HEALING THE HURT:
A TRAINING MODULE FOR USING EVIDENCE-BASED PRACTICES WHEN WORKING WITH FAMILIES WHO HAVE EXPERIENCED DOMESTIC VIOLENCE

A graduate project submitted in partial fulfillment of the requirements
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by
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ABSTRACT

HEALING THE HURT:
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By

Caitlin C. Newcomb

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Domestic violence affects not just the intimate partners involved but the children within the family as well. Community mental health workers must be prepared to work with families who have experienced domestic violence in order to provide ethically appropriate services. This project aims to provide education for counselors working at the Valley Trauma Center in the Family Preservation Program who work in the home with families. These counselors will come into contact with families who have experienced intimate partner violence and will be expected to be familiar with information about domestic violence as well as how it affects children and families. This project provides a training module for counselors that will include information about the effect of domestic violence on families as well as an evidence-based approach to treatment with this population. Research has shown that empirically tested treatments can be effective when working to decrease the negative symptoms in families who have experienced violence. This project contains a review of the research and literature related to domestic violence in families as well as evidence-based treatments for this population.
CHAPTER I

Introduction

Domestic violence is an equal opportunity experience. It can happen to any person, at any time, in any place and the effects can be incalculable. The National Coalition Against Domestic Violence reports that one in every four women will experience domestic violence in her lifetime (Tjaden & Thoennes, 2000; as cited in National Coalition Against Domestic Violence, 2007). It is well documented that women are more at risk for domestic violence than men, however men are victims as well. Domestic violence is seen in all ages of couples and families and the damage of these violent relationships does not end with the couple itself. As cited on the National Resource Center on Domestic Violence webpage, a 2008 national survey funded by the U.S. Department of Justice’s Office of Juvenile Justice and Delinquency Prevention and the Center for Disease Control and Prevention found that 6.2% of American children were exposed to domestic violence in the last year (Edleson, 2001). Witnessing violence in the home is the strongest risk factor in transmitting violent behavior from one generation to the next (Break the Cycle, 2006; as cited in National Coalition Against Domestic Violence, 2007). In families where domestic violence is prevalent, 30-60% of perpetrators of intimate partner violence also abuse children in the household (Edelson, 1999; as cited in National Coalition Against Domestic Violence, 2007). Multiple studies have concluded the detrimental impact intimate partner violence has on children in areas including emotional and cognitive functioning, social competence, academic performance, and physical health. It is also well documented that many instances of
domestic violence are not reported to the proper authorities; therefore, there are hundreds of thousands of victims suffering in silence everyday. The aftermath of domestic violence is often repeated from one generation to the next and continues to negatively impact children everyday.

Statement of Problem

Studies show how children are impacted by domestic violence in negative ways. It is from the information these studies bring that California has now adopted into their mandated reporting law that intimate partner violence witnessed by children must be reported to the proper authorities. Once these children are entered into the Department of Children and Family Services system, they are often involved in public mental health agencies that provide some sort of psychological services to either the individual or family involved. It is of the utmost importance that professionals working in this setting with this particular population be trained in domestic violence awareness so that they are competent to provide appropriate support and treatment. Inappropriate assistance or ignorance can possibly lead to increased violence and possibly death.

This project aims to incorporate evidence-based practices into therapeutic services provided to families who have experienced domestic violence and are involved with the Department of Children and Family Services or other government agencies. The information in this project will assist in building awareness of domestic violence and the impact on families and provides interventions that are clinically supported to assist in decreasing negative symptoms that may be present in populations where intimate partner violence has occurred.
Many families within the San Fernando and Santa Clarita Valleys who have open cases with the Department of Children and Family Services may be eligible to receive family preservation services. One community agency within this region is the Valley Trauma Center, which works with families experiencing domestic violence within their Family Preservation Program. This project was developed specifically for counselors working in this program at this agency.

**Purpose of Project**

The purpose of this project is to provide a training module for counselors in the Family Preservation Program at Valley Trauma Center providing services to families who have experienced domestic violence. This training is aimed to give a better understanding of domestic violence and how it affects children and families. The training includes teaching counselors how to implement evidence-based practices into their work with these families. Specific evidence-based practices that are described in the training module are Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) and Child-Parent Psychotherapy (CPP). The goal for this training module is for counselors working in the field with families who have experienced intimate partner violence to have a clear definition of domestic violence, the effects it has on the family, and specific interventions to use while providing psychological services.

**Terminology**

**Domestic Violence**: the willful intimidation, physical assault, battery, sexual assault, and/or other abusive behavior perpetrated by an intimate partner against another (National Coalition Against Domestic Violence, 2007)
Physical Abuse: an act carried out with the intention, or perceived intention, of causing physical pain or injury to another person (Straus & Gelles, 1986)

Sexual Abuse: Abusive sexual contact is defined as intentional touching, either directly or through the clothing, of the genitalia, anus, groin, breast, inner thigh, or buttocks of any person without his or her consent, or of a person who is unable to consent or refuse. (Centers for Disease Control and Prevention, 2009)

Emotional Abuse: Verbal abuse that affects another person’s feelings negatively including name-calling, yelling, blaming, shaming, and threatening. Intimidation, isolation, and controlling behaviors also fall under emotional abuse. (Smith & Segal, 2012)

