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Review Article

PTSD and Intimate Partner Violence: Clinical Considerations and Treatment Options

Abstract

Intimate partner violence (IPV) is a serious public health concern affecting over 40 million individuals at least once during their lifetime. Among the various negative implications for partners and families are economic, emotional, physical, and social consequences. Recently, it has become evident that female victims of IPV develop PTSD at alarming rates. Approximately 25% of American women will experience IPV in their lifetime resulting in mental health consequences. PTSD can be both a result of IPV and a contributing factor for engaging in IPV. Onset of PTSD can occur six months to years after the traumatic event. Common symptoms include a re-experiencing of traumatic events through memories and nightmares. Victims find themselves reliving the event through events called flashbacks. An avoidance of anything that reminds the person of the traumatic event often occurs. Victims are typically over aroused, easily startled, and quick to anger. This paper describes the literature on IPV and PTSD along with available treatment options, and concludes with recommendations for future research and practice.

Introduction

Intimate partner violence is a widespread public health concern which cuts across social, ethnic, and socioeconomic domains. The term "intimate partner violence" is an umbrella term, encompassing physical violence, sexual violence, stalking, and psychological aggression by a present or prior intimate partner [1]. Each of the facets of IPV may appear forthright, but they can manifest in various different ways. For example, physical violence can pertain to scratching, shaking, burning, and throwing, while sexual violence can refer to rape of a victim, or unwanted sexual contact, amongst other acts. The same is true for stalking and psychological aggression, which can refer to repeated, unwanted attention through calls, emails, and spying, or to the use of intentionally harmful communication in order to degrade another person and to exert control over them, respectfully [1].

IPV is the most common form of violence against women and as mentioned above, takes various forms, such as assaults with weapons, physical violence, homicide and sexual abuse, pushing, or shoving [2]. Approximately 25% of American women will experience IPV in their lifetime resulting in mental health consequences. Yet, women are not the sole population prone to IPV. Hyperarousal symptoms of anger, irritability, and hostility put combat veterans at increased risk of IPV [3]. Men are also vulnerable, comprising 25-50% of all IPV victims in a given year.

Recently, we have heard a great deal about the debilitating and long-lasting emotional disorders that can result after traumatic events. More recently, the conflicts in Iraq (Operation Iraqi Freedom [OIF]) and Afghanistan (Operation Enduring Freedom [OEF]), coupled with the terrorist attacks on September 11, 2001, and natural disasters (e.g., Hurricane Katrina) have increased public awareness of the effects of traumatic experiences. Posttraumatic Stress Disorder (PTSD) is one of the emotional disorders that can result from traumatic events [4]. PTSD has an etiological component, which is an event that may involve a life-threatening situation, serious injury, or death. Warzone identified exposure, assault, rape, torture, serious accidents, and childhood sexual abuse as examples of events that can trigger PTSD. However, it must be noted that not all individuals who experience a trauma develop PTSD. Failure to adapt is a key component to the development of the disorder. While it is normal to have strong emotional reactions when an individuals' life is being threatened, the intensity of these reactions should decrease when over time. Unfortunately, for individuals diagnosed with PTSD, a decrease in intense emotional reactions does not occur [5].

Onset of PTSD can occur six months to years after the traumatic event, and a diagnosis of PTSD cannot be made until at least one month after the event [6]. Common symptoms of PTSD include a re-experiencing of traumatic events through memories and nightmares. Victims find themselves reliving

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the event through flashbacks, thereby continuously being re-traumatized, which often results in an avoidance of anything that reminds the person of the traumatic event. Victims are typically over-aroused, easily startled, and quick to anger. The DSM-5 also notes an additional symptom of "reckless or self-destructive behavior" [4]. In addition to the aforementioned symptoms, individuals with PTSD have an elevated risk of mood, anxiety, and substance abuse disorders, and tend to experience greater functioning impairment, reduced quality of life, and have an elevated risk of poor physical health [5].

