Cognitive Trauma Therapy for Battered Women With PTSD: Preliminary Findings

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This paper describes a treatment–outcome study of Cognitive Trauma Therapy for Battered Women (CTT-BW) with PTSD. Derived from psychological learning principles, CTT-BW emphasizes the role of irrational beliefs and evaluative language in chronic PTSD. CTT-BW includes trauma history exploration, PTSD psychoeducation, stress management, psychoeducation about dysfunctional self-talk and self-monitoring of self-talk, exposure to abuse reminders, Cognitive Therapy for Trauma-Related Guilt (E. S. Kubany & F. P. Manke, 1995), and modules on assertiveness, managing contacts with former partners, self-advocacy strategies, and avoiding revictimization. Thirty-seven ethnically diverse women were assigned to Immediate or Delayed CTT-BW. PTSD remitted in 30 of 32 women who completed CTT-BW. Gains were maintained at 3-month follow-up. CTT-BW was efficacious across ethnic backgrounds. Issues related to disseminability of CTT-BW are discussed.

KEY WORDS: battered women; PTSD; depression; self-esteem; therapy; efficacy.

Introduction

Violence against women by their intimate partners is a problem of major proportions. Nearly one of three American women experiences at least one physical assault by an intimate partner during adulthood (American Psychological Association Task Force on Violence and the Family, 1996). In a random sample of urban women, one of four had been physically assaulted by a male intimate partner (Randall & Haskel, 1995). It has been estimated that between 22 and 35% of women who seek care in emergency rooms are there because of domestic violence (Abbott, Johnson, Koziol-McLain, & Lowenstein, 1995).

As a traumatic stressor, partner abuse can lead to the development of posttraumatic stress disorder (PTSD)—a syndrome with often debilitating symptoms—including intrusive distressing memories, nightmares, avoidance of trauma reminders, loss of interest in previously enjoyable activities, insomnia, and loss of concentration (American Psychiatric Association, 1994). Rates of PTSD among battered women are much higher than those in the general population. In shelter samples of battered women, PTSD prevalence has ranged from 45 to 84% (see Kubany, Abueg, et al., 1995). In two studies of women in support groups for battered women, 35 and 85% were estimated to have PTSD (Kubany et al., 1996; Kubany, Haynes, et al., 2000). In another study of treatment-seeking battered women, 84% were diagnosed with PTSD on the Clinician-Administered PTSD Scale (CAPS; Kubany, Leisen, Kaplan, & Kelly, 2000).

There has been a recent surge of interest in developing and evaluating treatments for PTSD, and cognitive–behavioral PTSD interventions have shown considerable promise (see Blake & Sonnenberg, 1998; Foa & Meadows, 1997). However, even though battered women
may comprise one of the largest traumatized populations in North America, if not the world (Heise, Ellsberg, & Gottemoeller, 1999), there has not been a single, published PTSD treatment–outcome study for battered women.

A Model of Posttraumatic Stress That Emphasizes the Role of Irrational Beliefs and Evaluative Language

Mowrer’s two-factor model of escape and avoidance conditioning, involving classical and operant conditioning, has been used by several authors as a conceptual framework for understanding the acquisition and persistence of PTSD (Mowrer, 1960; see Foa, Steketee, & Rothbaum, 1989). Applying Mowrer’s model to trauma, formerly neutral or positive events that were associated with trauma come to elicit strong negative emotions and control irrational escape and avoidance behaviors. Although events that symbolize the trauma (e.g., recollections or images of trauma) are not dangerous, they may evoke fear or anxiety. Also, any action that removes recollections from consciousness is reinforced with relief, thereby strengthening avoidance responding and prolonging the emotion-eliciting power of the recollections.

Although two-factor theory may be useful as a partial explanation of PTSD, it has limitations as a complete or comprehensive account. First, two-factor theory does not account for PTSD, which develops following traumatic losses—such as the sudden, unexpected death of a loved one (e.g., Breslau et al., 1998) or symbolic losses related to a shattering of assumptions about concepts such as innocence, trust, fairness, or marital happiness (e.g., Kubany & Watson, 2002; McCann & Pearlman, 1990). A second limitation of two-factor theory is that it fails to account for the role that cognitive factors, such as appraisals, may play in the maintenance of PTSD and related psychopathology.

A number of investigators have emphasized the importance of cognitive variables as factors that contribute to the maintenance or persistence of posttraumatic stress (e.g., Brewin, Dalgleish, & Joseph, 1996; Creamer & Burgess, 1992; Ehlers & Clark, 2000; Foa & Rothbaum, 1998; Kubany & Watson, 2002). When negative appraisals manifest themselves in consciousness as thoughts or speech (e.g., “I’m worthless. . . Dummy me”), such self-talk can function as self-punishment and have deleterious effects on a person’s well-being—thereby contributing to the maintenance of posttraumatic stress and depression. In addition, Kubany and Watson (in press–a) suggest that, an important reason why memories of trauma do not lose their capacity to evoke emotional pain . . . may be due to higher order language conditioning—whereby words that have acquired the ability to evoke negative affect (e.g., “stupid. . . I never should have . . .”) function, in effect, as “unconditioned stimuli” in pairings with images or thoughts of the trauma (Staats, 1972, 1990). Evaluative self-talk narratives which accompany memories of trauma may provide thousands of reconditioning trials that effectively interfere with the natural process of emotional extinction . . . (p. 7).

See Kubany and Watson (2003a) for a more extensive description of this model of posttraumatic stress, which serves as the conceptual basis for the intervention described below.

Cognitive Trauma Therapy is a multicomponent intervention designed as an all-inclusive treatment for PTSD in women—with histories of physical and/or sexual abuse, in particular—which has been specifically tailored to address posttraumatic stress in battered women (Kubany & Watson, 2002). Cognitive Trauma Therapy for Battered Women (CTT-BW) includes several treatment elements from existing treatments for PTSD: (a) psychoeducation about PTSD, (b) stress management (including relaxation training), (c) self-monitoring of maladaptive thoughts and speech, and (d) talking about the trauma and exposure homework.

The unique aspect of CTT-BW is its inclusion of systematized procedures for (a) assessing and correcting dysfunctional beliefs and (b) reducing negative self-talk—related to guilt and shame, in particular. Correcting guilt-related beliefs, which are largely erroneous, is conducted in a highly systematic step-by-step format (Kubany & Manke, 1995). Negatively evaluative thought and speech habits are addressed directly by teaching clients to observe their mental life by means of self-monitoring homework and to inhibit use of negatively evaluative words in speech and thought (Kubany, 1998).

CTT-BW also includes modules for addressing issues faced by many, if not most, women in a male-dominated society in which women are often subordinate to men, in which women’s needs are often considered less important than the needs of men, and in which women are often vulnerable to exploitation by men. These modules focus on self-advocacy and empowerment and include (1) self-advocacy strategies, (b) assertive communication skill building, (c) managing unwanted contacts with former partners, and (d) how to identify potential perpetrators and avoid revictimization.

Method

Participants

Participants included 37 battered women, most of whom were referred by victim services agencies that serve