Cognitive Trauma Therapy for Formerly Battered Women* With PTSD: Conceptual Bases and Treatment Outlines

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This article describes the conceptual bases and treatment outlines of Cognitive Trauma Therapy for Formerly Battered Women with PTSD (CTT-BW), a psychoeducational, multicomponent, cognitive-behavioral intervention aimed at alleviating posttraumatic stress disorder (PTSD), depression, guilt, shame, and negative self-esteem in formerly battered women. CTT-BW is derived from psychological learning principles, and emphasizes the role of irrational beliefs and evaluative language in posttraumatic stress. Assessment and assessment instrumentation used in CTT-BW are described. The main treatment components in CTT-BW include (1) exploration of partner abuse history and exposure to other trauma; (2) psychoeducation on PTSD; (3) negotiation of imaginal and in vivo exposure homework; (4) psychoeducation on maladaptive self-talk; (5) stress management and relaxation training; (6) cognitive therapy for trauma-related guilt (Kubany & Manke, 1995); (7) psychoeducation on assertiveness and responses to verbal aggression; (8) managing unwanted contacts with former partners; (9) learning to identify potential perpetrators and avoid revictimization; and (10) psychoeducation on positive coping strategies that focus on self-advocacy and self-empowerment (e.g., placing oneself first, decision-making that promotes self interest). Homework includes listening to audiotapes of the sessions, in-vivo exposure to abuse-related reminders, playing a relaxation tape, and self-monitoring of negative self-talk. Initial evidence for the efficacy of CTT-BW is discussed, as are issues that need to be addressed before CTT-BW can be reliably implemented and evaluated by other clinicians.

TRAUMATIC EVENTS, such as combat, serious accidents, sudden death of a loved one, and physical and sexual abuse, can result in the development of posttraumatic stress disorder (PTSD), a syndrome with debilitating symptoms, such as intrusive distressing memories, nightmares, avoidance of trauma reminders, loss of interest in previously enjoyable activities, insomnia, and loss of concentration (American Psychiatric Association, 1994). An estimated 10% of American women have had PTSD at some point in their lives (Kessler, Sonnega, Bromet, Hughes, & Nelson, 1995). Among American women, physical or sexual abuse is the most common precipitant of PTSD, accounting for an estimated 63% of the cases (Kessler et al.).

Although only a handful of well-controlled PTSD treatment-outcome studies were conducted prior to 1992 (Solomon, Gerrity, & Muff, 1992), there has been a recent upsurge in PTSD treatment-outcome research, and cognitive-behavioral PTSD interventions have shown considerable promise (e.g., see Blake & Sonnenberg, 1998; Foa & Meadows, 1997). Much of this research has been conducted with women survivors of sexual abuse or assault. In particular, cognitive processing therapy for rape victims (e.g., Resick & Schnicke, 1992) and Prolonged Exposure therapy with sexually assaulted women (e.g., Foa & Rothbaum, 1998) have reported reductions or elimination of PTSD in a substantial proportion of clients treated.

In spite of increasing interest in PTSD treatment-outcome research, no PTSD treatment-outcome studies have been reported for women who have been abused or battered by intimate partners. Lack of attention to therapy for this population is significant because battered women—as a group—may comprise one of the largest traumatized populations in North America (American Medical Association, Council on Scientific Affairs, 1992; Randall & Haskel, 1995). Nearly one in three American women experience at least one physical assault by an intimate partner during adulthood (American Psychological Association Task Force on Violence and the Family, 1996). It has been estimated that between 22% and 35% of women who seek care in emergency departments are there because of domestic violence (Abbott, Johnson, Koziol-McLain, & Lowenstein, 1995).

Rates of PTSD among battered women are much higher than in the population at large (Kessler et al.,

*We use the term "formerly battered women" to refer to women who are no longer in abusive relationships, who have no intention of reconciling, and who are considered relatively safe. The intervention described in this article was not designed for women who are still in abusive relationships or are considering reconciliation.

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1995). In shelter samples of battered women, PTSD prevalence has ranged from 45% to 84% (see Kubany et al., 1995). In a study of 168 women attending support groups for battered women, 35% were estimated to have PTSD (Kubany et al., 1996). In a study of 74 women who had received services from agencies or providers that serve battered women, 84% were diagnosed with PTSD on the Clinician-Administered PTSD Scale (Kubany, Leisen, Kaplan, & Kelly, 2000).

Battered women are at heightened risk for developing mental health problems, particularly depression, in addition to or other than PTSD (e.g., Orava, McLeod, & Sharpe, 1996). Among Hawaii women who had sought services for the effects of battering in the past year, 54% were at least moderately depressed (Kubany, Owens, Leisen, & Ramelli, 2002). Not surprisingly, many battered women also suffer from low self-esteem (e.g., Orava et al.).

There are several factors that may complicate the treatment of battered women. First, unlike survivors of single or relatively circumscribed traumatic events, most battered women have experienced prolonged, repeated trauma (see Herman, 1992). Not only are they likely to have been repeatedly traumatized by intimate partners in multiple ways (threats, stalking, sexual abuse; e.g., Tremayne, Kubany, Leisen, & Owens, 1998), but many also have histories of exposure to other forms of interpersonal violence, such as childhood physical and/or sexual abuse (Humphrey, Lee, Neylan, & Marmar, 1999; Kubany, Haynes, et al., 2000; Weaver & Clum, 1996). Such repeated and multimodal abuse may contribute not only to the severity of PTSD but also to collateral problems, such as deficits in assertiveness and tolerance of disrespect from others (Cloitre, Scarvalone, & Difede, 1997; Dutton, 1992a). Empowerment issues may be particularly important to address as a therapeutic theme in treatments for battered women (e.g., Douglas & Strom, 1988; Dutton, 1992b).

A second factor that may complicate the treatment of battered women is that attachments to abusive partners often result in ambivalences not faced by most trauma survivors (incest survivors are an exception). The lives of many formerly battered women remain enmeshed with their ex-partners because these men are fathers of the children, and continuing contacts are a frequent source of stress (Shalansky, Ericksen, & Henderson, 1999).

A third factor that may complicate the treatment of battered women is that many battered women may be at risk for revictimization by subsequent intimate partners. Many battered women have been abused by more than one intimate partner (e.g., Kubany, Hill, & Owens (in press); R. Martin, personal communication, July 29, 1999), and a module on ways to identify potentially abusive suitors and prevent revictimization may be important to include in comprehensive trauma recovery programs for battered women.

A fourth factor that can complicate the treatment of battered women is that battered women are very vulnerable to guilt and shame (e.g., Dutton, 1992b; Kubany et al., 1996; Street & Arias, 2001; Walker, 1994), problems which PTSD treatments often fail to remediate (e.g., Ehlers et al., 1998; Johnson et al., 1996; Pitman et al., 1991; see also Echeburua, De Corral, Sarasua, & Zubizarretta, 1996). In fact, several studies have found that guilt and self-blame are significant problems for battered women (Andrews & Brewin, 1990; Kubany et al.; O'Neill & Kerig, 2000). For example, in a study of 168 women in support groups for battered women, only six women reported no guilt related to their abuse, and guilt was significantly related to PTSD and depression (Kubany et al.). Battered women have some guilt and shame issues that are unique to the population, for example, guilt and shame related to a failed marriage, effects of the violence on the children, and their decisions to stay in or leave the relationship (e.g., Barnett & LaViolette, 1993; Dutton, 1992a). Guilt and shame among battered women may also reflect society's disdain of women who stay in abusive relationships (Barnett & LaViolette, pp. 75–76), and battered women may require cognitive interventions that target and facilitate the reprocessing of these complicated issues (e.g., Douglas & Strom, 1988).