Prevalence

The National Comorbidity Survey Replication, which was conducted between 2001 and 2003, estimated a lifetime prevalence of PTSD to be 6.8%. This survey, which was comprised of interviews with 9,282 Americans 18 years or older, revealed that women are twice as likely to develop PTSD (i.e., 9.7% lifetime prevalence rate) as compared to men (i.e., 3.8% lifetime prevalence rate). Additionally, rates of PTSD in veterans is higher with those in combat having a 39% lifetime prevalence. Veterans also have a greater likelihood of delayed onset and unresolved symptoms [5].

Intimate partner violence and PTSD

Intimate partner violence (IPV) is one of the most serious public health issues in the United States, affecting nearly 40 million individuals at least once during their lifetime [7]. Thus, it is important to examine how trauma resulting from IPV may manifest itself in the form of PTSD. In fact, it appears that PTSD and IPV share a bidirectional relationship; PTSD can be both a result of and contributing factor or engaging in IPV. Although becoming a victim of IPV is not exclusive to one gender, female victims of IPV develop PTSD at alarming rates. In cases of mild or non-severe forms of violence (e.g., isolated instance of a push or shove), the violent behavior tends to be bi-directional and is not used as a form of power and control. However, the more severe types which tend to be chronic and severe is predominately male perpetrated and typically used as a form of power and control. Thus, the two types of violence are delineated by the purpose (i.e., to control), frequency (how often), and severity (severe versus non-severe) of the violent behavior.

Posttraumatic stress disorder is a common result of IPV ranging from 31% to 84.4% among IPV survivors [8]. While there have been many studies demonstrating the risk women have of developing PTSD after experiencing IPV, little research has documented this association in men. Still, available studies suggest sustaining physical IPV is associated with increased symptoms of PTSD in men [9].

There are several risk factors contributing to violence as a result of suffering from PTSD. Examples include: prior IPV, anger and aggression symptoms associated with PTSD, auditory stimuli, past and current strained or deteriorating relationships, and lack of education in regards to PTSD and IPV. Clinicians should educate clients about the relation of PTSD and IPV along with the risk factors. Educating clients can help ensure individuals seek treatment when facing PTSD, especially if IPV is involved.

Treatment options

There are several methods of treatment that seem to be effective for those who have symptoms of PTSD and engage in IPV, as well as those who develop PTSD as a result of IPV. Personal mental health evaluations are encouraged for individuals who believe they have symptoms of PTSD and/or are diagnosed with the disorder. If IPV is present, infrequent, and non-severe (not being used as a form of power and control), carefully screened couples therapy may be helpful in eliminating maladaptive behaviors and cognitions. Whether delivered in an individual or conjoint format, therapy should include discussion of potential risk factors and concerns, as well as a collaborative goal development and the related pros and cons. In addition, providing psychoeducation, and resource information can also be helpful in treating co-morbid PTSD and IPV. It is also important to note that there may be situations in which referrals are necessary for medical assessment of traumatic brain injury and other complications.

Individual therapy: Individual therapy can include reduction of aggression through an anger management or batterers groups, and can take the form of either individual or group sessions. The use of cognitive behavioral therapy (CBT) can reduce auditory senses and assist in controlling thoughts, feelings, and reactions and or responses to the auditory stimuli that triggers flashbacks.

Addressing anger: Researchers report that patients who undergo CBT demonstrate fewer stress related symptoms than patients getting other psychological therapies. Those who either have PTSD and engage in IPV or those who develop PTSD because of IPV both can feel angry and exhibit unhealthy ways of dealing with their anger. CBT addresses distorted beliefs (about one's self) and attributions about the trauma, cognitive coping and processing, focuses on developing a support system and supportive environment. It is also suggested to discuss education on abuse, emotional and behavioral reactions to abuse and relaxation methods [2]. It was noted above that many people suffering from PTSD also deal with anger issues. CBT is noted as a treatment that yields positive outcomes with those trying to manage their anger. CBT for anger management seeks to intervene at the information processing level by reducing the degree of negative attributions toward one's partner, because the attributions tend to fuel and escalate anger to violence [10]. Stith and Hamby [11], identified four distinct anger management strategies based on CBT programs: escalating strategies (behaviors that increase reactivity to one's partner), negative attribution (cognitions, such as blame or negative intentions, attributed to one's partner and intended to increase the presence and strength of anger), self-awareness of rising anger, and calming strategies. Investigations suggest certain anger management strategies are adaptive and other are maladaptive. Specifically escalating strategies and negative attributions toward one's partner may increase the risk of violence. CBT can lower these two factors to decrease violence by using calming strategies and being aware of one's rising anger may reduce the likelihood of violence.

