6-2022

Combined Treatment Model Program for Survivors of Intimate Partner Violence

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School of Behavioral Health
in conjunction with the
Department of Counseling and Family Sciences

Combined Treatment Model Program for Survivors of Intimate Partner Violence

by

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A Project submitted in partial satisfaction of
the requirements for the degree
Doctor of Marital and Family Therapy

June 2022

Each person whose signature appears below certifies that this doctoral project in his/her opinion is adequate, in scope and quality, as a doctoral project for the degree Doctor of Marital and Family Therapy.

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ACKNOWLEDGMENTS

As I reflect on my journey that has brought me to where I am today, I am grateful and aware of the support and guidance I have received along the way. I am beyond thankful to have been given opportunities that have lead me to pursue my dreams and constantly challenge myself. Above all, I am thankful to God for His truths and promises that I have learned to rely on daily. While life can be extremely messy, I am grateful for God's mercy and faithfulness. His faithfulness is a concept I have been shown numerous times and one that I cling to often. He continues to challenge me and I pray I will be able to use my skills and knowledge to serve Him.

There are many people whom I would like to thank for their contributions both directly and indirectly to this project. I would first like to thank my committee chair, Dr. Nichola Seaton-Ribadu for her guidance and encouragement in this endeavor. Her constant guidance and continued motivation were critical in the work that has been completed. It is because of Dr. Ribadu's passion for program development I chose to complete this project and have further acquired the framework for developing programs for future areas of need. I am thankful for her dedication to the DMFT program and her positive influence on my project.

I would also like to thank Dr. Zephon Lister for his vast knowledge and competency in the field that he so kindly helped me explore. Dr. Lister challenged my thought processes and facilitated me looking at situations from a new lens. His calm presence always enticed me to search for more and dig deeper. To Dr. Solomon Wang, I am thankful for all your incredible suggestions and ideas. You brought more possibilities and expanded my view of what was possible within my project each time we talked. Your

passion is something I strive for, and your lighthearted spirit made every step enjoyable.

The most valuable opportunities I have been graciously afforded were by those who saw potential in me. Thank you to the professors, mentors, and supervisors who have encouraged me to reach beyond what I thought was realistic. Particularly, Dr. David Morrison who was the initial person to plant the seed to pursue a doctorate. While it took nearly a decade for his insight and my desire to meet, the culmination of one specific interaction has led me to where I am today. I would also like to thank Dr. Pedro Olvera who was instrumental in my early graduate education and set me on the career path I am on today. The warmth felt from his as a professor went beyond a knowledge base and offered meaning and connection as a person. I will forever be indebted to Dr. Francis Dizon, who I feel lucky to have received mentorship from for the last decade. His knowledge and expertise in our field is unparalleled to anyone I know. He took me under his wing early on and has had such an influential role in my career. We have a shared passion for a love of learning. He is always willing to provide guidance, encourage inquisitive conversations, help me challenge my own thinking, and be a support on so many levels. He is the fastest thinker I know and I am so grateful for his willingness to impart pieces of his knowledge to me. The mentorship I have received from him goes far beyond knowledge and learning. I will forever cherish wonderful memories that coalesce growing as a professional and enjoying what life has to offer (NASP, ice cream hamburgers, swamp rides, firetruck taxis, the Alamo, and Casa Franco).

No words could sum up the profound sense of gratitude I have for my mom. The one who believes in me in all things, the one who can make any situation better, the one who is always there to help when a hand is needed. She is always willing

to sacrifice to invest in my education and assist me in pursuing my dreams. I will forever be indebted to her for always investing in my children and me. She has seen me through every trial and every adventure, and I hope I continue to make her proud. She has the most gracious heart and has taught me more important things than school ever could. Thank you also to my sweet kids who give my life meaning. Somehow, we were able to do this and seeing their precious faces motivated me while bringing my heart joy throughout an extensive amount of work. I pray each one of you, Bryson, Presley, Walker, and Sutton, follow your dreams and never let anyone stop you. Be brave in your life to do the scary things, offer grace always, and love each other and be there for each other every single day. Thank you for being supportive throughout this process, you really are amazing little people. You all have my heart and will always be my greatest accomplishment.

To those I have not listed by name, I am thankful for the support, encouragement, and motivation that you provided throughout this process. God offers timely gifts and I am always amazed at his omnipotence. To those who believed in me when I didn't believe in myself, I am so grateful for your words of encouragement and support. Even though there has been more than enough reason to give up at times and no longer pursue this dream, I am grateful to have been able to stay determined and continue taking one day at a time. I am thankful to have been able to show my little ones perseverance and determination to pursue their dreams even in the face of hardships. I feel extremely lucky to have the ones that mean the most to me by my side daily. I am so blessed by all God has given me and thankful to have been able to go on this educational and personal journey.

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ABBREVIATIONS

IPV	Intimate Partner Violence
SIPV	Severe Intimate Partner Violence
CIPV	Current Intimate Partner Violence
PIPV	Prior Intimate Partner Violence
CBO	Community-Based Organization
CBT	Cognitive Behavioral Therapy
WHO	World Health Organization

EXECUTIVE SUMMARY

Combined Treatment Model Program for Survivors of Intimate Partner Violence
by

Hillary Jeanne May

Doctor of Marital and Family Therapy,
Department of Counseling and Family Sciences
Loma Linda University, June 2022
Dr. Nichola Seaton-Ribadu, Chairperson

This project seeks to fill a void in the mental health field by providing a combined treatment model program to address the needs of survivors of intimate partner violence. As such, the primary purpose of this project is the development of a treatment program with services that are easily accessible by survivors that is intended for future implementation in shelters or agencies that have contact with this population of women. This program offers a means to engage an underserved population in access to services and self-development to improve overall mental and physical health outcomes and attempt to prevent recurrent intimate partner violence traumatic experiences.