Child Abuse: The Federal Child Abuse Prevention and Treatment Act (CAPTA) (42 U.S.C.A. § 5106g), as amended by the CAPTA Reauthorization Act of 2010, defines child abuse and neglect as, at minimum: (1) Any recent act or failure to act on the part of a parent or caretaker which results in death, serious physical or emotional harm, sexual abuse or exploitation, or (2) An act or failure to act, which present an imminent risk of serious harm. This definition of child abuse and neglect refers specifically to parents and other caregivers. A "child" under this definition generally means a person who is younger than age 18 or who is not an emancipated minor. (Child Welfare Information Gateway, 2008)

Traumatic Stressor: A direct personal experience of an event that involves actual or threatened death or serious injury, or other threat to the physical integrity of another person; or learning about unexpected or violent death, serious harm, or threat of death or injury experienced by a family member or other close associate (American Psychiatric
Batterer/Perpetrator: The person who is abusive towards their partner. For this project, the batterer or perpetrator will be referred to with a male pronoun and the victim/survivor will be given a female pronoun. This does not mean men are not victims and women are not abusers. The pronouns used in this project are used to keep the flow of the narrative as well as highlight the fact that women are the majority of victims in abusive relationships.

There is an abundance of information regarding domestic violence and how violence affects families. The literature review that follows provides some information with a clear understanding of domestic violence, what to expect when working with a family who has experienced intimate partner violence, and information on evidence-based practices and how they can be used while working with this population.
CHAPTER II

Literature Review

Introduction

The purpose of the review of literature is to provide current information regarding domestic violence and evidence-based programs that apply to treating families with violence histories. Research regarding an in-depth understanding of domestic violence and its effects on children and families was looked at as well as possible treatments for this population within an evidence-based framework. For more information regarding these topics, please see reference section.

What is Domestic Violence?

There is no way to minimize the complexity of a violent relationship into an easy to understand definition. There are, however, numerous attempts at definitions for domestic violence that can be used for various reasons across multiple areas of study. Broadly understood, domestic violence can be considered a complex trauma an individual endures for an unknown amount of time. Domestic violence is a systematic pattern of dominance and control that shows itself through physical aggression, verbal and emotional abuse, intimidation, isolation, coercion and threats (National Coalition Against Domestic Violence, 2007). It can happen in any relationship regardless of race, ethnicity, religion, culture, sexual orientation, gender, or socioeconomic status. In other words, it is an equal opportunity experience.

A brief history of domestic violence shows that violence against women in particular can be seen throughout history. Violence within partnerships used to be accepted and hidden for many decades. With changes in civil rights came an alternative
view of intimate partner violence and new support for women against violence grew. Equality for women is still a struggle and with many cultures and communities still perceiving men as heads of the household, violence as a way of keeping control over a partner is still accepted within some populations.

Unfortunately, there is still a misunderstanding regarding the reasons domestic violence (DV) occurs or continues. Some people often place blame on the victim of the abuse, especially if she stays in the relationship. The complex nature of the DV relationship is not easily explored or understood; and individuals come to the conclusion that if the victim were smart enough, they would leave. There are many reasons why women may not leave their batterers, including financial security, love for the perpetrator, guilt in breaking up a family, or fear for their lives.

One way of understanding the power an abuser holds is by looking at the batterer’s role in the violent relationship. Perpetrators of abuse hold immense power and control, the two domineering pieces of domestic violence, over their partners. Victims are fearful for their lives and the lives of their children if they do not follow the rules put in place by the abuser. Perpetrators are not always physically or emotionally abusive and are usually extremely friendly to persons outside the family. As Ann Jones and Susan Schechter (1992) explain in their book *When Love Goes Wrong*, “If the controlling partner was always ‘bad,’ any woman would leave. By being ‘good’ the controller keeps her locked into the relationship, hopeful of change” (p. 29). It is important to realize that victims and perpetrators have trauma histories of their own. Often victims are unaware of the red flags for domestic violence. Judith Herman explains in her book *Trauma and*
Recovery: *The aftermath of violence- from domestic violence to political terror*, how a domestically violent relationship begins and evolves into a traumatic experience:

“The woman who becomes emotionally involved with a batterer initially interprets his possessive attention as a sign of passionate love. She may at first feel flattered and comforted by his intense interest in every aspect of her life. As he becomes more domineering, she may minimize or excuse his behavior, not only because she fears him but also because she cares for him. In order to resist developing the emotional dependence of a hostage, she will have to come to a new and independent view of her situation, in active contradiction to the belief system of her abuser. Not only will she have to avoid developing empathy for her abuser, but she will also have to suppress the affection she already feels. She will have to do this in spite of the batterer’s persuasive arguments that just one more sacrifice, one more proof of her love, will end the violence and save the relationship. Since most women derive pride and self-esteem from their capacity to sustain relationships, the batterer is often able to entrap his victim by appealing to her most cherished values. It is not surprising, therefore, that battered women are often persuaded to return after trying to flee from their abusers.” (p. 82-83)

The DV cycle includes three phases: tension-building, explosion, and honeymoon.

Tension building often looks like increased arguing, tension, or anger and the victim may feel like she is walking on eggshells. The explosion or acute battering can be any form of violence such as hitting, slapping, choking, kicking, restraining, use of objects as weapons, sexual abuse, or extreme verbal threats and abuse. The honeymoon phase is calmer and the perpetrator may make excuses or promises to the victim to never do the
negative behavior again. The honeymoon phase contributes to keeping victims in a relationship. Herman (1997) explains, “Traumatic events destroy the victim’s fundamental assumptions about the safety of the world, the positive value of the self, and the meaningful order of creation” (p. 51). Victims are often aware of what phase they are in once they are educated on the battering cycle, and the length of time within each step can vary depending upon the relationship and the people involved. The cycle inherently breaks down a victim in a way that may look like impassivity but, in reality, is the victim’s only known way of surviving. Once one possesses a basic understanding of what domestic violence can look like, it is important for one to understand the effects of this violence.