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Helping to overcome PTSD through empowerment: As noted by Johnson, Zlotnick, and Perez [12], Helping to Overcome PTSD through Empowerment (HOPE) is a new cognitive behavioral treatment influenced by Herman's [13]. Multistage model of recovery. It is a first-stage, present-centered treatment designed to address the need for PTSD treatment in sheltered IPV victims, and views recovery from chronic trauma, including IPV, as occurring in three stages: (a) establishing safety, (b) remembrance and mourning, and (c) reconnection [12]. HOPE is an efficient treatment due to its emphasis on safety and stabilization; it is vital for those suffering from PTSD and experiencing IPV to attain physical safety and have access to resources which will aid in improving their quality of life. HOPE integrates Herman's [13] stage approach with a cognitive-behavioral framework, including many elements of traditional CBT for PTSD such as cognitive restructuring and skills building. This is ideal, as previous research suggests that PTSD sufferers process trauma based on their preexisting belief about self, others, and the world [14,15]. This cognitive restructuring can contribute to PTSD by producing an exaggerated sense of current threat. Thus, negative emotions and dysfunctional coping strategies can serve as a cycle in maintaining PTSD symptoms.

Each HOPE session structure is identical. It begins with checking in with the individual regarding safety and progress on accomplishments and previously assigned homework (accomplishments). It them progresses to setting and agenda, discussing information regarding specific modules, and ends with conveying goals for the next session. Additionally, the HOPE hierarchy was developed to guide the pathway of treatment within and across session. It serves to determine the order of modules, and also in prioritizing safety issues per session. At the top of the hierarchy is attainment of immediate physical and emotional safety. This is followed by PTSD symptoms that may interfere with one's quality of life and attainment of shelter and treatment goals. Lastly, it addressed post-shelter goals and safety. Probing further, HOPE clients are provided with an "empowerment toolbox" consisting of positive coping strategies for establishing safety and empowerment, managing symptoms, and improving their relationships.

While each session is identical, the goals between sessions vary. The first two sessions are used for the participant to identify and prioritize their personal goals, which subsequently guide in individualizing their treatment. The first five sessions typically focus on educating clients about interpersonal violence, PTSD, safety planning, and empowerment, while later sessions aim to manage PTSD using previously established CBT skills.

The core modules of HOPE address engagement and goal setting, psychoeducation about abuse and PTSD, safety planning, empowerment, establishing trust, cognitive restructuring, managing triggers, self-soothing, establishing boundaries, anger management, and establishing long-term support. Clients are continuously urged to recognize any controllable threats to their physical and emotional wellbeing and to use their empowerment toolbox to control these threats.

Cognitive processing therapy: It was found that reduction in PTSD and depression predicts lower IPV, which indicates that those who did not recover from their PTSD or depression were at particular risk for new IPV or IPV revictimization. Cognitive Processing Therapy (a form of CBT) is a structured protocol in which the primary goal of treatment is to help clients learn skills to recognize and challenge cognitive distortions, first focusing on those related to their worst traumatic events and then the meaning of the events in terms of their self, others, and the world. Therapy includes education about PTSD; identification of relationships between events, thoughts, and emotions; and the development of alternative more balanced thinking [8,16] found that IPV exposure predicts PTSD treatment engagement and outcome in cognitive processing therapy. These findings highlight the importance of targeting treatment engagement among women who report recent IPV and suggest women who have experienced frequent IPV respond well to CPT treatment in spite of their IPV experience.