This program will utilize a psycho-educational approach to addressing specific lack of knowledge about intimate partner violence, family systems, and healthy relationships. Additionally, participants are integrated in both individual therapy and family therapy while being connected with community-based resources and support groups. Two key conceptual foundations of this program are Bronfenbrenner's Ecological Systems Theory and Family Systems Theory. Ecological theory is proposed as the meta-theory in the conceptual foundation of the program with Family Systems Theory integrated within the scope of ecological theory. The implementation of the two theories aims to improve educational awareness, mental health, and social support of individuals

who have experienced intimate partner violence. The four components of the program include providing resources, access to educational material, receiving and connecting to support, and engaging in therapy. This fluid process of services aims to allow clients to access priority services while acquiring knowledge and improving their mental health that will prevent recurrent intimate partner violent situations.

The initial contact with the program is with a service navigator who completes enrollment paperwork, background information, facilitates assessments, and creates a priority service plan for each individual client. This is an important process in the program implementation in order to ensure clients are accessing their most crucial needs first. Participants will be linked to the various services offered by the service navigator. Participants will ultimately access all program components. By building relationships with others in support groups and psycho-educational classes, an increase in social support will happen organically and sustainably.

The service navigator will check in with participants as needed and will be available during the opening time of psycho-educational classes to discuss changes that need to be made among service plans and order of services offered. The support groups are highly malleable to specific group needs as the facilitator will continually assess client feedback and the topics that were presented that week within the psycho-educational classes. The group sessions can take multiple directions based on group needs and specific cohort necessities. This aims to help group members feel like the topics can be personalized and the needs that are present are being specifically addressed through education, support, resources, and therapy.

The culmination of the program includes completing assessments to determine

overall effectiveness of the program per participant. Participants have continued access to needed services such as resources, continued support groups/connections, and therapy. The last unit of the psycho-educational classes is a 'Healthy Relationship Unit' where focus is maintained on what a healthy relationship looks like, creating boundaries, understanding the equity wheel, identifying healthy vs. unhealthy relationships, and planning for the future. Continuing to focus on healthy relationships while engaging in work in therapy and accessing connections to community support is the culminating goal. This program aims to build a foundational base for each participant that is focused on improved mental health, access to education, connections to resources, and engagement in support groups to stay on a path of eliminating incidents of intimate partner violence within their lives.

CHAPTER ONE

PROJECT PURPOSE

Impact of IPV

Intimate partner violence is a growing epidemic that has lasting effects on the victim and those with whom the victim interacts, including family, friends, and co-workers. Intimate partner violence affects those of any gender, race, socio-economic status or culture and can have extremely significant effects on the lives of those involved. Nearly 30% of U.S. couples (married and unmarried) will, at some point in their relationship, experience domestic violence (Straus & Gelles, 1990). The National Violence Against Women Survey found that 22.1% of women reported they were physically assaulted by a current or former spouse, cohabitating partner, boyfriend or date in their lifetime (Roehl, O'Sullivan, Webster, & Campbell, 2005). Numerous studies (Roehl, et al., 2005; Pollak, 2004; Alhabib et al., 2009) have examined how violence against women has become an epidemic problem in many societies.

In combination with the physical injuries that are often present within intimate partner violence relationships, many negative health effects are also typically present. Some of these negative health effects include many chronic conditions that range from issues with heart disease, digestive, muscle and nerve, reproductive, and nervous system concerns (CDC, 2020). Mental health problems are another area of concern with primary areas being depression and post-traumatic stress disorder (PTSD). While these personal effects are destructive, there are also many costs to society and the community. Exuberant costs are associated with factors of medical services and related aspects of

IPV. Injuries related to IPV, lack of productivity at work, criminal justice and additional associated factors cost upwards of $3.6 trillion in lifetime economic costs (CDC, 2020). Intimate partner violence is a significant public health issue that continues to be problematic even though there are programs of support for both perpetrators and survivors of IPV.

Intimate partner violence is broadly defined as abuse or aggression that occurs in a romantic relationship. Intimate partner refers to both current or former spouses and dating partners according to the Center for Disease Control and Prevention (2020). The severity of the abuse can vary in IPV situations. Four types of abuse that are noted by the CDC include physical violence, sexual violence, stalking, and psychological aggression. While IPV is the common term used for abuse between two individuals in a romantic relationship, domestic violence is another term used to describe violence within a couple relationship.

Prevalence of IPV

On average 1 in 4 women will experience some form of domestic violence within their lifetime (National Domestic Violence Hotline, 2019). Typically, women in more rural areas are more likely to experience domestic violence without having access to intervention or treatment. Women who live in a highly patriarchal society, reflecting patriarchal values, have been shown to be more vulnerable to domestic violence (Pitt, 2008). Even though women are able to complete surveys on intimate partner violence, it is often believed to be underreported (Pollak, 2004). Women either are unaware that the interactions they are experiencing are in fact domestic violence, or women are timid to

mark any indicators of domestic violence due to fear or shame. Many different types of violence are reported on most surveys including verbal, physical, and sexual assaults that violate a woman's physical body, sense of self and sense of trust (Alhabib et al., 2009). Many victims experience psychological trauma and provide input that it is more traumatic than physical violence; however, this type of violence is unable to be readily seen by society (Drieskens et al., 2017). This may be one of the reasons that domestic violence continues on a societal level with limited solutions that work toward a systemic solution. Women tend to have a high-level of non-response (up to 62%) on survey questions specifically asking whether or not they have experienced domestic violence (Drieskens, et al., 2017). Due to this silent underpinning trend, one specific need associated with this problem is educating women on the definitions of domestic violence and finding a way to communicate knowledge about domestic violence and its impacts to women in these situations. Individuals were still able to complete the survey even if they did not explicitly report experiences of domestic violence. Participants answered questions on the frequency of physical altercations and acts of violence throughout the survey, which is indicative of domestic violence. Contradictory responses on surveys like this identify a concern that women are experiencing violence from their intimate partner; however, due to various reasons such as naivety, cultural differences, religious upbringing, shame, and fear, women are not identifying this violence as intimate partner violence or abuse.