*Effects of Domestic Violence*

The effects of domestic violence on a person can be long-lasting and have severe consequences on daily functioning. As Herman (1997) states, “Traumatic events are extraordinary, not because they occur rarely, but rather because they overwhelm the ordinary human adaptations to life” (p. 33). Herman explains how repeated trauma breaks down the human psyche while the person’s self-defense system becomes overwhelmed and disorganized. Traumatic events create fragmentation in memory, or the inability to distinguish necessary functions from one another. This can show itself as either intense emotion but no recollection of the traumatic event or remembering every detail of the abuse without showing emotion. With repeated trauma, coordination of judgment and discrimination fail. Persons with a trauma history tend to react to everyday occurrences as if death were around the corner even when an imminent threat is not present. This is also known as hyperarousal. Victims of domestic violence also live with
intrusions which are spontaneous breaks of consciousness such as flashbacks or nightmares involving the trauma of the abuse. These reactive symptoms can hinder development of the adult and can have detrimental effects on children within a violent family.

Herman explains how the intrusive and numbing symptoms related to the violence create an inability in the victim to process events and difficulty in focusing on mundane tasks:

“Since neither the intrusive nor the numbing symptoms allow for integration of the traumatic event, the alternation between these two extreme states might be understood as an attempt to find a satisfactory balance between the two. But balance is precisely what the traumatized person lacks. She finds herself caught between the extremes of amnesia or of reliving the trauma, between floods of intense, overwhelming feeling and arid states of no feeling at all, between irritable, impulsive action and complete inhibition of action. The instability produced by these periodic alternations further exacerbates the traumatized person’s sense of unpredictability and helplessness. The dialectic of trauma is therefore potentially self-perpetuating.” (p. 47)

Living in this constant state of flux over a period of time can have lasting impressions on a child. If a child witnesses the violence, they too are caught between the extremes of reliving the trauma and states of forgetfulness. Children with parents who are victims are unable to see normal emotional processing and instead come to understand trauma and crisis as acceptable and comfortable.
The most well known effect of domestic violence is the diagnosis of Posttraumatic Stress Disorder (PTSD). The Diagnostic and Statistical Manual of Mental Disorders IV-TR (2000) explains the essential feature of PTSD as, “the development of characteristic symptoms following exposure to an extreme traumatic stressor involving direct personal experience of an event that involves actual or threatened death or serious injury, or other threat to one’s physical integrity; or witnessing an event that involves death, injury, or a threat to the physical integrity of another person” (p. 463). For adults, the response to this extreme traumatic stressor must be intense fear, helplessness, or horror, and, in children, the response may be disorganized or agitated behavior. The person with PTSD will also show symptoms of re-experiencing the trauma, persistent avoidance of stimuli associated with the trauma, and general responses of numbing or increased arousal. In order to be diagnosed with PTSD by a professional, one must have symptoms present for more than 1 month. Since PTSD can have serious consequences on daily functioning and may also include other diagnoses such as Major Depressive Disorder or Substance-Related Disorders (American Psychiatric Association, 2000), it is imperative that a client seek professional assistance in regards to diagnosis or medication treatment.

Intimate partner violence has effects on physical health as well as creating PTSD symptoms. Woods, Hall, Campbell, and Angott (2008) looked at the detailed physical health symptoms reported by women in intimate abusive relationships and the relationship between physical health symptoms, intimate partner violence, and PTSD. The authors looked at 157 women from crisis shelters and community agencies and used a correlationship-predictive design to assess the variables of the study. The authors write,
“The mean values show that the women in this sample experienced substantial physical violence, emotional abuse, sexual violence, threats of violence, and risk of homicide in their current intimate relationships. They also demonstrated high levels of PTSD symptoms severity- 92.4% met criteria for clinical diagnosis” (p. 542). Correlations indicated a significant positive relationship where higher levels of intimate partner violence were associated with more severe PTSD symptoms. Through the use of multiple scales measuring types of intimate partner violence, PTSD symptomology, and physical health symptoms, the results of this study indicate that the more severe the abuse is, the more severe the symptoms may be.

Sometimes it is not the violence itself that affects the family but the resulting life stressors that have the strongest impact on family functioning. For example, Levendosky, Huth-Bocks, Shapiro, & Semel (2003) examined the role of the mother-child relationship on preschool-age children’s functioning in families experiencing domestic violence. Results implicated, “additional stressors in battered women’s lives, some of which may be related to the violence, such as moving, job loss, and relationship breakup, cause additive pressures on women’s psychological functioning and thus increase depressive and trauma symptoms. In addition, in this study, children’s externalizing behavior was also negatively affected by life stress” (p. 283). These findings suggest that the results of the violence as opposed to the violence itself can create more detrimental effects on children and families.

There are clearly many factors that influence a child or family’s response to domestic violence and predicting the exact repercussions is near impossible. However, as research shows it is undeniable that violence has negative effects on victims and their
families. When these families are involved with community agencies that offer therapeutic services, there must be an understanding of these effects and what treatments are available to assist this population.