Group Therapy: Group therapy has been shown to be an effective means for reducing PTSD symptoms in individuals [17]. One of the more recently emerging forms of memory specificity training (MeST), which encourages memory reconsolidation and diminishes distress symptoms [18]. While MeST was originally developed for depression, there is speculation that it may be appropriate for treating PTSD, as sufferers may have difficulty retrieving memories. In addition, PTSD sufferers often tend to overgeneralize their memories, and MeST can aid in diminishing this tendency. As noted by Maxwell and colleagues [18], MeST sessions are geared toward moving individuals away from overgeneralization of memories. More specifically, individuals are taught to recover specific memories based on cue words that evoke negative, positive, or neutral emotions. Once individuals grasp the concept of each word, they are asked to write down a specific memory associated with the appropriate cue word. Each group member then takes turns sharing these memories with each other, and the group engages in a verbal exchange to help the member identify precisely why the chosen memory is associated with the negative, positive, or neutral cue word. As aforementioned, this group technique has been shown to reduce symptom distress among individuals with PTSD. In addition, this symptom reduction was still seen in a 3-month follow-up [18].

Couple's Therapy

Intimate partner violence: Although historically thought to be contraindicated, many clinicians are now using couple's therapy as a way to reduce IPV. In fact, carefully screened conjoint therapy has been shown to be rather effective in certain types of couples experiencing lower levels of IPV, particularly because it teaches important skills in problem solving, anger management, and conflict resolution [9]. As of 2016, only eight studies have tested couples approaches for addressing IPV [19]. Overall, these studies have suggested that interventions that address couples' communication and relationship skills can be beneficial and safe for couples who engage in situational violence. More specifically, the Creating Healthy Relationships Program (CHRP) appears to be particularly

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effective in increasing relationship satisfaction in couples who exhibit situational violence [20]. The CHRP is a couple group program which strives to provide couples with effective conflict management and a true meaning of their relationship. While CHRP was shown to reduce psychological abuse, it did not appear to significantly reduce physical violence, however, research with this intervention is in its beginning stages [21]. It is also important to note that CHRP has been shown to be effective in couples with which fear, domination, and control are not driving forces of violence. Still, this appears to be a valid intervention option for couples experiencing milder forms of IPV.

Integrative behavioral couple therapy (IBCT) has also been shown to decrease psychological aggression in couples, despite the fact that it was not explicitly developed to address IPV. In fact, IBCT focuses on the acceptance of partner differences and guides couples towards behavior change and acceptance [22]. Still, a study conducted by Simpson, Atkins, Gattis, and Christensen [23], demonstrated its utility for couples experiencing IPV. The researchers recruited a community sample of 142 couples experiencing low levels of aggression, and assigned them to 26 weekly sessions of IBCT. At their 6, 12, 18, and 24 month follow ups, they found that psychological aggression had significantly improved. In addition, there was an increase in marital satisfaction and individual functioning, suggesting that conjoint therapy may be affective for dealing with IPV. However, as noted above, more research is warranted in this domain.

A conjoint treatment for alcoholism and drug abuse that has received extensive empirical support for its clinical and cost effectiveness is BCT for substance abuse (BCT-SUD; O'Farrell & Fals-Stewart, 2006). BCT is a short-hand label for what is typically a treatment package that includes both partner-involved therapy integrated with standard substance abuse treatment for the alcoholic or drug-abusing partner only. The partner-involved elements, which are unique to this particular treatment package, teach skills that promote partner support for abstinence and emphasize amelioration of common relationship problems in these couples. With respect to IPV, nonsubstance-abusing partners are taught certain coping skills and measures to increase safety when faced with a situation where the likelihood of IPV is heightened. As such, emphasis is placed on using behaviors that reduce the likelihood of aggression when a partner is intoxicated (e.g., leaving the situation, avoiding conflictual and emotionally-laden discussion topics with an intoxicated partner). Thus, BCT is designed to reduce partner violence in these couples even when relapse occurs. In contrast to traditional individual treatment for substance abuse, BCT does not rely exclusively on abstinence as the mechanism of action for nonviolence.