Areas of Need

Additional needs identified within the ongoing domestic violence trend includes

mental health conditions and support for the victim. The need for psycho-education is apparent for women to be able to correctly identify their experiences. Without providing access to knowledge to women in IPV situations, it is highly unlikely that change can occur. Psycho-education on intimate partner violence and its effects can better help women evaluate their circumstances and make necessary changes. Another need within this topic of domestic violence includes the mental health conditions and support for the victim. Research has found that intimate partner violence and poor health outcomes for women have a significant correlation (Walsh et al., 2015). Some of the health effects include HIV infection, sexually-transmitted diseases, depression, suicide, induced abortion, premature birth, injuries, and death from homicide. In the study completed by Akyazi et al. (2018), 76.3% of the cases of women experiencing IPV were diagnosed with at least one psychiatric disorder. Approximately half of the participants of the study experienced PTSD and over half of the women had attempted suicide at least once, with 66% of these individuals attempting suicide after the violence had begun (Akyazi, et al., 2018). These mental health concerns are alarming and have overlap with salient public health concerns. Exposure to childhood abuse and previously diagnosed psychiatric disorders were risk factors for suicide attempts (Akyazi, et.al., 2018). As a result of intimate partner violence, other mental health issues such as depression, fear, anxiety, low self-esteem, sexual dysfunction, eating problems, obsessive-compulsive disorder, and PTSD can occur (Carretta, 2008). For most verbally abused women, after multiple experiences of verbal abuse, many women value themselves less and have feelings of being hopeless and worthless (Zosky, 1999), further separating them from any chances of growth toward a healthy lifestyle. Kuijpers et al. (2012) reported that a victim's mental

health factors and psychological difficulties were a predicting risk factor related to re-victimization. Without treating these underlying psychological difficulties, women are at a higher risk and will more than likely be re-victimized within an abusive relationship.

The last area of need for victims in intimate partner violence includes the system supports in which women are connected. Intimate partner violence programs often focus on victims' safety and emotional support as the main areas of focus; however, survivors of intimate partner violence have a variety of interconnected needs that are rarely fully met. Some of these needs include "long-term safety and healing, housing, economic stability, health and well-being, and community connection" (Sullivan & Goodman, 2019, p. 2007). While it would be difficult to meet all of these needs within a single program, creating programs with a more comprehensive and systems-based approach should be a priority. Focusing on aspects such as linking survivors to concrete resources, providing information on protection and other opportunities has been found to be an effective strategy that is well-received (Sullivan & Goodman, 2019). Women survivors of intimate partner violence often lack support at multiple system levels including their microsystem, meso-exosystem, and macrosystem. By addressing the effects of intimate partner violence in each of these system levels, real change can occur that has lasting effects at both the individual and the community levels. Identifying the various systems that impact a woman's mental health and support can provide a valuable framework when working with this specific population. Conversely, applying an ecological systems theory perspective to the concepts of domestic violence within all system levels may help to explain the systemic barriers women face in domestic violence relationships.

While the psychological effects of domestic violence on women are abundant,

certain aspects of the violence perpetuates the violence cycle. As women experience physical and emotional abuse and feel less than adequate (Zosky, 1999), the cyclical abusive interactions in the relationship gradually become the norm and consequently traps the woman in the relationship. The interactions in the relationship become the normal homeostasis in the environment. This cycle is one that contributes to the gradual escalation and perpetuation of domestic violence. Children being exposed to domestic violence and the intergenerational effects of family violence also perpetuates the cycle of abuse and trauma. Studies have shown that women involved in domestic violence are frequently experiencing psychological distress, even to the point of attempting suicide (Akyazi, et al., 2018). With increased psychological distress experienced by mothers, children are often not engaging in secure attachment relationships with their caregivers, putting them at risk for deficient psychosocial development. Consequently, many children within these families experiencing violence will continue to negatively impact the individual as an adult. If women continue to blame themselves for the abuse, have increased psychological distress, or have lack of knowledge about the various types of abuse, the cycle continues.

Gaps in Service

If this gap in services is addressed, treatment support and intensive psychological services for women, the effects will help women regain their mental health and make gainful and enduring agentic choices that halts the domestic violence cycle. After educating women on the definitions of intimate partner violence, providing therapeutic services for psychological difficulties, and providing support in the form of concrete

resources (Sullivan & Goodman, 2019), survivors will have a possible chance at making changes towards eradicating intimate partner violence from their lives. It is the goal of this program to provide education, system supports, and treatment through psychological services to help women make informed choices and have access to opportunities. If women choose to stay in their relationship, it is highly likely that with education and improved mental health, they will be able to create a new, healthy family interpersonal dynamic. If a new dynamic is not possible, it is the hope that the individual will have a positive mental capacity, education and knowledge, and a system of supports in order to leave the harmful relationship and create a healthy environment for herself and her family.

Providing a comprehensive and integrated mental health and wellness service to female victims of intimate partner violence is necessary for changing the cycle of abuse that perpetuates in intimate partner violence relationships. There is a need for a program that attempts to incorporate therapeutic services, psycho-educational/relational classes, and social resource supports to address various components of the ecological systems that IPV survivors are nested in. Treatment options offered can provide support and psychological services to women to help victims regain their mental health and establish social supports to make choices that are productive to their life and facilitate positive change. Providing intensive psychological support and treatment services for women in intimate partner violence situations can have a profound positive effect on the individual and the community. Brofenbrenner's ecological systems theory coupled with family systems theory can help explain the complex layers of interwoven systems that oppress victims of IPV. While intimate partner violence is beginning to be seen as the

responsibility of the healthcare system, the interventions and supports needed to create lasting change needs a comprehensive approach incorporating system supports and providing resources (Gainor, 2004).

The definitions of the categories for this project are defined with the specific criteria below.

- Intimate Partner Violence - Self-reported experience of one or more acts of physical and/or sexual violence by a current or former partner since the age of 15 years.
- Physical violence is defined as: being slapped or having something thrown at you that could hurt you, being pushed or shoved, being hit with a fist or something else that could hurt, being kicked, dragged or beaten up, being choked or burnt on purpose, and/or being threatened with, or actually, having a gun, knife or other weapon used on you.
    - Sexual violence is defined as: being physically forced to have non-consensual sexual intercourse, having sexual intercourse out of fear, and/or being forced to do something sexual that you found humiliating or degrading.
- Severe Intimate Partner Violence - Is defined on the basis of the severity of the acts of physical violence: being beaten up, choked or burnt on purpose, and/or being threatened or having a weapon used against you is considered severe. Any sexual violence is also considered severe.
- Current Intimate Partner Violence - Self-reported experience of partner violence in the past year.

- Prior Intimate Partner Violence - Self-reported experience of partner violence before the past year.