Evidence-Based Practice

Treatment options have never been more varied and available. With the increase in information comes an overwhelming body of literature on alternative interventions. Evidence-based practice (EBP) refers to the process by which decisions about clinical practice are supported from research using scientific models and theoretical paradigms (Hurley, Denegar, & Hertel, 2011). By providing services that have been researched and clinically supported, counselors are holding themselves and their work to a higher standard. Lang, Ford, and Fitzgerald (2010) explain, “The availability of effective treatments, combined with pressures to reduce the length of psychotherapy, has encouraged many community agencies to begin adopting evidence-based practices” (p. 554). As Allen Rubin (2012) writes in his book, Clinician’s Guide to Evidence-Based Practice: Programs and interventions for maltreated children and families at risk, “In light of the serious ways that maltreatment can harm the child’s psychosocial well-being, effective interventions for abused or neglected children are needed to ameliorate that damage” (p. 4). The goal is to use the best, up-to-date research available to provide clinical care in order to diagnose and treat clients (Hurley, Denegar, & Hertel, 2011). By providing children and families with services that are empirically supported, community-based programs can deliver treatments and interventions that have been researched, tested, and shown to give positive results.

Incorporating EBP in Treatment for Families with Domestic Violence
In an article, Katrina Vickerman and Gayla Margolin (2007) review the existing empirically-supported treatment options for children and adolescents exposed to family violence. The authors first explain treatment considerations by stating, “Interventions with younger children frequently incorporate play, whereas interventions with adolescents draw on adult-oriented treatments but attend to the unique challenges of adolescents regarding risk taking and social pressures” (p. 620). The authors maintain that although many treatments and interventions are available, most share similar strategies aimed at decreasing negative symptoms seen in children who have witnessed intimate partner violence. As the authors explain, most evidence-based treatments that follow a cognitive-behavioral model use a combination of trauma re-exposure, violence education and cognitive restructuring, emotion expression and regulation, social problem solving, safety planning, and parent training. These intervention techniques will be described further as they are integral parts to each specific intervention program.

When using re-exposure interventions, the overall goals are for children to be able to separate thoughts and cues surrounding the trauma from overwhelming negative emotions and to make sense of reactions during and after the trauma as well as the ability to discuss and rehearse alternative responses (Vickerman & Margolin, 2007). Vickerman & Margolin (2007) express the theory behind this intervention when stating, “By discussing the event and the conditioned aversive stimuli surrounding the event without retraumatization, conditioned responses between the aversive stimuli and the painful emotional reactions are extinguished. If there is a reduction in the physiological and psychological reactions to trauma cues and intrusive thoughts, then the child no longer will need to avoid those cues or suppress the thoughts and will be able to engage in
normal activities” (p. 621). By repeating the story of the trauma, the fear and confusion surrounding it becomes clearer and less threatening. This technique can be helpful in preparing children for the possibility of future violence and how they can cope. A common technique used for reexposure is the trauma interview or narrative, in which the child is able to organize the fragment of the trauma into a coherent story and increase their tolerance for the negative reactions to the experience. The narrative can be drawn, written in novel form, or dictated to the therapist and reenacted through puppets or dolls. Again Vickerman & Margolin (2007) explain, “the child first writes an account of the details and facts, then elaborates that story with thoughts and feelings, and eventually adds the worst part that previously was too difficult to discuss” (p. 621). As expected, the child will begin to address the personal meanings of the events. The therapist’s ability to normalize, validate, and offer comfort while engaging with this intervention can lead to the child becoming more comfortable with his or her experience and a greater ability to express and process negative emotions surrounding the violence. At this stage, and every other area of treatment, it is imperative for the therapist to continue to emphasize strategies the child can use to stay safe.

The goal of educating clients on violence focuses on cognitive restructuring or challenging negative thoughts about the self and the world in relation to the trauma. As explained by Vickerman and Margolin (2007), “Children typically experience considerable relief as they learn that their seemingly out-of-control symptoms actually are quite normal, given the circumstances of the violence exposure” (p. 621). Children have been given mixed messages about love and aggression that usually results in an inability to appropriately identify and express negative feelings. Children living in
violent homes have learned that violence is an acceptable way to express anger and/or love, and cognitive restructuring, with information on violence, helps children and families undo this lesson. It is suggested that, “thought-stopping, self-talk, and positive imagery are strategies to help children interrupt intrusive, distressing thoughts” regarding the violence (Kerig et al., 2000; Wekerle et al., 2006-as cited in Vickerman & Margolin, 2007, p. 622). The most important part of this technique is that children and families understand that they have control over their thoughts and that by changing their negative cognitions, they can change their feelings and behaviors.

One of the most important techniques to use with children who have witnessed violence involves emotion recognition and expression. As Vickerman and Margolin (2007) explain, “Attending to and expressing one’s own emotions can lead to improved emotional regulation” (p. 622). Learning to identify and process numerous emotions can assist families in their ability to respond to stressful situations more appropriately. Emotion identification can be completed by connecting feelings in the body and developing a wide emotional vocabulary with the family. During the emotion identification intervention step, “deep breathing, relaxation, guided imagery, and visualization are often taught so that youth have strategies to interrupt anxiety and short-circuit the common occurrence of fear escalating into anger” (Kolko & Swenson, 2002; Wekerle et al., 2006; as cited in Vickerman and Margolin, 2007, p. 622). The ability for families to successfully practice stress-relieving techniques can be helpful for all families coping with any kind of future stress.

After educating families on emotion identification and cognitive restructuring, counselors have an opportunity to teach clients social problem solving and social
interaction skills. This step can be completed using behavioral rehearsal including specific techniques such as modeling. For school-age children, social interactions focus on taking turns and being polite, while adolescents and adults techniques focus on assertiveness training (Vickerman and Margolin, 2007). Building appropriate social skills can help prevent future violence as well as assist clients with handling future conflict in any relationship.