Several noncontrolled studies have examined the effects of BCT on IPV prevalence and frequency among alcohol- and drug-abusing men and their nonsubstance-abusing female partners (e.g., Chase et al., 2003; O'Farrell et al., 2004). In these investigations, participating couples reported a 60% decrease in IPV prevalence during the year after treatment compared to baseline levels. In a sample of drug-abusing couples (including those with and without histories of IPV) Fals-Stewart et al. (2002) compared changes in levels of IPV of couples who received BCT versus those who received standard substance abuse treatment, or Treatment-As-Usual (TAU). A significantly smaller proportion of couples who received BCT reported episodes of IPV compared to those who participated in TAU. The results of these studies highlight the promise BCT holds as an intervention for IPV.

Posttraumatic stress disorder: A goal of couple's therapy is to have the couple readjust to change, get to know each other again and adjust to household tasks. Erbes et al. [3], recommend individual therapy for both partners along with couples' psychoeducation (labeling PTSD symptoms, validation of the experience and helping them unite around the ways PTSD has affected their lives). Treatment should acknowledge a full range of feelings and thoughts, with later sessions discussing issues that arise each week. Mutual activities and exploration are emphasized to help the couple work together. The authors report that greater social support upon return has been identified as one of the strongest correlates with lower rates of PTSD. Couples therapy offers a means of increasing social support, decreasing interpersonal conflict, and addressing the experiential avoidance that maintains posttraumatic symptoms.

Cognitive behavioral conjoint therapy (CBCT) is an intervention that has been shown to reduce PTSD symptoms and enrich intimate relationship functioning [24]. CBCT improves conflict management, enhances communication skills, and reduces the client's avoidance of trauma-related stimuli through the use of behavioral interventions. Similarly, it addresses maladaptive believes pertaining to trust and intimacy, which theoretically contribute to relationship distress and PTSD. Sautter, Glynn, Thompson, Franklin, and Han [25] provided evidence for the notion that the benefits of including one's partner in PTSD therapy surpass those of individual therapy. More specifically, their research demonstrated that a couple's approach to PTSD therapy provides a context for identifying and sharing emotions, resulting in an improvement of the emotional numbing symptoms often experienced by those suffering from PTSD. These results have been replicated by Macdonald, Pukay-Martin, Wagner, and Fredman's [26] study, further providing support for the use of couple's therapy as opposed to individual therapy in addressing PTSD. The authors found that in addition to a decline in emotional numbing, CBCT reduced effortful avoidance, re-experiencing, and hyperarousal symptoms of PTSD.

Pharmacotherapy

Psychopharmacological treatment has also been effective in treating PTSD. Currently, the more emphasized first-line of drug treatment is either selective serotonin reuptake inhibitors (SSRI) or serotonin/norepinephrine (SNRI) reuptake inhibitors (or SRIs); however currently only sertraline and paroxetine are approved by the Federal Drug Agency for **PTSD [27].** There are also other drug types such as antipsychotics, anticonvulsants, anxiolytics, as well as other antidepressants [28]. In addition,

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prazosin can be helpful for nightmares and sleep disturbances that individuals with PTSD might experience [27]. However, Davidson [28] suggests that more research should focus on the use of tricyclic antidepressant drugs (TCA) in the alleviation of PTSD symptoms. He notes that TCAs may effect several neurotransmitters that are unbalanced in PTSD, mainly norepinephrine transporters and serotonin transporters, which may have mood-elevating, anti-anxiety, anti-panic, and anti-phobic effects. However, as mentioned above, more research needs to be conducted with TCAs before they can become the first-line treatment for PTSD. As it stands, SSRIs should be the first means of drug treatment.