The definition of intimate partner varies between settings and includes formal partnerships, such as marriage, as well as informal partnerships, including dating relationships and unmarried sexual relationships. Definitions are taken from the World Health Organization (2013).

CHAPTER TWO

LITERATURE REVIEW

Research has found that intimate partner violence and poor health outcomes for women have a significant correlation (Walsh et al., 2015). Some of the health effects include HIV infection, sexually-transmitted diseases, depression, suicide, induced abortion, premature birth, injuries, and death from homicide. In the study completed by Akyazi, et al. (2018), 76.3% of the cases of women were diagnosed with at least one psychiatric disorder. Some of the astounding statistics included approximately half of the participants experienced PTSD. Due to many of these health concerns, estimates of as much as $5 billion to $10 billion U.S. annually for issues related to domestic violence (Carretta, 2008). As a result of domestic violence, other mental health issues such as depression, fear, anxiety, low self-esteem, sexual dysfunction, eating problems, obsessive-compulsive disorder, and PTSD can occur (Carretta, 2008). For most verbally abused women, after multiple experiences of verbal abuse, feelings of worthlessness are noted (Zosky, 1999).

Intimate partner violence (IPV) is a type of trauma that is pervasive to every area of a woman's life including mental health effects, physical harm, and distress for victims. This form of trauma has been proven to increase clinical rates of depression and posttraumatic stress disorder among abused women when compared to non-abused women (Al-Modallal et al., 2008). While there are many treatment interventions available and aimed at the perpetrator, there are far less treatment interventions that aim to address the psychosocial distress symptoms of the survivor. A review of survivor treatments

found that a majority focus on reducing trauma-induced mental health symptoms were in the survivor's past. While some of the interventions and treatments may still be helpful in addressing the symptoms that many survivors face, there are few evidence-based trauma interventions that apply specifically to the IPV survivor population in their present and future state. These women are often still living in a context with a looming threat of abuse, which has an acute and chronic effect on their physical and psychological well-being. Identifying treatment and interventions specifically for women who have, as well as, are experiencing IPV is imperative to understanding the treatment effects of specific therapy options. This paper attempts to review the literature identifying the multiple intervention and treatment options presently available to address symptoms of victimization in women survivors of IPV.

Risk and Protective Factors

Risks and protective factors for women in IPV situations can have a profound impact on the outcome of an abusive relationship. Pitt (2008) posit that a culture which hold traditional gender role values tend to subordinate women, providing men executive power within the context of the relationship and the family, placing women to higher risk of capital punishment or and abuse (Pitt, 2008). In contrast, others hold that violence risk factors are found in the family of origin regardless of culture (Pitt, 2008; Pollack, 2004). Abusive men who experience emotional ruptures in early developmental periods had a fear-based and preoccupied attachment styles that put them at a higher risk for adapting aggressive and abusive behaviors (Zosky, 1999). In Pollak's (2004) study, he finds that the probability of husband's use of violence in a relationship depended on whether he

grew up in a violent home. Conversely, the probability that a woman will remain with her violent husband can be dependent on whether she grew up in a violent home (Pollak, 2004). Another predetermining factor that was assumed within this study by Pollak (2004) was that individuals who grew up in violent homes are drawn to each other as well marry each other. While witnessing domestic violence in the family of origin is not a direct precursor of violence, it does increase the likelihood of experiencing violence in adult relationships (Pollak, 2004). From this perspective, violence that was grounded in a history of violent familial background places the motivation for intimate relationship violence as expressive rather than instrumental in nature. Individuals tend to act and react in ways that are familiar to them, likely expressing intense emotions such as anger, fear, and frustration in a familiar yet violent manner. Perpetrators and victims also have a higher level of tolerance to violent situations in which they have already been predisposed. Being aware of this risk factor is relevant in intimate partner relationships, is the critical first step in addressing and ceasing this problem when one or both partners grew up in families where violence was utilized. Taking precautionary steps to observe and identify violence as well as create change in interactions prior to more severe events of abuse would be possible by first exploring and confronting the abuse psychosocial history and affect IVP couples.

Other risk factors that have been documented to contribute to IVP is a male's poor mental health. As the frequency of mental health problems increased, the frequency of IPV perpetration also increased (Shorey et al., 2012). Some of the mental health symptomatology that has been correlated with IPV includes antisocial personality disorder (ASPD), borderline personality disorder (BPD), post-traumatic stress disorder

(PTSD), depression, generalized anxiety disorder (GAD), panic disorder, social phonic, and alcohol and drug disorders (Shorey, et. al., 2012). While information on how these factors directly contribute to violence in relationships may still be unknown, screening for mental illnesses can be foundation of identify and treating IVP perpetrators. Conversely the victim's psychological health has also been documented as a key factor in predicting the risk of re-victimization (Kuijpers et al., 2012). For example, an avoidant attachment style was shown to be a "significant predictor of both physical and psychological IPV revictimization" (Kuijpers et al., 2012, p. 22). Victims with psychological difficulties often had other areas of instability that included poor interpersonal relationships, low affect, poor self-image, and marked impulsivity (Kuijpers et al., 2012). Collectively, these mental health symptoms were positively associated with relationship problems. Another well documented contributor to violence in intimate relationships is poor communication. Verbal and physical altercations can be contributed to poor communication patterns, another crucial factor in IVP relationships. While the factors that are related to the victim are noted, it is in no way meant to imply that victims are responsible for repeat victimization. Factors affecting victims/survivors are noted in order to highlight areas of focus to help prevent re-victimization.

Systems of Influence

Some of the systems of influence of this epidemic within our society are found in the systems of beliefs within the general population. Cultural differences are often at play within domestic violence. Vandello & Cohen (2003) explore the differences between cultures where male honor is one of the main themes within the culture. The study

portrayed that female infidelity damages a man's reputation, violence can partially repair the damage, and women within honor societies are expected to remain faithful and loyal within this context (Vandello & Cohen, 2003). In cultures where male honor plays a significant role in the relationship, it is possible that domestic violence will be a more likely occurrence. Women who stayed loyal in the relationship after experiencing intimate partner violence were viewed as weak to some cultures and viewed as equally strong and showing warmth and goodness in other cultures (Vandello & Cohen, 2003). While both groups communicated their intolerance of the aggression to the abused, certain cultures communicated more messages of tolerance and suggestions to stay within the private confines of the family (Vandello & Cohen, 2003). The way society views domestic violence and its significance in levels of community and culture can influence the victims' perception of domestic violence. While some cultures view it as acceptable to leave in the situation of domestic violence, there are other cultures that would have disdain for a woman leaving the relationship.