Throughout any treatment, research indicates the importance of creating and maintaining a safety plan with the family for any future violence. As the literature states, “Children who remain in family environments with the potential for violence need to learn to recognize and plan for future instances of family aggression” (Vickerman & Margolin, 2007, p. 622). Safety plans can be introduced at the beginning of treatment and be edited throughout the course of counseling as needed. Safety plans can be detailed through worksheets and include information on who children can call when violence takes place and what areas of the house are safer for members to stay in when violence occurs.

In order for parents, offending or nonoffending, to assist children with techniques taught in therapy, it is important the counselor builds rapport and a trustworthy relationship with parents. Counselors can do this by empowering parents to assist their children in developing better coping techniques and skills. It is important that the counselor explains the reasoning behind all techniques and interventions used in treatment in order for parents to follow through in assisting with implementation of these techniques outside of counseling sessions. Many studies suggest involving parents
through in-home visits as a way to incorporate interventions and assist parents with new techniques (Vickerman & Margolin, 2007; Graham-Bermann, 2001).

There are numerous treatments for families who have witnessed or experienced domestic violence within the evidence-based field. The ones described in detail in the next section include Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) and Child-Parent Psychotherapy (CPP). These specific interventions were chosen due to the high volume of literature and studies describing the effectiveness and the empirical support of these programs. For more detail, clinicians may visit resources listed in the reference section.

**Trauma-Focused Cognitive Behavioral Therapy**

Deemed the “gold standard for the treatment of traumatized children and their nonoffending caregivers” (Rubin, 2012, p. 123), TF-CBT was developed by Judith Cohen, Esther Deblinger, and Anthony Manarino. Most of the empirical support for TF-CBT comes from treatment of PTSD symptoms surrounding child sexual abuse; however, it has been connected to treatment of physical abuse and domestic violence (Rubin, 2012). As Lang, Ford, and Fitzgerald (2010) describe, “TF-CBT was developed to decrease posttraumatic stress reactions through cognitive-behavioral skill building and gradual exposure to feared trauma memories and reminders. TF-CBT is a components-based psychotherapy that incorporates trauma-sensitive interventions with cognitive-behavioral, family, and humanistic principles” (p. 557). This model has a goal of alleviating avoidance of the trauma through a process of habitually discussing the thoughts and feelings surrounding the trauma within a safe environment. TF-CBT is designed to incorporate parents and caregivers throughout treatment. This treatment
program should not be used if trauma was not substantiated through child protective services or if clients have a vague memory of the trauma. It is also not recommended for children with severe pre-existing behavioral difficulties (Rubin, 2012). Training in TF-CBT can be provided online through http://tfcbt.musc.edu.

TF-CBT is designed to assist children 3-17 years of age and begins with a thorough assessment to provide the counselor with a baseline for treatment planning. As Rubin (2012) describes, “The TFCBT model is a directive approach to treatment that requires acknowledging the trauma within the first session” (p. 125). The program provides an acronym for treatment that can be useful in remembering the key steps:

- Psychoeducation and Parenting Skills
- Relaxation
- Affective expression and regulation
- Cognitive coping and processing
- Trauma narrative development and processing
- In vivo gradual exposure
- Conjoint child-parent sessions
- Enhancing safety and future development

This PRACTICE acronym involves all aspects important to the TF-CBT program and should be incorporated throughout the course of treatment. The ideal pace of treatment would be 12 sessions at 90-minutes or sixteen to twenty 60-minute sessions. The first third of sessions would incorporate the first four letters of PRACTICE: psychoeducation and parenting skills, relaxation, affective expression and regulation, and cognitive coping. The next grouping of sessions would involve the trauma narrative
development and processing with in vivo gradual exposure. The final third of sessions would ideally include conjoint parent-child sessions and focus on enhancing safety and future development. As described earlier, TF-CBT is components based, which means treatment progresses by building skills that are matched to the individual needs of the client (Rubin, 2012). Providers of this treatment must be flexible and adaptive, striking a balance between adhering to the protocol of the program while adjusting the model in order to fit the particular family.

When looking at each particular step in this model, it is clear that TF-CBT includes the aspects of treatment that Vickerman and Margolin (2007) describe as explained earlier. Beginning with psychoeducation and parenting training, TF-CBT focuses on normalizing and validating a family’s reaction to the trauma as well as providing information about domestic violence or abuse. The type of psychoeducation provided will depend upon the developmental level of the children and family. Hoch (2009; as cited in Rubin, 2012) maintains that clinicians should explain the importance of caregivers participating in treatment even if their own history of trauma is triggered. This is why relaxation is an important step in treatment as it teaches clients how to cope with negative feelings using breathing, meditation, visualization, or progressive muscle relaxation. Different relaxation techniques may be more helpful than others for each client so it is important for counselors to provide multiple options for families to use. These techniques may be used while clinicians assist clients with affect expression and regulation, specifically teaching families how to identify and manage negative emotions related to the trauma. Cognitive coping and processing involves the therapist teaching clients how their thoughts, feelings, and behaviors are all connected using the cognitive
triangle model. With this lesson, families can learn how they can change their thoughts in order to change their feelings or behavior and empower members to reinforce positive feelings about themselves.