Additional considerations

The social, economic, and political dynamics of race and ethnicity in America have resulted in a complex and longstanding confluence of mistrust, prejudice, and differential resources that have tragically seeped into the systems of mental health care delivery. Psychotherapy research suggests that members of racial and ethnic minority groups are less likely to receive empirically supported treatments, more likely to be misdiagnosed, and more likely to drop out of treatment [29]. Despite evidence that the working alliance (WA) is an important factor in psychotherapy outcome and that race/ethnicity plays an important role in the process of therapy, few studies have directly examined associations between WA and race/ethnicity. These relationships may be particularly salient for difficult-to-engage populations, such as men participating in treatment for intimate partner violence. Walling et al. [29], examined WA ratings in a sample of 107 male intimate partner violence perpetrators attending a 16-week cognitive-behavioral group program. Approximately 50% of these participants were Caucasian and 50% were members of a racial/ethnic minority group (i.e., African American, Asian American, Hispanic and American Indian). Growth curve modeling was used to assess changes in both therapist and client WA ratings across four time points during therapy. Findings indicated that there was no mean level of change in therapist WA ratings over time. However, clients' WA ratings demonstrated a reliable, steady increase across sessions. A significant interaction between WA and race/ethnicity emerged such that the Caucasian participants reported significant increase in WA over time, whereas members of racial/ethnic minority group did not report a consistent pattern of change.

Both active duty and veterans are being diagnosed with PTSD, and of those diagnosed with PTSD the incidences of IPV are indeed high. It is critical to look at how contributing and potential risk factors go hand in hand in regards to PTSD and IPV. To treat one (i.e. PTSD, IPV) one must look at treatment options for both if they are present. It is crucial to emphasize the contributing factors to IPV as follows: prior IPV, mental health (untreated), prior marital discord, substance abuse, childhood trauma, demographics (age, job position, marriage, children etc.), and stress that is absent when away from loved ones. As shown, there are many effective treatments for those suffering from PTSD who engage in IPV.

Recommendations and future directions

PTSD is a major public health concern that affects many Americans. Unfortunately, due to certain political, social and economic dynamics in the United States, many individuals are both undiagnosed and/or misdiagnosed. In order for treatment to be successful with those experiencing PTSD, not only does a correct diagnosis need to be made, but mental health services also need to be available.

The relationship between PTSD and IPV are both bidirectional and complex. On one hand, those who experience IPV, especially women, are at risk for developing PTSD. On the other hand, having PTSD makes one more likely to engage in IPV. There are several treatment approaches available that are effective in treating individuals with PTSD who engage in IPV. Both individual and couples therapy are shown to be effective for the treatment of PTSD and IPV. For those who engage in lower levels of IPV, couples therapy may be more beneficial because it teaches problem solving skills, anger management and conflict resolution. When working with a couple, it is crucial that providers are able to make sure that both parties needs are being met throughout the treatment. There seems to be a lack in integrated treatments for both IPV and PTSD. Integrated treatments should be developed and minimally each phenomena (IPV and PTSD) should be assessed in situations involving IPV or PTSD. For example, for someone whom presents as a victim of IPV, therapists should assess for PTSD and vice versa.

It is imperative that clinicians are aware of the different treatment approaches that are effective in treating those suffering from PTSD and engaging in IPV. Having knowledge of all the local resources and knowing when to refer for specialized treatment can result in lower dropout rates, higher success rates, and more access to mental health services. To treat one (i.e. PTSD, IPV) one must look at treatment options for both to determine if they are present. It is crucial to emphasize the contributing factors to IPV as well risk factors for the development of PTSD. If an individual has a diagnosis of PTSD and has clear maladaptive thinking, providers should help guide clients towards changing their thinking to a more practical and healthy way. It is incumbent upon providers to make sure clients have sufficient information and awareness about their condition. Providers need to be sensitive and aware of what their clients are going through, especially in regards of what topics or events may trigger a flashback.

As aforementioned, while there is some research pertaining to IPV and PTSD separately, more research needs to be conducted viewing the two in unison, particularly in terms of integrative treatment. Still, clinicians must continue to be perceptive with clients in order to identify whether one or both conditions exist. They must also continue to utilize evidence-based research to assist the client towards working through their symptoms and relationship issues, whether it be through the existing individual, couples, or group methods.

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