Previously discussed in this paper were the intergenerational effects of domestic violence, exposure to childhood abuse, and previously diagnosed psychiatric disorders were risk factors for suicide attempts (Akyazi, et.al., 2018). Due to many of these health concerns, estimates of as much as $5 billion to $10 billion U.S. annually for issues related to domestic violence (Carretta, 2008). As a result of domestic violence, other mental health issues such as depression, fear, anxiety, low self-esteem, sexual dysfunction, eating problems, obsessive-compulsive disorder, and PTSD can occur (Carretta, 2008). Along with these mental health issues that arise within IPV relationships, women often feel shame from their experiences (Zhu, et al., 2020). This shame can influence multiple

areas within their lives. Survivors are personally connected and involved with the perpetrator resulting in violation of trust, control and integrity leading to a shattered sense of self (Zhu, et al., 2020). Individuals who feel a sense of shame due to a traumatic event are often more self-critical in their thinking and less self-reassuring in their thinking (Zhu, et al., 20220).

Women in intimate partner relationships tend to have difficulties at multiple systemic levels in which they are involved. One example of the microsystem level includes the difficulty that women often have developing healthy relationships. Rather than being a source of support, survivors' intimate partners, friends, and family can potentially be a source of distress and/or additional shame (Zhu, et al., 2020). Without addressing the concept and feelings of shame related to IPV, other relationships are inevitably affected and there is often an increase in additional interpersonal distress for the victim. While shame may often prevent victims from sharing their experiences, supportive responses from members of survivors' support systems can help in decreasing levels of shame (Zhu, et al., 2020). The meso-exosystem is another level that has influence on a survivor's recovery. Various experiences and perspectives are presented within entities such as health care, legal, education systems, and neighborhoods that can either promote or reduce levels of shame. Survivors of IPV have direct connections and interactions with some of these social entities (mesosystem) and indirect connections and interactions with other social entities (exosystem). Many women survivors are blamed, not believed, or violated through their contact with the legal system. Supports are needed to help provide resources and knowledge about the process and interactions that take place for survivors/victims of IPV within the legal system.

Religious Influence

There are many aspects of religion that play various roles within the framework of domestic violence. For this program, the focus will center around intrinsic vs extrinsic religiosity. An intrinsic religious individual can be described as someone who reflects inwardly on their faith and builds to maintain a relationship with their God. On the opposite end, would be a extrinsically religious individuals who use religious services to access specific supports within the church or religious communities (Ake & Horne, 2003). In a study completed by Ake & Horne (2003), negative psychological distress is directly affected by intrinsic religious orientation. This is helpful for mental health professionals as they can be used as a screener for positive effects that may help to reduce the overall psychological distress that a victim is experiencing by providing an internal source of strength and resiliency.

Within the macro system, women in IPV relationships experience the larger social norms and values that are place upon them. The Western individualistic culture, which glorifies self-sufficiency and independence has an aversive effect IPV survivors feel as though they lack the ability to meet these social expectations (Zhu, et al., 2020). Religion as a macro-level influence may also enact harm on IVP victims as many religions hold the conviction that women should stay in the relationship and even conform to the "pattern of loving obedient submission" to their abusive partners (Ake & Horne, 2003). Along the same vein, patriarchy as a cultural and religious value also plays a role within the religious context of abusive relationships. Unsurprisingly, religious IVP victims often reported having negative aspects related to church involvement including a lack of church support, feeling fear of shame from other members, and having to make other changes

within their church to have a successful recovery (Ake & Horne, 2003). Depending on the level and type of religious belief, some women see themselves as partly responsible for their own abuse (Ake & Horne, 2003). While some religious beliefs may incorporate thoughts that once the perceived problem person is forgiven of their sins, the violence will decline. Some religious beliefs would see a woman attending a shelter to be a noble act because it prevents the perpetrator from being able to continue the violence (Ake & Horne, 2003). Others may feel pressure to stay in an abusive relationship because of their religious beliefs. Religious clergy and staff may even encourage the victim to stay because the perpetrator means well and may attempt to understand his shortcomings. Religious leaders may focus on the victim working toward forgiveness of the perpetrator without helping to create any changes in the systems of interaction of the couple. Many religions have very strict allowances for divorce per interpretation of their scripture and domestic violence is not an acceptable reason. Women may find positive support through the church; however, the church system may also encourage women to stay in a situation that is dangerous and harmful to her and her children.

Understanding these risk factors makes it possible to look at the areas that make intimate partner violence more likely and determining how it sustains. Identifying these risk factors is imperative because intimate partner violence substantially increases the odds of poor health outcomes for women, specifically depression, which puts her at risk for re-victimization and becoming caught in the IVP abuse cycle. Studies focusing on treatment outcome from programs addressing intimate partner violence in the context of a integrated treatment program that systemically combines psycho-education, individual therapy, and resource supports are non-existence in the current literature. Addressing the

mental health needs of victims of intimate partner violence from a combined systems-based treatment programs framework can provide information on the positive effects of addressing mental health needs in support of multiple ecological levels. Combined treatment model programs addressing multiple ecological levels have a better and more sustainable, positive mental health outcome for women who have experienced intimate partner violence.

It is imperative to look at the literature available on intimate partner violence to not understand the health risks of women experience IPV but also its interplay with the violence cycle. With the substantially high number of women who have attempted suicide due to mental health concerns that began after the IPV had begun, this review is necessary to determine the most effective treatment approach. By approaching treatment through a embedded standpoint where individual level is nested within the mico level in an ecological framework, integrated treatment model programs have the ability to make systemic and lasting mental health changes in women regarding their depression and overall social supports.