The few accounts of counseling or therapy approaches for battered women that have been reported are largely descriptive and/or anecdotal in nature, and few have been subjected to peer review (e.g., Barnett & LaViolette, 1993; Douglas & Strom, 1988; Dutton, 1992b; Goodman & Fallon, 1995; Walker, 1994). In fact, there is a dearth of treatment-outcome studies with battered women addressing *any* aspect of their mental health.[1] The only treatment-outcome study for this population identified in our review of the literature was a quasi-experimental evaluation of outcome across 12 support groups for battered women (Tutty, Bidgood, & Rothery, 1993). The authors found significant improvements on measures of social

[1] There are several reasons why survivors of domestic abuse, as a group, have been relatively understudied in the psychological treatment literature. Historically, following early descriptions of spouse abuse, which used a wife's "masochism" as an explanatory mechanism (e.g., Snell, Rosenwald, & Robey, 1964), some domestic violence activists argued that "treating" battered women could be seen as pathologizing victims' normative responses to abuse (e.g., Adams, 1988). Instead, most of the therapeutic models developed to address domestic violence have targeted the batterer (e.g., Hamberger, 1997) or, in some instances, the marital dyad (e.g., O'Leary, 1996). In addition, it has only been recently recognized that women's exposure to partner abuse represents an important risk factor for the development of psychopathology, particularly depression and PTSD (e.g., Astin, Ogland-Hand, Coleman, & Foy, 1995; Cascardi, O'Leary, Lawrence, & Schlee, 1995; Frank & Rodowski, 1999).

support, self-esteem, and coping at pre- and posttreatment, suggesting that battered women are likely to benefit from post-abuse interventions.

A Cognitive-Behavioral Model of Posttraumatic Stress That Emphasizes the Role of Language

Below, we describe the treatment outlines of a new intervention for battered women, called Cognitive Trauma Therapy for Formerly Battered Women With PTSD (CTT-BW). We present preliminary findings on the efficacy of CTT-BW and discuss further work that needs to be done to assure that CTT-BW can be reliably implemented by other clinicians. First, we outline a cognitive-behavioral model of posttraumatic stress (Kubany & Watson, 2002) that serves as the conceptual basis for CTT-BW.

Mowrer's (1960) two-factor model of escape and avoidance conditioning, involving classical and operant conditioning, has been widely proposed as a conceptual framework for understanding the acquisition and persistence of PTSD (see Foa, Steketee, & Rothbaum, 1989). Applying Mowrer's model to trauma, formerly neutral or positive events that are associated with trauma come to elicit strong negative emotions and control irrational escape and avoidance behaviors. Events that symbolize the trauma may evoke fear or anxiety, and any action that removes recollections from consciousness is reinforced with relief, thereby strengthening escape and avoidance responding.

Although two-factor theory may be useful as a partial explanation of PTSD, it does not account for PTSD that develops following traumatic losses, such as the sudden, unexpected death of a spouse or child (Bonanno & Kaltman, 1999; Breslau et al., 1998; cf. Lehman, Wortman, & Williams, 1987) or symbolic losses related to a shattering of assumptions about concepts such as innocence, trust, fairness, or marital happiness (e.g., Janoff-Bulman, 1985; Kubany & Watson, 2002; McCann & Pearlman, 1990; Resick & Schnicke, 1992). A second limitation of two-factor theory is that it fails to account for the role that cognitive factors play in the maintenance of PTSD and related psychopathology.

A number of investigators have proposed that cognitive variables may play a central role in the maintenance or persistence of posttraumatic stress (Brewin, Dalgleish, & Joseph, 1996; Creamer & Burgess, 1992; Dunmore, Clark, & Ehlers, 1999; Ehlers & Clark, 2000; Foa & Rothbaum, 1998). In the aftermath of trauma, many survivors make harshly negative appraisals about the world, other people, and, particularly, themselves and their own trauma-related actions (e.g., Foa & Rothbaum; Janoff-Bulman, 1985; McCann & Perlman, 1990; Resick & Schnicke, 1992). Such appraisals often represent significant distortions of reality. According to Foa and Rothbaum, beliefs that "the world is completely dangerous" and "I am totally incompetent" (e.g., Foa & Rothbaum, 1998, p. 83) are dominant cognitive themes among many trauma survivors, and maintain posttraumatic stress. Likewise, irrational guilt-related beliefs, such as exaggerated perceptions of responsibility for causing negative outcomes and beliefs that unforeseeable outcomes were preventable, are common among treatment-seeking trauma survivors (e.g., Kubany et al., 1996; Kubany & Manke, 1995). In our view, when negative appraisals manifest themselves in consciousness as thoughts or speech, such self-talk can have devastating effects on a person's well-being, and play an important role in maintaining PTSD. We have proposed that an important reason why memories of trauma do not lose their capacity to evoke emotional pain over time may be due to higher-order language conditioning (Kubany & Watson, 2002), 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, 1996). That is, negatively evaluative words habitually paired with recollections of trauma may repeatedly recondition memories of the trauma with negative emotional valence or distress. In fact, evaluative self-talk narratives that accompany memories of trauma may provide thousands of reconditioning trials that effectively interfere with the natural process of emotional extinction (Kubany & Manke).

Maladaptive language repertoires may also maintain and exacerbate posttraumatic stress in some relatively complex ways. The following examples illustrate how evaluative language may foster the persistence and elaboration of psychopathology in battered women suffering from PTSD (cf. Staats, 1996). Phrases such as "I should have left sooner" may elicit negative affect that function as self-punishment. Such phrases may also trigger or control other negative self-talk. For example, the guilt-related belief "I knew better" may control or lead to shame-related self-talk such as "There is something wrong with me," "I'm so stupid," or "I'm a bad mother." These shame-like statements, with accompanying negative affect, may then control operant escape thoughts such as "I hate thinking about it" or "I don't want to be around anybody," which, in turn, give rise to escape behavior such as social withdrawal or use of drugs.

CTT-BW

CTT-BW is a multi-component, cognitive-behavioral intervention aimed at alleviating PTSD, depression, guilt, and shame, and at elevating self-esteem in formerly battered women. CTT-BW incorporates elements from existing treatments for PTSD that have been shown to be ef-

fective. Procedural components in CTT-BW, which are not unique to CTT-BW, include (1) psychoeducation about PTSD, (2) stress management (including relaxation training and homework practice), (3) self-monitoring of maladaptive thoughts and speech, and (4) talking about the trauma and imaginal and in vivo exposure homework.

One important treatment component that CTT-BW has in common with other trauma therapies involves exposing clients to trauma reminders. First, detailed discussions about traumatic experience begins in the first session and continues in subsequent sessions. Clients are asked to describe in great detail what happened during trauma-related events, and considerable time is spent reprocessing this experience. Second, clients are given audiotapes of the sessions for listening homework. Third, the therapist helps clients identify aversive reminders that are idiosyncratic (e.g., photographs of their abusive partner, the smell of a certain brand of aftershave or alcohol, TV programs on domestic violence, places where violence occurred) and gives clients homework to self-expose themselves to these stimuli. Fourth, clients are encouraged to be assertive in their social interactions and not to avoid conflict or disagreements, trauma reminders that many battered women avoid.

The aspect of CTT-BW that is unique is a highly systematized body of procedures for assessing and correcting irrational and maladaptive cognitions related to guilt and shame. CTT-BW incorporates a protocol for modifying guilt-related cognitions and for alleviating guilt (Kubany & Manke, 1995). Correcting guilt-related beliefs, which are largely irrational, is conducted in a highly systematic format. In CTT-BW, clients' use of dysfunctional or negatively evaluative language is also addressed directly by teaching clients to raise their awareness of the negatively evaluative words they say and think (e.g., "I'm worthless . . . a fake . . . a fool") by means of around-the-clock self-monitoring homework, and to try to break habits of using these words to describe themselves and their experience.

CTT-BW also includes modules for addressing trauma sequelae that are not core features of PTSD but that contribute to disempowerment, low self-esteem, and vulnerability to exploitation by predatory men (e.g., Douglas & Strom, 1988; Dutton, 1992b; Orava et al., 1996). Modules were developed specifically with the needs of battered women in mind, and address empowerment, self-esteem enhancement, and relapse prevention. These secondary modules include (1) psychoeducation on coping strategies that promote self-advocacy in five areas of functioning (e.g., placing oneself first, decision-making that promotes personal happiness), (2) assertiveness, (3) managing unwanted contacts with former partners, and (4) identifying potential perpetrators and avoiding revictimization.