Once families have practiced and are comfortable with these first few steps, it is important for the therapist to develop a trauma narrative with the family. Lang, Ford, and Fitzgerald (2010) report that the majority of evidence in support of TF-CBT shows that the trauma narrative should be included whenever possible. As Rubin (2012) describes, “The foregoing cognitive restructuring techniques can also be used with children after the narrative has been completed and problematic feelings, thoughts, and body sensations have been identified in the narrative” (p. 133). The counselor uses cognitive restructuring in order to allow clients to change their current thoughts about the abuse when compared to the negative thoughts and feelings that were experienced during the trauma. If the trauma narrative does not eliminate current negative stimuli within the child’s life, counselors may use in vivo gradual exposure which attempts to gradually overcome avoidance of triggers associated with the trauma (Rubin, 2012). In-vivo exposure gradually exposes children to harmless stimuli that they can tolerate while implementing relaxation techniques when anxiety increases with exposure. The final stages of treatment involve conjoint child-parent sessions that focus on enhancing safety and future development using activities that teach skills that will assist family members in assessing their own internal and external cues for safety.

Trauma-Focused Cognitive Behavioral Therapy was originally developed for treating children who had experienced sexual abuse but has shown positive effects in reducing PTSD symptoms in children who have witnessed domestic violence (Lang,
This components-based model has been supported by five completed randomized clinical trials that were published in peer-reviewed journals and two open studies (Lang, Ford, & Fitzgerald, 2010). The lessons learned in this model will assist clients throughout their lifetime as well as reduce any trauma-related negative symptoms.

*Child-Parent Psychotherapy*

As Grossman (2000; as cited in Dimmler et. al., 2012) explains, children under five are subject to a higher risk of violence exposure in comparison to other age groups and suffer higher rates of injury after abuse and violence. Child-parent psychotherapy (CPP) was initially developed for families experiencing domestic violence and is a relationship-based intervention used with children from birth to age 5 and their families. Theories that apply to CPP include psychodynamic, attachment, trauma, cognitive-behavioral, and social learning theory (Dimmler, Wang, Horn, & Lieberman, 2012). This program was developed by clinical researchers at the Child Trauma Research Program at the University of California, San Francisco and is now listed as an empirically supported treatment in the National Registry of Evidence-based Programs and Practices.

In a study assessing the efficacy of CPP treatment for preschool-age children exposed to marital violence (Lieberman, Van Horn, & Ippen, 2005), results showed evidence that this treatment modality provides a decrease in children’s PTSD symptoms and emotional or behavioral problems. This particular study involved 75 mother-child dyads from diverse backgrounds who were randomly assigned to two groups where one received CPP treatment and the other group received only case management and community referrals for individual treatment. Symptoms were assessed by
questionnaires filled out by the adult participants that focused on children’s PTSD symptoms and emotional or behavioral problems. The major limitations of this study include a small sample size and a reliance on maternal report for the major outcome variables. However, the clinical implications for this research show the importance of including a parent or caregiver in the treatment of a young child’s negative symptoms that are a result of witnessing intimate partner violence in the home.

The primary goal of CPP is to strengthen the relationship between a child and his or her parent in order to restore the child’s sense of safety and attachment. This is done through child-parent interactions that promote congruence within the dyadic relationship. In the training manual for CPP, *Don’t Hit My Mommy!*, Lieberman and Van Horn (2005) explain, “Child-parent psychotherapy advocates the flexible tailoring of therapeutic interventions to the specific aspects of the child-parent relationship that interfere with the child’s healthy development, while supporting the growth-promoting aspects of the relationship” (p. 3). In the studies listed on the CPP page on the National Registry of Evidence-based Programs and Practices (2012), participants engaged in weekly sessions for approximately one year with therapists who principally used this manual. It is highly recommended that any counselor who will be providing services to families with preschool age children who witnessed domestic violence, read and work from this training manual in order to provide appropriate child-parent psychotherapy treatment.

As Lieberman and Van Horn (2005) write, “Parents who are prone to violence and/or victims of violence are even more ill-equipped to respond to challenging or unmodulated child behavioral because they themselves have difficulty regulating strong emotion and because they are often anxious, depressed, or suffering from posttraumatic
stress disorder” (p. 12). Child-parent psychotherapy provides clients with an understanding of how to modulate their responses to the traumatic events of violence in the home and how to restore trust in one another.

**Summary of Literature Review**

The literature shows the importance of using evidence-based treatments when working with families who have been effected by domestic violence. Specific treatments such as trauma-focused cognitive behavioral therapy and child-parent psychotherapy have been found to achieve positive results in reducing negative symptoms related to domestic violence exposure. This project was developed from the literature review that shows the necessity for community counselors to provide appropriate treatment for this population. The project should be used to train new counselors at the Valley Trauma Center in the Family Preservation Program who will be working with families who have experienced domestic violence.
CHAPTER III

Audience and Implementation Factors

Introduction

The effect domestic violence has on a family is undeniable. Due to the increase in childhood exposure to violence, community resources must be educated in how to work with this population. As mental health providers, it is important for counselors to be well educated on domestic violence, how it affects individuals, families, and children, and what strategies to use in treatment. This project will develop a workshop to train counselors who are providing community services to families who have a history of domestic violence in order to provide a higher standard of care.

Development of Project

Creating this project will involve many steps. Information will be gathered regarding domestic violence including characteristics of a DV relationship, red flags for an abusive relationship, how DV affects victims and families, and truths and myths about domestic violence. Sources for this information will come from scholarly journals, textbooks, workbooks, and domestic violence organizations.