Searching between three databases for relevant articles published after 2000, findings will be reported on ‘16’ relevant articles with a focus on outcomes and challenges encountered in the treatment of IVP victims. The literature shows that IPV interventions primarily focus on the survivors and primary level of prevention, such as safety and housing. Findings concluded that many treatments that focus on a single form of intervention such as Cognitive Behavior Therapy or an Empowerment Model were successful in reducing depressive symptoms and vulnerability in women. Measured indicated that intimate partner violence was often reduced throughout the treatment

program when women were already separated from their abuser prior to entering the program. Some of the guidelines presented after the review of literature include the importance of intimate partner violence education, steps to provide social supports to survivors of intimate partner violence and understanding the limits of treatment approaches that focus on a singular intervention. By integrating these singular interventions into a more comprehensive treatment program to address various levels of concern, it is theorized that women in IPV situations experience better mental health outcomes and a reduced sense of psychosocial vulnerability in women.

Interventions

Throughout the literature, the most common intervention focused on women receiving help at intervention centers focused on IPV prevention and shelters for battered women (Choi & Byoun, 2014). The use of support groups and other therapy groups was also prevalent in the literature (Ragavan et al., 2019). Various treatment and intervention services were frequently offered through shelter resources. Some of the services included cognitive behavioral therapy, strength-based approaches, community-based intervention, addressing negative cognitions, stress management, and incorporating social supports for women. Very few studies were present that incorporated a combined treatment model addressing the systemic needs that IPV survivors face. One combined treatment program was found that focused on education (both complex health issues and local resources), consultation services, and having access to a trauma-informed clinic (Poleshuck et al., 2018). Unfortunately, this study was an intervention program development with community-based participatory research principles and did not provide results for

survivors completing the program.

Intrinsic religiosity is documented to play a complex yet supportive role within intervention of domestic violence. In a study completed by Ake and Horne (2003), "intrinsic religious orientation had a direct negative effect on psychological distress." Findings from this and other similar studies provide helpful therapeutic and programmatic information for mental health professionals as they can be used to screen for positive effects of intrinsic religious values that can be utilized to reduce psychological distress in IPV victim. These intrinsic values can be described as someone who reflects inwardly on their faith and builds to maintain a relationship with their God as compared to extrinsically religious individuals who are use the religious services to access specific supports within the church or religious communities (Ake & Horne, 2003). Religious and spiritual institutions have multi-dimensional support to IPV victims such as social support, community, and a sense of belonging. When it comes to intrinsic values, intrinsic values play a channel through which women establish and maintain a relationship with God, yet another form of social support. Unfortunately, many shelters and treatment centers that offer interventions do not provide religious components within their program.

'Circles of Peace' is an alternative restorative justice-based program for IPV women that includes the participation of the victims and perpetrators (Barocas et al., 2016). In this program, participants engage in discussions with both the perpetrator and the victim discussing the ways in which they were harmed while working on actions to promote healing. This type of restorative practice allows the perpetrator to take accountability for their actions. While this approach may not be considered safe or

practical in all situations, it has proven effective in some less violent situations and circumstances. When the 'Circle of Peace' is an appropriate option, intimate partners can heal from their abusive histories (Baracos et al., 2016). This program aims for more systemic change within the 'Circle of Peace' program because there are aspects that involve multiple individuals in the system, such as the victim, the perpetrator, and family bystanders (i.e. children or extended family members). Communication and patterns of interactions are explored as discussions about the how the victim was harmed and how the perpetrator harmed others are discussed.

Education is an intervention that was frequently utilized in treatment models to help women understand they have been part of victimization including information about abuse tactics, how to create and develop safety and survival techniques, and becoming inn tuned with their intuition (Enache et al., 2019). Psycho-education works toward helping women become aware of the important messages that her body sends her when in a abusive relationship (Czerny & Lassiter, 2016). Part of education is also understanding the abuse tactics and learning to change the unconscious self- talk that was ingrained in her after prolonged verbal or emotional abuse. Boundaries are another core topic that is in psycho educational programs for abused women. Boundaries dictate how a woman's abuser and others behave towards them. It is not until women are able to feel an enact the power of setting boundaries will they feel empowerment and move forwards in their personal lives (Czerny & Lassiter, 2016).

Group Therapy has been documented to be effective in helping women learn to manage their emotions, become less dependent on the abuser, and being aware of their worth and value (Ogunsiji & Clisdell, 2017). Women in group sessions also tend to report

a sense of belonging and community that is created through story sharing (Ogunsiji & Clidell, 2017). Individuals who had a perceived availability of people to which they could do things with, such as belonging support, showed positive effects (Suvak et al., 2013). Cognitive behavioral therapy is the most frequent therapeutic modality used group therapy. A specific treatment intervention that resonated with participants was a mind-body intervention, which had 100% retention; however other important variables, such as baseline measures, length of intervention, consistency of intervention, etc. within the study were not listed.

Types of Interventions for IPV Survivors

Psychological Models

A wide variety of psychological interventions have been used to provide various types of therapy for women who have experienced a range of psychological afflictions associated with IPV. Most commonly female IPV survivors suffer from depression, anxiety, and post-traumatic stress disorder. Cognitive Behavioral Therapy has been the most prominent therapy utilized to treat women in IPV situations. In the study by Rimsha et al. (2021), it was suggested that it may be beneficial to target negative thoughts when treating PTSD and depression for women who have experienced trauma. Combating these negative thoughts (described as negative thoughts about themselves, negative thoughts about the world, and self-blame) may have positive effects on PTSD and depression. Another study, completed by Andre et al. (2020), studied the effects of cognitive-narrative therapy in treatment of depression, post-traumatic stress disorder

(PTSD), complex posttraumatic stress disorder (CPTSD), and borderline symptoms for women who have experienced IPV. Results indicated that cognitive-narrative therapy was an effective intervention in the treatment of depression, PTSD, and borderline (Andre et al., 2020). In a study that utilized emotionally-focused therapy in addition to antidepressants, the treatment group and control group both experienced improved scores in the area of depressive symptoms; however, the treatment group that received medication management and emotionally-focused therapy experienced significantly more improvement in relationship quality (Denton et al., 2012). Treatments that implemented behavioral activation showed significant association with less severe depressive symptoms at 12 months (Patel et al., 2019). All of the psychological treatment models reviewed have shown decreases in depressive symptoms after intervention.