Homework is assigned at each session to reinforce and extend learning that occurs during sessions. Homework assignments include (1) studying PTSD symptoms; (2, 3) identifying harmless trauma reminders that are distressing or avoided, and imaginal and in-vivo exposure to these reminders; (4) self-monitoring and self-regulating negative self-talk; (5) listening to audiotapes of the sessions; (6) listening to a relaxation audiotape; (7) practicing relaxation techniques when stressed; (8) reading a brief article on "thinking errors, faulty conclusions, and cognitive therapy for trauma-related guilt" (Kubany, 1997a); and (9) writing about the personal relevance of 25 cognitive and behavioral coping strategies directed at self-advocacy and self-empowerment.

We have also developed and are refining a therapist-client workbook to promote client learning and to provide some CTT-BW adherence guidance for therapists.

CTT-BW was designed for women who are no longer in abusive relationships, who do not intend to reconcile with an abusive partner, and who are, for the most part, safe. Issues having to do with safety (e.g., whether to stay with an abusive partner, development of safety plans), which are central themes or concerns in support groups for battered women (cf. Douglas & Strom, 1988), are not central themes in CTT-BW. We address safety issues if they arise, and routinely refer clients to support groups and agencies that provide other services, such as legal advocacy, for battered women.

Assessment Instruments in CTT-BW

Two instruments are considered essential to the practice of CTT-BW: (a) the Traumatic Life Events Questionnaire (TLEQ) and (b) the Attitudes About Guilt Survey (AAGS). The TLEQ (Kubany, Haynes, et al., 2000) assesses prior exposure to a broad range of traumatic events.[2] The TLEQ is completed by clients before starting CTT-BW, and it is used in Session 1 to identify all sources of traumatization other than partner abuse. The therapist asks clients about experienced TLEQ events and probes for grief and guilt related to these events, which may be addressed in subsequent sessions.

The AAGS (Kubany et al., 1995; Kubany & Manke, 1995) is a 7-item questionnaire used to assess the presence and magnitude of guilt and guilt cognitions (e.g., beliefs about wrongdoing or violation of values) with respect to highly specific guilt issues (e.g., guilt about not leaving an abusive relationship sooner). Clients fill out a separate AAGS for each guilt issue targeted for interven-

[2] In separate studies with college students, Vietnam veterans, battered women, and residents of a substance-abuse program, most TLEQ items possessed adequate-to-excellent temporal stability. In a study comparing questionnaire and structured-interview inquiry of trauma history, the two formats yielded similar rates of disclosure.

tion, and it is used in the guilt therapy to assess progress in correcting faulty thinking with respect to each of the four guilt-related beliefs.

For treatment-outcome assessment, we administer the following six instruments before and after therapy: (a) a brief questionnaire measure of PTSD, the Distressing Event Questionnaire[3] (DEQ; Kubany, Leisen, et al., 2000), (b) the Beck Depression Inventory (Beck, Ward, Mendelson, Mock, & Erbaugh (1961), (c) the Trauma-Related Guilt Inventory[4] (TRGI; Kubany et al., 1996), (d) the Sources of Trauma-Related Guilt Survey—Partner Abuse Version (STRGS-PA; Kubany, Owens, & Leigh, 1998),[5] (e) the Rosenberg Self-Esteem Scale (Rosenberg, 1965), and (f) the Personal Feelings Questionnaire (Harder & Lewis, 1986), which includes scales of guilt and shame proneness.

Cognitive Therapy for Trauma-Related Guilt

Cognitive Therapy for Trauma-Related Guilt (CT-TRG) is the most well-developed (and in our view the most important) treatment component in CTT-BW. In CT-TRG, guilt is a multidimensional construct comprised of distress and four guilt-related beliefs or guilt cognitions, including (1) perceived responsibility for causing a negative outcome, (2) perceived lack of justification for actions taken, (3) perceived violation of values, and (4) beliefs about outcome foreseeability and preventability, that is, the degree to which a person thinks he or she knew that a negative outcome was going to occur and could have been prevented (Kubany et al., 1995; Kubany et al., 1996; Kubany & Watson, in press).

Numerous authors have noted that trauma survivors tend to distort or exaggerate the importance of their roles in trauma (see Kubany, 1998a, for a brief review). Kubany and Manke (1995) identified 15 thinking errors that lead to distortions in each of the four types of guilt-related beliefs.

Beliefs about outcome *foreseeability and preventability* often become distorted by hindsight-biased thinking (Fischhoff, 1975; see Kubany, 1998a, pp. 138–139), whereby survivors falsely "remember" unforeseeable outcomes as foreseeable and, hence, preventable (Kubany, 1994). For example, many formerly battered women falsely believe they "knew" they were going to be abused *before* they got married or, when abused the first time, that they knew the abuse was going to continue and get worse.

Two common thinking errors that contribute to distorted beliefs about *justification* for actions taken are (1) tendencies to overlook "benefits" associated with actions taken and (2) focusing only on "good" things that might have happened had alternative courses of action (which were considered at the time) been taken. Many battered women, who think they should have left an abusive relationship sooner, fail to realize or remember that, at the time they think they should have left, they thought they had better reasons for staying than for leaving. Examples of benefits of staying (knowing only what a woman knew at the time) include retention of an intact family and retention of hope that things would get better. Examples of "bad" things that might have been associated with leaving include poverty, the possibility that the partner would carry out serious threats, and loss of a marital dream when a woman still had hope.

A common thinking error that contributes to distorted beliefs about *causal responsibility* is failing to realize that most events have multiple sources of causation. This typically includes a concomitant failure to recognize the contributions of causal factors outside of oneself. For example, many formerly battered women believe that they, alone, were to blame for staying in an abusive relationship. In fact, many factors might contribute to the decision to stay, including (1) "supposed to" beliefs acquired while growing up, such as beliefs that marriage is supposed to be forever and divorce is a personal failure, that it is a woman's responsibility to make the relationship work, that a woman is supposed to accept her husband's apologies and is obligated to stay, that the children need their father (e.g., Barnett & LaViolette, 1993); and (2) certain realistic fears, such as fears that, if she leaves, the partner will hurt her or the children, she will be impoverished or homeless and unable to provide for the children, her partner will get custody of the children, and anticipation of guilt (e.g., over invalidation of "supposed to" beliefs).

A common thinking error that contributes to distorted beliefs about *wrongdoing* is the tendency to conclude that one has violated values because of an unfortu-

[3] The DEQ assesses PTSD according to criteria in *DSM-IV*. In samples of 120 Vietnam veterans and 255 physically and/or sexually abused women, the DEQ exhibited very good discriminative validity when judged against the CAPS (Kubany, Leisen et al., 2000). The DEQ exhibited strong convergent validity with other PTSD measures and exhibited strong convergent validity as a measure of PTSD across ethnic groups in both the veteran and the combined women's samples.

[4] The TRGI assesses guilt and cognitive and emotional aspects of guilt associated with specified traumatic events (e.g., combat, partner abuse). The TRGI includes a global guilt scale, a trauma-related distress scale, and a guilt cognitions scale, which assesses 22 specific, guilt-related beliefs that are often distorted (e.g., "I should have known better") and that are direct targets for modification in CTT-BW. In validity studies with Vietnam veterans and battered women, TRGI scales were significantly correlated with other measures of guilt and with measures of PTSD, depression, guilt and shame proneness, and negative self-esteem.

[5] The RGS–PA was developed (a) to help clinicians identify important sources of partner-abuse-related guilt to be targeted in CTT-BW and (b) as a treatment-outcome measure for assessing the generalization of treatment effects to nontreated guilt issues. The RGS—PA assesses 95 potential sources of partner-abuse-related guilt (e.g., "not leaving sooner").

nate, albeit unforeseeable, outcome—rather than on the basis of one's intentions before outcomes were known. For example, many women believe they did a dishonorable service to themselves and their children by staying in an abusive relationship, even though they did not want themselves or their children to suffer, and believed at the time that things would get better, or believed that if they left, things would get worse.