The second section of this project will involve treatment pieces. Information will be found on evidence-based practices and how they are used in counseling families who have experienced domestic violence. This information will come from textbooks, journal articles, and the National Registry of Evidence-Based Programs and Practices.

In development of this project, the author will draw upon professional experience working with families who have experienced intimate partner violence. Specifically,
experience will be utilized in training counselors by drawing upon examples and providing information.

**Intended Audience**

This project will be used to train counselors who are providing in-home therapeutic services to families who have open cases with the Department of Children and Family Services due to domestic violence. This project was developed from experience working at the Valley Trauma Center in the Family Preservation Program. The training module can be used in training new In-Home Outreach Counselors at this agency. The information can also be used to train counselors in other community agencies who are working with families who have experienced domestic violence.

**Personal Qualifications**

The person providing the training module must have experience working with families or individuals who have experienced domestic violence. This is important as questions will arise during training and the presenter must be knowledgeable in the field. The person presenting the information may be a licensed therapist or at least supervised by a licensed therapist.

**Environment and Equipment**

The training module will be presented in a classroom or conference room-like setting. Listeners are intended to be counselors in training who will use the information to provide therapeutic services. In order to present the information effectively, a power point is to be displayed on a projector large enough for the audience to follow the information as it is being presented. Handouts of the power point presentation for the audience to take home and review afterwards or in the future should be provided.
Summative Evaluation

In order to provide an informative and helpful training module on the topic of domestic violence, counselors and staff from the Valley Trauma Center may be asked to provide input on what additional information they would have liked to have received in their previous training on this topic. At the end of the training module, the presenter may pass out a short questionnaire for the counselors in training that includes questions on information they learned as well as future questions they would have after the training. The evaluation form can be seen in Appendix C. This information will be used to determine what areas the presentation should focus more or less on depending on the demand and necessity. The evaluation will also provide important feedback on information clarity for the audience.

Project Outline

The following outline explains how the powerpoint presentation of the training will be organized. The information that will be in the presentation is briefly outlined below as more specific information will be integrated throughout the training.

Slide 1: Title Page

Slide 2: How Media Portrays Domestic Violence

Slide 3: The Facts: Statistics

Slide 4: What is Domestic Violence: Definition

Slide 5: Who Are Victims of Domestic Violence

Slide 6: Types of Abuse

- Physical Abuse
- Emotional/Psychological
- Sexual Abuse

Slide 7: Power/Control Wheel
Slide 8-9: Red Flags for Abuse
Slide 10: Battering Cycle
Slide 11-12: Myths & Truths about DV
Slide 13: Birdcage Exercise
Slide 14: Psychological Effects of Abuse
Slide 15: Physical Health of Victims
Slide 16: Posttraumatic Stress Disorder
Slide 17-18: DSM Criteria for PTSD
Slide 19-22: Effects of DV on Children
Slide 23: Goal of In-Home Counseling with Families of DV
Slide 24: Safety Planning
Slide 25: Evidence-Based Practices
  - Definition
Slide 26: EBP and DV
Slide 27: Cognitive Behavioral Therapy Evidence-Based Practices Models
Slide 28-43: Trauma-Focused Cognitive Behavioral Therapy
  - Basic Introduction
  - Goals of Treatment
  - Training Information
  - Components
    - Moody Cow Activity
Slide 44-49: Child-Parent Psychotherapy

- Introduction
- Goals of Treatment
- Intervention Modalities
- Domains of Interventions
- Training Information

Slide 50: Case Vignette
Chapter IV

Conclusion

Summary

Domestic violence affects not just the intimate partners involved but the children within the family as well. Community mental health workers must be prepared to work with families who have experienced domestic violence in order to provide ethically appropriate services. This project aims to provide education for counselors working at the Valley Trauma Center in the Family Preservation Program who work in the home with families. These counselors will come into contact with families who have experienced intimate partner violence and will be expected to be familiar with information about domestic violence as well as how it affects children and families. This project provides a training module for counselors that will include information about the effect of domestic violence on families as well as an evidence-based approach to treatment with this population. Research has demonstrated that empirically tested treatments can be effective when working to decrease the negative symptoms in families who have experienced violence. This project contains a review of the research and literature related to domestic violence in families as well as evidence-based treatments for this population.

Evaluation

Professionals working at the Valley Trauma Center who have had experience working with families exposed to domestic violence evaluated this project. These individuals have been with the agency for over a year and are familiar with treatment
options used in the home with families experiencing many different issues, including intimate partner violence.

Discussion

Evaluations of this project provided important feedback regarding how the training module might be helpful for future counselors at the agency. Changes were made to the training module to include specific treatment interventions used at the Valley Trauma Center including those used to teach families techniques such as relaxation and cognitive coping.

Future Work and Research

This project can be used at the Valley Trauma Center to train future counselors working in the Family Preservation Program. As the presentation is used in the future, the curriculum may need to be updated as more research becomes available. More information on how helpful the training is will be given to the presenter from counselors in training through the evaluation given after the presentation. Necessary changes to the presentation will need to be made as the module is used in the future.

One area of research that continues to be vague in the literature is how some children are more or less affected by domestic violence when compared to other children. The reason for this phenomenon of resilience or vulnerability is unknown. The research on this topic was not included in this specific project but may be included in future trainings as more research is provided. It may be helpful for counselors to understand how some children in the home may not be as negatively affected by the violence as other children in the home.
This project may also be improved and implemented in working with Spanish speaking families who experienced domestic violence. Information would need to be gathered on how specifically Spanish speaking families differ in their experiences of domestic violence effects when compared to the English speaking population. This may be helpful for the Valley Trauma Center as the Family Preservation Program is involved with a large number of Spanish-speaking families.
References


Los Angeles County Board of Supervisors Domestic Violence Council. (2009). It
Shouldn’t Hurt To Go Home: The domestic violence victim’s handbook.
Retrieved on 2 November 2012 from

Retrieved on 9 September 2012 from

CA: Seal Press.