Advocacy/Case Management Intervention

Advocacy and case management intervention utilized interventions that focused on IPV survivors. Case managers and advocates would help identify community-based resources while offering a supportive relationship for the survivor from the effects of the IPV (Ogbe et al., 2020). This supportive relationship offers advice and information in a non-judgmental atmosphere while also creating a sense of community and connection with others who have dealt with similar experiences. Advocacy intervention in contrast with case management include helping abused women access services, guiding them through the process of safety planning, and improving abused women's physical or psychological health (Ramsey et al., 2009). Some of the advocacy strategies included training healed IVP survivors who acted as advocates to mentor and support other IPV survivors. Evaluations

of this advocacy/case management intervention approach found a "reported a decrease in depression, fear, post-traumatic stress disorder, and increased access to social support for the IPV survivors" (Ogbe et al., 2020, p. 39). Many of the studies on case management and advocacy interventions reported a decrease in experiences of IPV, as well as in depression scores over time. Gilbert et al., (2015), showed that regardless of the type of intervention used, participants in both groups had an increase in 'access to social support, IPV self-efficacy (ability to protect themselves from IPV) and abstinence from substance use' which are all considered key milestones in the treatment of IPV (Ogbe et al., 2020). Still other program intervention studies have found that advocacy based intervention programs report reduced psychological distress as well as reduced health care needs.

Group Intervention

Group intervention is another common intervention that was reviewed throughout the articles. Specifically, in the study by Echeburua et al. (2014), treatment that focused on PTSD, emotional discomfort, and impaired functioning was assessed between an individual cognitive-behavioral therapy (CBT) cohort and an individual CBT plus group CBT cohort. 'Most treated patients in both groups improved in all variables (PTSD, emotional discomfort, and impaired functioning) at all assessments, the combined individual and group therapy did better than the individual therapy regarding PTSD symptoms and impaired functioning at follow-up assessments' (Echebura et al., 2014). Another group intervention that was reviewed looked at the effects of 8-week strengths-based perspective group intervention on hope, resilience, and depression in women who left an IPV relationship. This study resulted that a 'strengths-based perspective support

group intervention designed specifically for women who left a violent intimate partner relationship significantly reduced the participants' level of depressive symptoms and improved the pathway component of hope' (Wen-Li et al., 2016). The articles that were reviewed that incorporated a group therapy model approach all had significant results in reducing depression or other concerning factors (PTSD, emotional discomfort, or impaired functioning) than the control group that did not receive the group therapy.

Empowerment Model

The empowerment model was a consistent theme of intervention throughout the review of articles. For a woman who has endured IPV, increasing her empowerment can have many positive effects. In one study, the effects of advocate relationships with IPV survivors were measured to determine if advocate alliance is related to lower symptoms of depression and PTSD (Goodman et al., 2016). This study also attempted to measure the association with the survivors' sense of empowerment in the area of safety (Goodman et al., 2016). Empowerment was increased through a strong survivor-advocate alliance with decreased scores of symptoms of depression (Goodman et al., 2016). By utilizing these findings and promoting strong survivor-advocate alliances, potential contributing factors to healing for IPV survivors can be implemented in more programs and treatment models.

Another intervention that aimed to identify the effects of an empowerment model program is called HOPE (Helping to Overcome PTSD through Empowerment). This study compared HOPE to present-centered therapy (PCT) in women who experienced PTSD from IPV. HOPE is a cognitive-behavioral treatment that focuses on an

empowerment approach. Both HOPE and PCT were ‘associated with significant and large reductions in intimate partner violence-related posttraumatic stress disorder symptoms’ (Johnson et al., 2020). ‘Both treatments also resulted in significant small to medium effects on IPV, depression, empowerment, posttraumatic cognitions, and health-related quality of life’ (Johnson et al., 2020). Since PCT can be delivered by paraprofessionals and individuals without mental health expertise, this shows evidence on the power of the alliance between survivor and practitioner in terms of lessening depressive symptoms. By improving perceived empowerment in both the HOPE treatment and the PCT treatment, IPV survivors saw positive effects in multiple areas.

Writing/Healing Arts

Other articles evaluated more eclectic styles of approaches for reducing depression among IPV survivors. Some of these methods include holistic healing, writing, and meditation. In a study completed utilizing a holistic healing approach of mind, body, and spirit, the results of an ‘open trial found support for improvements in stress related outcomes (posttraumatic stress symptoms, insomnia, somatic symptoms, perceived stress, depression symptoms, fatigue, general life satisfaction, burnout, secondary traumatic stress) and resilience-related outcomes (self-esteem, self-judgment, self-compassion, nonjudgment, mindful acceptance) over 3 months’ (Dutton et al., 2017). While this study lacked a control group, it may be beneficial to incorporate a holistic approach into other treatment model programs due to the positive outcomes in this model.

Another study examined the effects of expressive writing on those who have experienced IPV, specifically looking at the effects on depression, posttraumatic stress

disorder (PTSD) and pain symptoms (Coopman et al., 2005). In the study, women who were assigned to the expressive writing group had significant decreases in depression (Coopman et al., 2005). Being able to express thoughts, feelings, and ideas through expressive writing can be considered a form of healing therapy. Incorporating an expressive writing intervention within other treatment models may lead to reduced depression for women who have experienced IPV.

A third type of eclectic methodology that was reviewed is transcendental meditation (TM). TM is a convenient relaxation technique that is effortless and easily practiced. Studies have shown that transcendental meditation has proven beneficial across multiple and varied populations (Leach et al., 2020). By utilizing the transcendental meditation method, IPV survivors may have a treatment option that addresses domestic violence-induced distress, anxiety, and depression (Leach et al., 2020).