Procedural Outlines of CT-TRG. CT-TRG consists of three phases: (a) guilt-issue assessment, (b) guilt-incident debriefing exercises, and (c) cognitive therapy. During guilt-issue assessment, partner-abuse-related guilt issues are identified by means of a structured interview, which probes about specific sources of guilt (e.g., "Do you feel guilty about anything you did related to the abuse? . . . Tell me about that"). During the guilt-incident debriefings, clients are asked to describe in minute detail exactly what happened during events leading up to and ending up with the situation which is the source of guilt (e.g., "Tell me what happened leading up to the point where you think you should have left your husband"). We have found that detailed retelling of exactly what happened—as opposed to superficial retelling—is more likely to facilitate tearful grieving, and is also more likely to yield useful assessment information about distortions in logic (see Kubany, 1998a, pp. 150-151). Distortions in guilt-related beliefs are addressed in the context of four semi-structured procedures for teaching clients to distinguish what they knew "then" from what they know "now," and for reappraising perceptions of justification, responsibility, and wrongdoing (in light of beliefs held and knowledge possessed when the trauma occurred).

CT-TRG procedures are spelled out in considerable detail elsewhere (Kubany, 1997a, 1997b, 1998a; Kubany & Manke, 1995). We recently refined and streamlined the foreseeability/preventability analysis, which involves identification and correction of hindsight-biased thinking (Fischhoff, 1975). The format of this analysis is now more operationally precise in its basics, down to the level of recommended phraseology in places. We illustrate portions of the foreseeability/preventability analysis below.

T: You indicated on the Attitudes About Guilt Survey that you absolutely should have known better. What is it that you should have known better?

C: I should have known that if he hits you once, it's going to happen again. I should have known that he was going to continue to do it, and that it wasn't going to get better.

T: What is it you should have done differently?

C: I should have left him the first time he hit me.

T: When did you first realize or learn that that is what you were supposed to do?

C: When I was out of the relationship. I don't know. Maybe when I started reading self-help books. Maybe, the next time it happened.

T: At the earliest. Or maybe not until you realized with 100% certainty that it wasn't going to get better. Do you see what's happening here? You're remembering yourself knowing something you didn't learn until much later. However, you can't use knowledge you acquire *after* making a decision to help you make that decision.

C: Because it's hindsight.

T: Right. You can't use information you learned from reading a book years later to help you make a decision years earlier. Similarly, you can't use information you acquire on Wednesday to help you with a decision you made a day earlier on Tuesday. You can't use knowledge that the stock market went up 500 points today to help you with an investment decision yesterday. Have you seen the TV program, Early Edition?

C: No.

T: In the program, the star gets tomorrow's newspaper today, and he spends all day today preventing tomorrow—because tomorrow is foreseeable.

C: Oh, that's interesting. He goes about saving lives or something?

T: Yes. And this has to do with an extremely important concept, called hindsight bias. It's something that trauma survivors have a strong tendency to do; but it's not something that just trauma survivors tend to do. Everybody tends to do it.

We then describe the type of experiment conducted to illustrate hindsight bias (e.g., Fischhoff, 1975), and tell clients a few anecdotes, like the one below, about survivors who engaged in hindsight-biased thinking:

T: I was working with a 38 year-old woman who had been sexually molested by her cousin's husband when she was 12 years old. I was having a hard time getting her to accept that she wasn't responsible for the abuse, so I took a another approach. I asked her if she had any nieces or nephews who were about 12 years old. She said she had several. Then, I asked her, "Can you imagine a scenario whereby, if you molest one of your nieces or nephews, that they could be in any way responsible for the molestation?" She immediately answered, "Of course not!" Then, she didn't say anything for a few seconds, and it was as if a light bulb went on over her head. She then said, "Do you know what I think I've been doing. I think I've been putting my 38 year-old mind in my 12 year-old body." She was remembering herself as being street smart when she was still a very naïve little girl. Anything having to do with sex was the furthest thing from her mind when she was being

friendly with her cousin's husband. I asked her if she would have gone into his room if she even had the remotest thought that he might molest her. "Never!," she said. To which I responded, "Well, then, that's proof that you didn't have the slightest idea that he was going to molest you."

C: It doesn't make any sense.

T: It doesn't, and, based on my clinical experience and feedback from clients, hindsight-biased thinking is the single most important factor that contributes to guilt, shame, low self-esteem, and the maintenance of PTSD and depression. If I only had 1 hour to speak with you, it would be about guilt. If I only had 10 minutes, it would be about hindsight bias.

Now let me say a little something about the word *should*. To say, "I should do something" means I am obligated to do it—because that's the definition of should.

It's an obligation to do something.

C: Right.

T: But you can only be obligated to do something if you are capable of doing it. For example, you can't say you should jump up and touch the ceiling if you can't jump.

C: Maybe on the table I could (laughing).

T: Similarly, You can't say, 'I should go to the store and buy milk and bread for my starving children if your legs are broken and you're chained to the bed. Should is the past tense of shall. Should implies power and capability, and it is related to the word could. Could is the past tense of can and means a capability of doing something. You are only capable of preventing something if that something is foreseeable.

Let me give you an example to illustrate. Let's say that there's a mine field over here, and I say to you that if you don't walk through the minefield, I'm going to shoot you. Now, if there are flags designating where the mines are, and you walk into a mine and it explodes, you could accurately say, "I should have known better and could have prevented the explosion."

C: Right.

T: But, if there were no flags, and you start inching across the mine field and hit a mine, could you say, "I should have known better. I could have prevented the explosion?"

C: No.

T: If it's not foreseeable, it's not preventable. If you knew that he was going to abuse you over and over for three years when he hit you the first time, would you have stayed?

C: Absolutely not. I would have run the other way.

T: That's proof you didn't know what was going to happen. Otherwise, you wouldn't have done what you did. All right, now. What is the correct answer to the first item [on the AAGS]?

C: It's [choice] "a." There is no possible way I could have known what was going to happen.

The foreseeability/preventability analysis can become more difficult or complicated if clients incorrectly insist they had foresight knowledge of the outcomes, as in the example below:

T: When did you first realize or learn that you shouldn't have married him?

C: I *knew* I shouldn't have married him *before* I married him, but did anyway. Stupid.

T: Was the abuse foreseeable when you married him?

C: I knew better. My family didn't want me to marry him. And my older sister said that he had a reputation for having a really bad temper. I should have listened to them. I could have prevented the abuse.

T: Then, why did you marry him?

C: Because I loved him and thought we would be happy.

T: Did you believe your sister?

C: No. I didn't think she really knew him, and I thought I could prove my family wrong.

T: If you knew he was going to abuse you when you married him, would you have married him?

C: No.

T: That's proof you didn't know he was going to abuse you.

When clients insist that unforeseeable negative outcomes were foreseeable, the therapist may ask "what negative outcomes were *preventable*" when they did something they don't think they should have done (such as staying in the relationship). For example, a client might answer that the negative effects of subsequent abuse on her children were preventable. The therapist might then ask, "if you *knew* with certainty your child was going to develop emotional problems because of continued exposure to family violence, would you have stayed?" Clients typically answer *no* to this type of question. Sometimes, clients did something that was a foreseeable minor violation of values and, as a result, conclude they could have prevented a "related" tragic outcome that was not foreseeable. For example, one client insisted that she could have prevented an acquaintance rape if she hadn't cut school to go to the beach with the subsequent assailant ("I knew I shouldn't have cut school. I wouldn't have been raped if I had just done what I was supposed to do"). If the woman (as a teen) had a great time at the beach and developed a positive romantic relationship with her then-friend, playing

hooky that day may have assumed little or no significance—the point being that the rape was unforeseeable and, if the rape had been foreseeable, she wouldn't have cut school that day. In our experience, learning how to effectively conduct the foreseeability/preventability analysis across the range of client resistances is the single most difficult CTT-BW therapist skill to acquire.

Session-by-Session Description of CTT-BW

CTT-BW is conducted in a two-sessions per week, one-on-one format. CTT-BW was originally designed for delivery in eight 1.5 hour sessions for most clients. In practice, the modal number of sessions has been eight, with as many as 14 sessions for a few clients, with CTT-BW designed for delivery in 10 sessions with most clients.

Session 1. The purpose of Session 1 is to establish rapport, obtain a partner-abuse history, inquire about other significant traumatic experiences, and provide clients an overview of our theoretical orientation and the topics that will be covered in each of the sessions.