Rubin, A. (2012). Clinician’s Guide to Evidence-Based Practice: Programs and
interventions for maltreated children and families at risk. New Jersey: John Wiley
& Sons, Inc.

Smith, M., & Segal, J. (2012). Domestic Violence and Abuse: Signs of Abuse and
Abusive Relationships. Retrieved on 2 November 2012 from

Straus, M. A. & Gelles R. J. (1986). Societal change and change in family violence from
1975 to 1985 as revealed by two national surveys. Journal of Marriage and the

Exposed to Family Violence: II. Treatment. Professional Psychology: Research
and Practice, 38, 620-628.


APPENDIX A

Birdcage Exercise Script

Instructions

Have a volunteer read for the victim and 9 volunteers read for the friends or family within the script. Have the victim stand in the front of the room to read her part and all other members stand around her facing her in a circle. Once each person reads their section, they turn their back towards the victim. In the end, the victim will be in the middle of the circle with all 9 participants’ backs turned towards her to represent how the victim may feel alone after trying to access assistance from members of her inner circle. The presenter may also process how the victim may feel trapped (such as a bird in a cage) in the relationship as no members of her life are open or able to help her.

Claudia

My name is Claudia and I’m 22 years old with a 2 year old daughter. When I met my husband 3 years ago he was charming, attentive, and intense. Jack owns his own construction company. We had a whirlwind romance and he swept me off my feet. I met him in a church group and both my friends and family fell in love with him like I did. They all thought I was so lucky to find someone so captivating.

Once we moved in together, I lost touch with a lot of my friends and family. I have a lot of responsibilities at home like cooking and cleaning and taking care of my daughter so I rarely get out. I have a high school degree but am not working so that I can take care of my daughter. Plus, my husband has said that he makes enough money for our family with his company. Lately he has been more controlling of where I go and what I do. He even tracks my cell phone and limits my calls to my friends and family members. He has broken a TV at the house during an argument with me this last week. I’m worried about what he will break next as he has a short temper.

1. Claudia to Sibling:
   “Jack isn’t like how he was when we were dating.”
Sibling’s Response:
   “You are so lucky to have found someone so early in life who has such a great career and can take care of you and your daughter. I wish I could find the full package like you have.”

2. Claudia to Parent:
   “Sometimes Jack’s anger is so scary I am afraid of what he’ll do to me or our daughter.”
Parent’s Response:
   “He is so wonderful I doubt he would hurt you two. You should try not to make him so angry. He is such a wonderful man and takes care of you so well. Look at what
an amazing apartment he was able to provide for you. And you don’t even have to work!”

3. Claudia to Landlord:
   “I have some questions about my lease…”
Landlord’s Response:
   “I got a call from the neighbors the other evening about a loud argument. If you and Jack can’t keep quiet, I will need to evict both of you and you will be financially responsible for any damage to the property.”

4. Claudia to Friend:
   “I have to cancel our plans again today. Jack would like me to stay home.”
Friend’s Response:
   “It isn’t like you to cancel plans so often. We used to get together once a week. But I understand why such a busy man like Jack would need your assistance so I guess I’ll forgive you this time.”

5. Claudia to Banker:
   “I am interested in some information about protecting my finances.”
Banker’s Response:
   “I see here you have a joint account so you don’t need to worry about financial affairs. You’re so lucky to have a husband who is able to help you. He seems to have a good handle on the family’s finances.”

6. Claudia to Attorney:
   “I am interested in information regarding custody for my daughter if my husband and I separated.”
Attorney’s Response:
   “Most likely since your husband is the sole provider for your family and you have no education or job, custody would go to him.”

7. Claudia to Clergy Member:
   “My husband seems to have a problem with his anger. What should I do?”
Clergy Member’s Response:
   “Marriage can be a struggle at first. I suggest you try harder to please your husband. It must be difficult for him to adjust to marriage after being so busy with building his business and being alone for so long.”

8. Claudia to Doctor:
   “I have been having chest pains lately.”
Doctor’s Response:
   “Your heart checks out fine. I think you may be nervous or depressed. I am going to prescribe an antidepressant.”

9. Claudia to Law Enforcement:
   “I am afraid he is going to hurt me.”
Law Enforcement Response:
    “Unless there is physical proof, fear alone is not sufficient enough for us to intervene.”
APPENDIX B
Evaluation on Healing the Hurt Presentation

Name: _______________________________ Date: ________________

Presenter Name: ________________________________________________

1. Before this presentation, how much information did you have about domestic violence? (circle one) none very little some a lot

2. After the presentation, how much information do you have about domestic violence? (circle one) none very little some a lot

3. What were three important pieces of information you gained from this presentation?
   a. __________________________________________________________
   b. __________________________________________________________
   c. __________________________________________________________

4. Suggestions for improvement on this presentation include:

5. Circle the appropriate number (1=standards not met, 5=standard fully met)
   a. Information was logically organized 1 2 3 4 5
   b. Time was used appropriately 1 2 3 4 5
   c. Activities were useful and informative 1 2 3 4 5
   d. Information presented in organized, clear manner 1 2 3 4 5