancement of conditioned suppression. Behav. Res. Ther. 1972; 10(2): 125–130.
14. Condino V, Tanzilli A, Speranza AM, Lingiardi V. Therapeutic interventions in intimate partner violence: An overview. Res. in Psycho: Psychopa. 2016; 19(2): 79–88. doi: 10.4081/ripppo.2016.241.
15. Constantino R, Kim Y, Crane PA. Effects of a social support intervention on health outcomes in residents of a domestic violence shelter: a pilot study. Issu. in Ment. Hea. Nurs. 2005; 26(6): 575–590. doi:10.1080/01612.
16. Karakurt G, Whiting K, Esch Ch, Bolen SD, Calabrese JR. Couples therapy for intimate partner violence: a systematic review and meta-analysis. J. Mar. Fam. Ther. 2016; 42(4): 567–583. doi: 10.1111/jmft.12178.

17. Józefik B, Treger B. Terapia wielorodzinna dla rodzin z problemem domowej przemocy. Psychoter. 2015; 1 (172): 47–57.
18. Watts B, Schnurr P, Mayo L, Young-Xu Y, Weeks W, Friedman M: Meta-analysis of the efficacy of treatments for posttraumatic stress disorder. J. Clin. Psychiatry 2013; 74: e541–e50.
19. Frommberger U, Angenendt J, Berger M. Review article. Post-Traumatic Stress Disorder —diagnostic and therapeutic challenge. Dtsch Arztebl Int 2014; 111(5): 59−65.
20. Beck JG, Tran HN, Dodson TS, Henschel AV, Woodward MJ, Eddi J. cognitive trauma therapy for battered women: replication and extension. Psychology of Violence 2016; 6 (3): 368–377. doi.org/10.1037/vio0000024
21. Aupperle R L, Allard CB, Simmons AN, Flagan, T, Thorp SR, Norman SB, Stein MB. Neural responses during emotional processing before and after cognitive trauma therapy for battered women. Psychiat. Research: Neuroima. 2013; 214: 48–55. doi.org/10.1016/j.pscychresns.
22. Johnson D, Zlotnick C. HOPE for battered women with PTSD in domestic violence shelters. Prof. Psychol. Res. Pract. 2009; 40(3): 234–241. doi: 10.1037/a0012519.
23. Schauer M, Neuner F, Elbert T. Narrative exposure therapy. A short term treatment for traumatic stress disorders (2nd edition). Cambridge: Hogrefe Publishing 2011.
24. Foa EB. Prolonged exposure therapy: Past, present, and future. Depression and Anxiety. 2011; 28(12): 1043–1047. doi.org/10.1002/da.20907
25. Orang T, Ayoughi S, Moran JK, Ghaffari H, Mostafavi S, Rasoulian M, Elbert T. The efficacy of narrative exposure therapy in a sample of Iranian women exposed to ongoing intimate partner violence — a randomized controlled trial. Clin Psychol Psychother. 2018; 25:827–841. doi:10.1002/cpp.2318.
26. Tarquinio C, Brennstuhl MJ, Rydberg JA. Schmitt A, Mouda F, Lourel M, Tarquinio P. Eye movement desensitization and reprocessing (EMDR) therapy in the treatment of victims of domestic violence: A pilot study. Europ. Rev. Appl. Psych. 2012; 62(4): 205–212. doi.org/10.1016/j.erap.2012.08.006
27. Rothbaum B, Astin M, Marsteller F. Prolonged exposure versus eye movement Desensitization and Reprocessing (EMDR) for PTSD rape victims. J. Trau. Stre. 2005; 18, 607–616. doi:10.1002/jts.20069.
28. Iverson K, Shenk C. dialectical behavior therapy for women victims of domestic abuse: A pilot study. Prof. Psychol. Res. Pract. 2009; 40(3): 242–248. doi: 10.1037/a0013476.
29. Gołuchowska G, Bartosiewicz-Dudek E. Interwencja kryzysowa w podejściu poznawczo- behawioralnym – techniki oraz strategia problem solving. Psychi. i Psychot. 2002; 8(1): 4–13.
30. Nezu A. Problem solving in behavioral therapy revisited. Behav. Ther. 2004; 35(1): 1–33. doi: 10.1016/S0005-7894(04)80002-9.

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