After completion of the partner-abuse history, clients describe other experienced traumatic events, as reported on the TLEQ. After each event description, clients are asked whether they experience any guilt about that event. Important guilt issues identified during this session may be addressed, along with guilt related to intimate partner abuse, with CT-TRG in later sessions. Session 1 concludes with a 20-minute overview of the rationale for CTT-BW and a summary of topics that will be covered in subsequent sessions. Clients are told that therapy is based on an educational model rather than a disease or medical model and "that is why we refer to the people we see as *clients* rather than *patients*." We explain that we consider problems like depression, anxiety, and PTSD to be *thinking problems* rather than emotional or *mood disorders* because "How we think affects how we feel. If you change the way you think about the trauma, it will change the way you feel. We can't change what happened, but we can help you to change your interpretation of what happened."

Clients are told that, at the end of every session we will ask them, "What did you learn today?" Clients are also told that, starting with Session 2, they will be loaned audiotapes of the sessions for "listening homework" and will be asked at the beginning of each subsequent session, "What did you learn from listening to the tape?"

Sessions 2 to 4. Occasionally, clients' trauma histories are too extensive to cover entirely in Session 1. If this is the case, the trauma history exploration is completed in Session 2. The rest of the agenda planned for Sessions 2 to 4 is almost entirely psychoeducation, which is delivered in a conversational and Socratic style. The therapist (a) provides education about PTSD and the rationale for exposure homework, (b) assigns imaginal and in vivo exposure homework, (c) provides education on learned helplessness and the importance of a solution-oriented attitude, (d) provides education on negative self-talk and assigns homework to monitor self-talk, (e) provides education on stress management, and (f) teaches the client how to do progressive muscle relaxation.

PTSD education. The PTSD education provided in Session 2 is directed at normalizing the PTSD experience and getting clients to buy into the CTT-BW treatment model, thereby promoting compliance with the exposure homework and willingness to talk about painful events. Clients are taught (1) that symptoms of PTSD are "normal" reactions to extreme stress; (2) this model of PTSD, which emphasizes the importance of trauma-related guilt and unresolved grief over tangible and symbolic losses as critical issues that interfere with recovery; (3) the model of escape and avoidance that accounts for the persistence PTSD; (4) why reappraisals of the meaning of the trauma are a critical key to recovery; and (5) why "avoidance busting" (Resick, 1993) contributes to recovery.

Homework assignment to identify reminders of the abuse and the abuser. Clients are given a homework assignment to identify abuse-related reminders that are being avoided as the basis for exposure homework to be assigned at the next session. Clients are asked to complete the Identifying Harmless Reminders Survey (IHRS; Kubany, 1998b), which lists 24 different types of reminders that formerly battered women may avoid (e.g., pictures of the abusive partner, visualizations of the abusive partner, certain types of articles in magazines or newspapers, certain types of movies or programs on TV, certain places or types of activities, disagreements or conflict, and certain tastes, textures, and smells). For each type of reminder, clients are asked to rate the degree to which they avoided that reminder in the previous month. For each type of reminder avoided, the IHRS prompts respondents to provide examples.

Imaginal and in vivo exposure assignments. Based on the client's responses on the IHRS, the therapist negotiates with her to systematically expose herself to reminders between sessions. In a typical exposure assignment, clients devote 10 minutes a day looking at pictures of and/or visualizing the abusive partner while simultaneously exposing themselves to other reminders (e.g., the scent of a certain cologne, cigarette smoke, a towel drenched in beer, certain music or songs the partner liked). We also ask clients to rent and watch two movies on domestic violence—*Sleeping with the Enemy* and *Once Were Warriors.* We advise clients to remind themselves, when viewing these films, that no one is actually getting hurt—the violence is only simulated. We also suggest that, if the movies are upsetting, to watch them a second time; and, if any

segments are particularly distressing, to watch these segments over and over until they no longer evoke distress.

Examples of other commonly assigned exposure exercises include watching TV programs that depict violence, angry people, or interpersonal conflict (e.g., the *Jerry Springer Show*). Other assignments (drawn from clients' idiosyncratic responses on the IHRS) have included exercising, going places where the client frequently went with her partner or where abuse occurred (e.g., a certain beach), wearing jewelry that was a gift from the partner, wearing make-up or feminine clothes, or showing affection.

Psychoeducation on learned helplessness. Clients are provided psychoeducation about learned helplessness (Peterson & Seligman, 1983) and the importance of developing a solution-oriented attitude that focuses on looking for ways problems can be solved—as opposed to focusing on obstacles or reasons why problems can't be solved.

Self-talk education and homework assignment for monitoring self-talk. Clients receive considerable psychoeducation about three categories of maladaptive self-talk (thoughts and speech), and are given an ongoing homework assignment to self-monitor their self-talk. The three categories of negative self-talk are (a) the phrases "should have," and "could have," and "why" questions; (b) shame-related, global self-put downs (e.g., "I'm stupid . . . I'm a coward"); and (c) "I feel . . ." statements ending with words that are not emotions (e.g., "I *feel* obligated . . . stuck . . . overwhelmed . . . responsible . . . unsafe"). The therapist may say that, "These categories of self-talk are not good for you, and if you never think or say them again, you will be a happier person."

Clients are taught that *should have* and *could have* phrases often signal the presence of guilt and a thinking error, which leads to guilt, which has no rational basis (i.e., *falsely* remembering a negative outcome as foreseeable and preventable). Clients are told that thinking or saying "I should have" or "I could have" is self-criticism or self-punishment that makes them feel bad. They are taught that "why" questions can keep them stuck in the past, often lead to guilt and anger, and are associated with a slow recovery from the effects of traumatization (e.g., Frazier & Schauben, 1994).

We tell clients that self put-downs (referring to themselves as stupid, foolish, crazy, less of a person, etc.) can have devastating effects on their well-being. The therapist may say, "You don't deserve to be talked to this way. You need to start giving yourself the same respect you want to get, and deserve to get, from others."

Clients are strongly discouraged from using the phrase, "I feel," in sentences ending with words that are not emotions. The therapist may say,

> "Words like *overwhelmed, obligated,* or *responsible* are not emotions. They are intellectual judgments, beliefs, or opinions about fact—the validity of which depends on evidence. Feelings that accompany these words are not evidence for the truth, accuracy, or validity of the conclusions that these ideas convey. Saying 'I feel' with words that are not emotions is called emotional reasoning because the feelings are used as evidence for the conclusions and give them a 'false ring of truth' [see Kubany & Manke, 1995, pp. 43–44]. Such "I feel" statements interfere with your ability to think clearly."

The primary purpose of the self-talk education is to maximize client motivation to comply with a self-monitoring homework assignment. The self-monitoring homework involves having clients track negative self-talk during all waking hours for the remainder of therapy, using the self-monitoring form shown in Table 1.[6] Instructions are given in the footnote in Table 1. Considerable research has shown that the use of self-monitoring homework can aid in modifying a variety of habits, including ruminative thinking (e.g., Frederiksen, 1975; Korotitsch & Nelson-Gray, 1999).

The therapist emphasizes that heightened awareness of mental activity is a necessary precursor to breaking any self-talk habit, and conscientious performance of the self-talk monitoring homework is a means toward that end. Clients are told that it is imperative that they carry the self-monitoring form with them at all times and that they record occurrences of negative self-talk as soon as they occur. They may be told that, "waiting until later defeats the purpose of the exercise. It may be inconvenient or mildly punishing to write it down at the time. But that's the whole idea. Mild punishment for this behavior may help break the habit." Clients are told that the first goal of the self-monitoring homework is to increase their awareness of their "mental life," and that awareness precedes change. They are told that, "after awhile you will start catching yourself when you start to think or say these words, and this may interrupt a chain of negative self-talk, which in the past may have had a life of its own, of which you may not even have been aware."

Because we have come to attribute great importance to the way clients talk to themselves, we now assign the self-talk homework at Session 1 because the exercise can sometimes have immediate effects on clients' well-being, and it affords us more opportunities to hold clients accountable for doing this homework. At the beginning of

[6] In Beck's (1995) model of cognitive therapy, clients are given homework to identify maladaptive automatic thoughts and to evaluate the evidence for and against these thoughts when they occur. Our approach, which has much the same goal, is simpler and more direct. Self-talk psychoeducation is directed at persuading clients that negative self-talk is not good for them and tries to break the habit of using negatively evaluative words and phrases.

Table 1
Self-Monitoring Recording Form[a]

Person Observed: _____ Dates: From _____ To _____

Phrases of Concern: **1 = "I should have . . . I could have . . . Why . . . ?"**
2 = Self-Put-Downs of your entire personality or character
(e.g., Stupid . . . I'm inadequate . . . I'm a wimp . . . There's something wrong with me, etc.)
3 = "I *feel* . . ." statements ending with words that are not emotions
(e.g., *I feel* obligated . . . responsible . . . overwhelmed . . . sorry for, etc.)

Dates								
	Mon.	**Tues.**	**Wed.**	**Thurs.**	**Fri.**	**Sat.**	**Sun.**	
8 am – 12 pm								
12 pm – 4 pm								
4 pm – 8 pm								
8 pm – 12 am								
12 am – 8 am								

Monday Phrases:	1: _____ 2: _____ 3: _____
Tuesday Phrases:	1: _____ 2: _____ 3: _____
Wednesday Phrases:	1: _____ 2: _____ 3: _____
Thursday Phrases:	1: _____ 2: _____ 3: _____
Friday Phrases:	1: _____ 2: _____ 3: _____
Saturday Phrases:	1: _____ 2: _____ 3: _____
Sunday Phrases:	1s: _____ 2s: _____ 3s: _____

[a] Clients are instructed to record (in code, with numbers 1, 2, or 3) only the first occurrence of each type of statement in the interval in which it is observed to occur (e.g., between 4 P.M. and 8 P.M.). If a type of statement does not occur in an interval, nothing is recorded. Clients are instructed to write on the bottom half of the form the content of the first occurrence of each type of negative self-talk each day.

all subsequent sessions, we ask clients to show us the completed self-monitoring homework form, and ask, "How is the self-talk going?" Based on how the form is filled out, we can usually tell whether clients are doing the homework as assigned (e.g., by the degree to which written examples of negative self-talk are shown on the form; by the degree to which entire days have no coded marks). When clients haven't been monitoring their self-talk, we reemphasize its importance and try to gain clients' commitment to start doing it. In addition, we may bring it to clients' attention when they use negative self-talk in the session to facilitate clients' awareness of their mental life (e.g., "Did you hear what you just said?"). When clients reliably track and record their negative self-talk, it almost always goes down in frequency by the end of CTT-BW (as reflected by clients' recordings on completed self-monitoring forms and by clinical observations during CTT-BW sessions).

Stress management education, and training in progressive muscle relaxation. Clients receive psychoeducation about stress (e.g., about the role muscle relaxation can play in controlling one's mood and well-being), and they are given training in progressive muscle relaxation, which involves a sequential tensing and releasing of major muscle groups (Wolpe & Lazarus, 1969). At the end of the relaxation exercise, clients are played an audiotape of the song "How Could Anyone" (Roderick, 1992) sung by Shaina Noll. The following "message" is repeated several times during the song:

> How could anyone ever tell you you were anything less than beautiful? How could anyone ever tell you you were less than whole? How could anyone fail to notice that your loving is a miracle? How deeply you're connected to my soul.[7]

Clients are often deeply touched by this song, and we emphasize that it is important that they embrace the song's message as true for them. Clients are given an audiotape of the relaxation exercises (in the therapist's voice) and the song, with instructions to listen to the tape twice a day. Clients are also instructed to do a body scan (i.e., systematically scan or attend to the different muscles in their body so as to identify loci of tension) when experiencing stress and to tense and release the tension in the major muscles affected by the stressor (to attempt to return to their level of arousal prior to the stressor's onset).

Sessions 5 to 7 or 8. ICT-TRG. Typically, two to four sessions are devoted to CT-TRG (Kubany, 1998a; Kubany & Manke, 1995). By far the most common guilt issue we encounter in our work with formerly battered women relates to women's beliefs that they "should have left [the abusive relationship] sooner." Frequently, we also address guilt issues related to other traumas (e.g., incest, an abortion, sudden death of a loved one), which were identified in Session 1. Addressing and resolving two to three guilt issues have usually been sufficient to alleviate all clinically significant trauma-related guilt.

Mini-module on challenging "guiding fictions" or "supposed to" beliefs. We have identified nine "should" or "supposed to" values or assumptive beliefs, which are "guiding fictions" that lead many battered women to act in ways that are not in their best interests and to remain in abusive relationships. Five of these beliefs and statements that challenge the validity of the beliefs are shown in Table 2. When guilt about not leaving a relationship sooner is addressed as an issue, we follow up with an exercise, in which we take turns reading aloud each of the nine "supposed to" beliefs and the statements that challenge their validity. To the extent that battered women hold these expectations of themselves, which may represent central aspects of their identity or self-concept, and act in ways that are consistent with these expectations, they may be motivated to stay in an abusive relationship. To the extent that formerly battered women continue to hold these beliefs after leaving an abusive relationship, they are likely to experience guilt. To the extent that formerly battered women reject or discredit these beliefs, guilt is expected

Table 2

"Supposed to" Values or "Guiding Fictions" That Lead Many Women to Stay in (or Return to) an Abusive Relationship and Statements That Challenge the Validity of These Values (Partial)

C: You *have* to keep your "commitment" to your marriage vows. . . . Marriage is *supposed* to be forever."
T: Even though he broke *his part* of the marital "contract" over and over again?
C: The children *need* their father. Therefore, you *need* to stay (or go back).
T: Do they need a *biological* father who mistreats me and them? Isn't it far preferable to have a single-parent mother who is loving and consistent?
C: You *feel sorry* for him, don't you? Therefore, *you should* stay (or go back).
T: Even though staying (or going back) is not in my best interests or my children's best interests? Even though staying (or going back) will *not* make *me* happy in the long run?
C: If *you* just try hard enough or "get it right," he'll change and you'll be happy. If the relationship doesn't work, *you* failed.
T: No woman will ever be able to "get it right" with a man who is incapable of having a healthy intimate relationship *with anyone*.
C: It's *your responsibility* to make the relationship work.
T: If two people are in a rowboat and each one has an oar, they *both* have to row to make the boat move forward. If only one person rows, the boat will go around in circles and not get anywhere.

[7]We have received permission from Shaina Noll and Libby Roderick, who wrote the words and music to "How Could Anyone," to make audiotape copies of the song to give to our clients for nonprofit purposes. Inquiries regarding the song should be directed to Libby Roderick Music, Turtle Island Records, P.O. Box 203294, Anchorage, AK, 99520-3294, (907) 278-6817.

to diminish. We have found that challenging "supposed to" beliefs reinforces clients' beliefs that they made the right decision by leaving and helps clients understand why they stayed in the relationship as long as they did.

Assertiveness module. In the assertiveness training module, clients are trained to increase their awareness of aggressive speech by others and taught how to respond assertively to "the nasty words that come out of other people's mouths." A page in the therapist-client workbook gives examples of aggressive speech and suggested replies that focus on the *style* of the aggressive message, rather than the *content* of the message. For example, in response to an accusation that "You're selfish," a person might respond, "That's not a very nice thing to say," or "Your saying that I'm selfish doesn't necessarily mean that I'm being selfish," or "I don't deserve to be talked to that way." Therapists and clients take turns speaking some of the aggressive lines shown in the workbook (e.g., "Why are you so needy?") and selecting from and speaking assertive replies, which are also shown in the workbook (e.g., "That's not a nice thing to say, and it hurts my feelings").

Module on how to identify potential perpetrators and avoid revictimization. Early in a relationship, many formerly battered women do not know how to distinguish men who will treat them with respect from men who are likely to become abusive. In this module, clients are taught ways of identifying potentially abusive men. They are taught about several signs that a man may have potential for becoming abusive, including possessiveness, jealousy (often perceived early on as flattery), wanting to rush into a serious relationship, unreliability (e.g., lateness), always checking on or wanting to know his girlfriend's whereabouts (e.g., calling her several times a day), overcontrolling about how, where, and with whom his girlfriend spends her time, disliking his girlfriend's friends or relatives, lying or secrecy (about activities, whereabouts, or previous relationships), subtle putdowns, trying to impose his opinions and world views on his girlfriend, known to have been physically aggressive or otherwise abusive with someone else, a bad temper (even if he is "happy go lucky" most of the time), and a history of heavy use of alcohol or drugs (e.g., Tremayne et al., 1998).

Clients are also given strategies for directly assessing a new boyfriend's potential for abusive, controlling, angry, or other disrespectful behavior. For example, we encourage clients to provoke conflict by expressing disagreements or insisting on something they would like (e.g., "We went to two movies that you like. Next time, I want to go to a movie I like"). The therapist may say, "Many abusive men are capable of being incredibly charming, but they do not have the skills or willingness to resolve conflict in mutually respectful ways." When provoked or confronted with conflict, they will reveal their "true colors" and will get mad, argumentative, or act in some otherwise controlling way. Clients are also taught other subtle ways of provoking conflict, such as postponing sexual intimacy, saying "No" without saying why (e.g., "I can't make it"), wanting to talk about his prior relationships and why they didn't work out, and being willing to get together only infrequently for the first several weeks or months of a relationship.

Sessions 9 and 10. In the final sessions, we conduct modules on (a) managing unwanted phone and face-to-face contacts with former abusive partners (using psychoeducation, modeling, and role-playing) and (b) self-advocacy coping strategies. Optional modules may also be included, based on their relevance to specific clients. These modules address (a) decision making (e.g., related to employment, moving, etc.); (b) trauma-related anger management; (c) addressing an old or persistent interpersonal problem (e.g., how to confront a relative who molested the client as a child; conflict with a supervisor or co-worker; chronically negative phone conversations with a parent), and (d) additional grief work, which includes a critical incident stress debriefing (Kubany & Manke, 1995, p. 48).

Module on ways of dealing with unwanted contacts with an abusive ex-partner. The prospects of unwanted face-to-face and telephone contacts with an abusive ex-partner is a source of considerable anxiety and even dread for many formerly battered women. The module provides clients with behavioral action plans, including modeling and role-playing training to promote skill acquisition and anxiety management or desensitization, for dealing with unwanted contacts. The importance of having a *plan* for what to say and do if unwanted contacts occur is emphasized. Clients are given tips on how to keep unwanted contacts brief, and how to avoid being maneuvered into an extended interaction. Women may be advised that, if the relationship is definitely over, there is nothing to talk about *no matter what* the former partner says. For example, if the ex-partner calls on the phone, the same brief script might be appropriate no matter what an ex-partner says or why he says he is calling. The therapist may model how the client might respond to her ex-partner ("Jack") the next time he calls. The therapist may say "Ring . . . Ring" and then pick up the phone and say, "Hello . . . Oh, hello Jack. Jack, I want you to know that the relationship is over. I am not going to change my mind, and I have nothing more to say. Please don't call me anymore. I have to go now. Goodbye." Clients are advised that if the ex-partner keeps calling back (and batterers often do), the client may then tell him that if she hears his voice, she is not going to say anything. Clients are advised to just hang up (softly) every time he calls.

We indicated earlier that CTT-BW, in its present format, is designed for women who are no longer in abusive relationships, have no intention of reconciling, and con-

sider themselves relatively safe. As a result, safety issues related to problematic interactions with ex-partners arise relatively infrequently. However, if safety issues do arise, we address them. For example, if an ex-partner threatens a client with death or bodily harm, we will exhort the client to call the police and activate safety plans. It is important to note that we work very closely with victim services providers and communicate regularly. For example, if safety issues arise, we will refer clients for lethality assessments, detailed safety planning, and/or consideration of restraining orders.

The importance of helping clients reduce anxiety associated with anticipated contacts cannot be overemphasized because if a woman's anxiety is high when she "faces" her ex-partner, her ability to function may be seriously impaired. For example, in states of high anxiety (and particularly if there is no plan of action), women may "freeze" and act impulsively in ways that may be maladaptive and unsafe. One example will be given to illustrate. The client was avoiding going out in public because she was afraid she would run into an abusive ex-boyfriend, whom she had not seen for 3 years. Standing, the therapist first modeled for her how she might consider acting if her ex-boyfriend approached her at a shopping mall. He said, "Hello, George (speaking softly and maintaining eye contact). Please excuse me. I have nothing to say. Good bye and good luck." He then slowly turned around and started walking away. After modeling variations of the above script three or four times, the therapist asked the client to play herself.

He approached her and said, "Hi Lisa. How are you doing?" The client put her head down and said, "Go away!" Therapist and client reversed roles four times before she was able to play her role as intended.

It may be important to add that using pre-planned strategies like the ones described above when confronted by an abusive ex-partner are not a *guarantee* that he will not become emotionally or physically abusive or will not continue to harass. However, our clinical observations suggests that very brief interactions—in which a woman speaks softly, calmly and assertively—decrease the likelihood of abuse or continued harassment (relative to responding on impulse or without a plan). These clinical observations relate to experimental evidence that hostility begets hostility (e.g., Smith, Sanders, & Alexander, 1990) and that anger evokes antagonism (Kubany, Bauer, Richard, & Muraska, 1995).

Self-advocacy coping strategies module. Many battered women have very traditional sex role attitudes (e.g., Douglas & Strom, 1988) and have spent a large part of their lives putting the needs of other people above their own. Many of the women entering our program have been made to feel rude, selfish, guilty, undeserving, or worse when they tried to stand up for their rights or express their own needs. Abused women's lack of self-advocacy comes up over and over again. The module on positive coping strategies is directed at empowering clients to take control of their lives and to become their own strongest advocate. Twenty-five cognitive and behavioral coping strategies have been embodied in 25 sets of written statements, which are included in the therapist-client workbook. Areas addressed by the statements include (1) getting one's needs and wants satisfied as a top priority; (2) making decisions that promote one's best interests, not making decisions based on *shoulds* (3) communicating more influentially (e.g., by directly expressing wants and not tolerating disrespect); (4) dealing with "aggressive words" spoken by others; and (5) adaptive self-talk. Seven of the strategies are shown in Table 3.[8] Prior to the coping strategy module, clients are given a homework handout, which lists the 25 statements and includes space after each statement for clients to "write down what you believe about this set of statements and indicate how important or relevant each coping strategy is for you (e.g., how important it is for the ideas expressed to become true for you)."

When discussing the coping strategies in the session, clients are asked to read each set of statements aloud and then to read aloud and elaborate upon what they had written about each set of statements. The therapist may than respond to what the client wrote and may expand on the implications of the strategies. An example of therapist-client dialogue is shown below, starting with the client's reaction to what she had written about promoting her own interests (coping strategy #2, shown in Table 3).

C: [*laughing*] Can I change my answer?

T: Yes. Of course. One of your basic human rights is that you can change your mind.

C: I wrote that, "This isn't very important for me. It's more important to satisfy the needs of my kids and other people I'm obligated to. I can always wait." I can't believe that I put that down!

T: So, what is it that you would say now?

C: It's important for me to get my wants and needs satisfied because I don't think I'm going to be much use to anyone else if I'm not satisfied. I can't believe I put that.

T: Obviously, you learned something, and you believe something differently.

C: What I wrote is totally false. I wonder what I was thinking when I put that down.

T: Well, I think we've been taught that to act that way is to be *nice*—that we were considered nice if we always put other people's needs ahead of our own.

[8] The complete coping strategies homework handout is available on written request from Edward Kubany.

Table 3
Positive Coping Strategies (Partial List)

2. Getting my wants and needs satisfied belongs at the *top* of my daily "To Do" list. If I don't make myself *first*, who will? If I get my needs satisfied, I will have more energy to satisfy the wants and needs of others.
4. To get my needs met, I need to tell people *how I feel* (e.g., "I'm upset," "My feelings are hurt") and *what I want* (e.g., "I would appreciate it if . . ."). Other people *cannot* read my mind and won't know how I feel or what I want unless I tell them.
6. I need to make decisions based on what is in *my best interests* (and my children's best interests). I need to stop doing things "because I think I *should*." (i.e., The question to ask myself when trying to decide what to do is: "What course of action is most likely to promote my long-term happiness or quality of life?")
12. Just because someone blames me (or blamed me) *does* not *mean it was my fault*.
13. Just because someone *apologizes* to me for some wrongdoing does *not* mean I am now *obligated* to do what that person wants or go back to the way things were (whether or not I "forgive" the person).
14. If I never say "could have" or "should have" again, I will be a *happier* person.
15. Tearing myself down with self-put-downs (e.g., I'm worthless, stupid, never going to be happy, etc.) makes me depressed and want to give up or go away. I need to start treating myself with the same respect that I would like to get (and *deserve*) from others.

To focus on our needs would be considered *selfish*. We didn't like being called selfish.

C: This is my upbringing. I can see my father saying stuff like that. My father always told me it was more important for him to be satisfied than me. It was more important because my mother was working, and I was taking care of everyone at home.

T: Yes. And that is an example of what we call a *guiding fiction*, a belief that was forced on you that you came to believe and used to define who you are. It was more important for everybody else to be alright than for you to be alright. But it was a fiction that guided you into all kinds of behavior that were not in your best interests.

C: You're right.

We recently started assigning the coping strategies homework twice: first at the first session, and again at the second-to-last session. At the second session, we do not discuss clients' written responses at length, but simply ask clients what they thought about and learned from the exercise. Generally, our clients like the strategies a lot, and even though they typically have not been living in accordance with the strategies (which may seem foreign to them), the strategies make sense to them and provide a road map of what they want to accomplish in therapy. In addition, when clients complete the exercise a second time, their written responses typically indicate that they have made progress in thinking and acting in accordance with the strategies and are incorporating them as a set of guidelines for conducting their lives.

To illustrate the kinds of cognitive shifts we are striving for in CTT-BW, we quote one client's written responses:

WRITTEN AFTER THE FIRST SESSION

I have always put the needs of my children and others ahead of mine, but I have often been unhappy in the end. When I try to do things for myself, I feel selfish and guilty.

WRITTEN AT THE LAST SESSION

If I don't advocate for myself, who will? I like this immensely. It makes me feel happier. I've changed! I like being Number One! I don't feel guilty anymore. I feel good!

Discussion

Efficacy of CTT-BW

Two recent studies have been conducted to evaluate the efficacy of CTT-BW (Kubany, Hill, & Owens, in press; Kubany et al., 2001). Both studies utilized a design in which women were randomly assigned to immediate or delayed CTT-BW conditions. In the initial study (Kubany et al., in press), Edward Kubany was the sole therapist of 37 ethnically diverse women. There were no significant reductions in symptomatology among women in the delayed CTT-BW condition over the 6 weeks between the first and second pre-therapy assessment. Of 32 women who completed CTT-BW (85% of the initial sample), PTSD remitted as a diagnosis in all but two of the women (with a mean 83% reduction in PTSD symptomatology) based on structured-interview assessment (with the CAPS). Compared to pre-therapy assessments, there were also significant reductions in depression (M = 83%), trauma-related guilt (M = 83%) and guilt cognitions (M = 82%), as well as significant reductions in overall guilt proneness (M = 75%) and shame proneness (M = 72%; Harder & Lewis, 1986). Self-esteem scores increased to a mean 92%. All gains were maintained at a 3-month post-therapy follow-up assessment (N = 25).

In a second CTT-BW treatment-outcome study, employing seven therapists, PTSD remitted in 75 of 44 women (89%) who completed treatment (Kubany et al., 2001). Of 74 women in both studies who were reassessed 6 months after completion of therapy, 80% were still PTSD-negative.

Issues Related to Learning How to Conduct CTT-BW and Therapist Qualities

The two CTT-BW treatment-outcome studies conducted were guided by a preliminary procedural manual. Because the completed manual was unavailable, therapists in the second study required intensive mentoring

and supervision from Edward Kubany. Although straightforward in most respects, there are many subtleties and nuances in CTT-BW that can complicate its faithful implementation. In recent months, we have been making refinements and elaborations to the procedural manual to flesh out the procedures and to make refinements as CTT-BW has become better delineated. We have also developed rating scales of therapist adherence and competence in conducting CTT-BW.

When completed, the manual and related materials will be made available to interested clinicians. We will also make audiotapes of CTT-BW sessions available to qualified clinicians, for the cost of duplication and handling. The pace of CTT-BW is very fast, and listening to tapes of sessions will help interested clinicians more fully appreciate how CTT-BW is conducted, the educational and Socratic style in which the intervention is delivered, and the dynamics of the therapist-client interactions. Availability of the completed procedural manual and all related materials will enhance the ability of clinicians outside of our group to reliably replicate CTT-BW and independently evaluate its efficacy.

Clinicians who want to work with battered women should be well informed about domestic violence issues and would be well-advised to complete at least one of the widely offered multi-day training workshops for individuals wanting to work in the domestic violence field.

For any therapeutic modality to be successful in work with battered women, the capacity to communicate genuine empathy and positive regard and, above all, to be *nonjudgmental*, is essential for therapy to be successful. In the experience of our project team, two of the most common types of complaints battered women make about therapists are that their therapists told them to put the trauma behind them and "get on with your life," and that their therapists judged them negatively for staying in the relationship after the abuse first occurred (e.g., "Why didn't you just leave?"). Related value judgments, with Freudian or psychodynamic undertones, include references to the women as in denial or codependent, labels with pejorative connotations.

CTT as a Treatment for PTSD of Any Origin

CTT, without the focus on battered women, may be an appropriate and efficacious treatment for PTSD in response to any kind of trauma, such as combat trauma. For example, in CTT-BW we attempt to identify and treat posttraumatic stress in response to all significant sources of traumatization, including intimate-partner abuse. Several elements of CTT-BW are appropriate for use with any trauma survivor—including comprehensive trauma history exploration, psychoeducation about PTSD, imaginal and in vivo exposure, self-monitoring of dysfunctional self-talk, and CT-TRG. The self-advocacy, coping-strategies module and the module on assertiveness are relevant for survivors of sexual abuse or assault, whether or not they have been battered by an intimate partner. In light of the high rates of female victimization and sexual harassment in our society (e.g., Jorgenson & Wahl, 2000), even the modules on preventing (re)victimization and managing unwanted contacts with *anyone*, including formerly abusive partners, might be relevant for almost any woman. In this regard, we have been awarded a grant to evaluate the efficacy of CTT as a treatment for women with PTSD related to diverse sources of trauma (Kubany, Detwiler, Schnurr, & McCaig, 2001). Eventually, we intend to compare the efficacy of CTT with other established treatments for PTSD, such as Cognitive Processing Therapy (Resick & Schnicke, 1992), Prolonged Exposure (PE), or a combination of PE and Stress Inoculation (Foa et al., 1999).

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Targeted Treatment of Catastrophizing for the Management of Chronic Pain

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Pain catastrophizing refers to a negative mental set brought to bear during the experience of pain. Individuals who catastrophize often feel helpless about controlling their pain, ruminate about painful sensations, and expect bad outcomes. Not surprisingly, such individuals often fail to improve with treatment. This paper provides an assessment tool and outlines a cognitive-behavioral group treatment approach for chronic pain that is specifically designed to reduce catastrophizing. Principles from stress management, cognitive therapy for depression, assertiveness training, and communal coping models are incorporated within the treatment framework to address specific needs posed by catastrophizing. Suggestions are provided for organizing treatment sessions and for assigning homework based on treatment principles.

According to recent estimates, approximately 10% of individuals in the United States experience pain conditions on more than 100 days per year (Osterweis, Kleinman, & Mechanic, 1987). The individual and societal "costs" associated with chronic pain are numerous. Individuals affected by chronic pain struggle not only with the physical ramifications of pain but also with associated emotional and social stressors. Many individuals are unable to work and require disability benefits. For some, this means a significant change in self-concept, from providing for a family to requiring support from the government. Chronic pain also affects family members in

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