Combined Treatment Model

While much of the literature focuses on a single treatment model, there are few articles that examine the impact and suggest positive outcomes for treatments that integrate a combine or integrated treatment model. Since IPV impacts women survivors in the areas of physical health, mental health, and social connections, it is understandable that the most effective treatment model would need multi-faceted interventions/treatments. One combined treatment model that was reviewed looked at the contextual model of family stress to focus treatment and support in multi-level areas of addressing stressors, resources, perceptions, and contextual elements of IPV (Rolling et al., 2010). The HOPE treatment model, as discussed earlier, is another model that uses a

combined treatment method. By utilizing a cognitive-behavioral treatment that empowers women who have experienced IPV, positive outcomes were measured in multiple areas (Johnson et al., 2020). Another article by Poleshuck et al. (2018) suggested implementing a community-advisory board (CAB) of survivors, healthcare professionals, and researchers. After identifying the preferred range of support ranging from formal help-seeking, coping strategies, and spirituality, the CAB defined a comprehensive IPV intervention/program. The intervention would consist of 'education regarding both complex health issues and available local resources, an integrated consultation service of providers to seek recommendations…, and a trauma-informed/accessible clinic' (Poleshuck et al., 2018). By implementing a combined treatment model, these programs are working toward enhancing survivors' 'knowledge, skills, self-concepts, sense of hope, social connections, safety, health, stability, and access to community resources' (Sullivan, 2017). The goal of the combined treatment model programs is to address the multi-faceted needs of the survivor. By addressing these needs, 'the expectation is that these improvements will create a positive spiral, resulting in more positive social and emotional well-being over time' (Sullivan, 2017) and lasting change.

Almost all of the treatment models that are currently being implemented to support women who have experienced IPV are in a single intervention format. Many treatment modalities focus on specific interventions in relation to depression. Some of the interventions were psychological models incorporating cognitive behavioral therapy approaches, some were advocate centered - working with the participant on empowerment, some looked at the effects of depression in the setting of a group treatment model, while still others used eclectic modes of intervention such as writing

and meditation. While each of the interventions and treatments had positive outcomes in the areas of depression as the unit of study or as a secondary outcome, many of the studies that had control groups also had positive outcomes with the control groups as well. Furthermore, the area of need for women who have experienced IPV goes further than just attempting to deal with depressive symptoms. Because both the treatment group and control group showed improvement in depression, it is indicative of the fact that any intervention and treatment for this population of women is more beneficial than not having any treatment at all. It is imperative to fully understand that depression is only one area of need for survivors of IPV.

Implications

The literature review suggests that it is common for women who have experienced IPV to have a multitude of symptoms with depression being one of the most common. While many of the interventions/treatments that are available in the literature do improve depression rates among women survivors of IPV, this may not address women who have experienced more severe abuse. Many women who have experienced IPV need more comprehensive treatments than what is currently in the literature. One study portrayed information that women who were linked to receive social assistance or disability payments had an increase in their odds of taking antidepressants and getting the needed treatments (Comeau & Davies, 2012). This is imperative to help women get connected with meaningful and effective services. It is hypothesized that those women that are experiencing more severe abuse may be more socially isolated. Determining interventions and treatments that can access these women that may be socially isolated is

one concern. Other concerns address women's economic situations as a factor preventing women from receiving services for depression and other impacts related to the IPV. Economically disadvantaged women face difficulties in access to services to treat concerns related to their abuse as well as difficulties including financial strain, affordable housing, food, childcare, and health services (Comeau & Davies, 2012). Considering these additional barriers for women who have experienced IPV, programs and treatment models should look to incorporate a multi-faceted approach making it easier for women to access the services. Maximizing the treatment time and intervention within programs by creating combined treatment model programs is necessary in order to provide women with resources and supports in the areas of financial need, affordable housing, food, childcare, health services, etc. By only treating women in a single model format, no matter what model is being implemented, is still doing a disservice to these women who need a more comprehensive approach.

Even with the multitude of services that are available in a single treatment model format, the effectiveness of the interventions are left unknown. Many of the studies did not have a control group to compare participants of one intervention compared to another intervention. Other interventions had small sample sizes, which may not have been large enough to make inferential statements. Still other treatments saw decreases in depression in both the treatment group and the control group, indicating that any intervention would decrease levels of depression in women IPV survivors. It would also be important to consider the socioeconomic level of the women who participated in these intervention treatments. While many studies had limited information on the demographic information of the participants, this is an important area to consider. Socially and economically

disadvantaged women often experience the most severe abuse and would need the most intensive treatment. These individual treatment models did not address this concern. There are many complex issues within cases of domestic violence and having more screening information on participants before completing a study would prove beneficial in being able to infer the results to additional populations of IPV survivors.

Further research is needed in treatment interventions aimed at decreasing depression among women who have experienced IPV. Further research should be completed that considers the severity of depression prior to starting the intervention as well as comprehensive demographic information from participants. Researchers may benefit from determining a timeline of when the depression began for participants, whether prior to IPV, during IPV, or post IPV. Further research should also take into consideration a strong methodology for interventions including larger sample sizes of participants. To address socially and economically disadvantaged women, researchers should look to incorporate diversity within their studies. Additional focus in further research should also look to complete studies on programs that are multi-faceted, offering various services, interventions/treatments, and resources to women who have experienced IPV.

Conclusions

Depression is a common mental health concern for women who have experienced IPV. 76.3% of women who have experienced IPV were diagnosed with at least one psychiatric disorder (Akyazi et al., 2018). Many intervention treatment models are presently described in the literature that focus on the treatment of depression for women

who have experienced IPV. There is a wide range of interventions used to combat mental health concerns for this population that include typical cognitive-behavioral therapy to advocate services to meditation and healing arts. The literature shows that all the interventions that were given were effective in decreasing depression. Many women who have experienced IPV have multiple areas in their life that is causing distress. By implementing treatment interventions that address the concerns in more than one area, it is hypothesized that positive effects and outcomes would be seen in this population of women. It would also be important to consider the subgroups within this IPV population and to address concerns about providing access to women who are socially isolated and/or economically disadvantaged.

In conclusion, treatment and interventions for women who experience depression after living through IPV was examined through the current available literature. Understanding the various models of treatment or interventions and their effects or outcome on depression in this group of women is critical for developing more comprehensive program models that address multiple areas of difficulties and hardships these women face. The greatest costs associated with IPV are correlated with the number of repeated services that women need because of repeated violence and violence exposure (Godenzi & Yodanis, 1999). “Research now provides strong evidence that a more comprehensive response to IPV that considers the diverse range of women’s needs and recognizes the relationship between abuse, poverty, and mental health is required to minimize the personal and social costs associated with violence against women” (Comeau & Davies, 2012). By developing more comprehensive and combined treatment model programs it is suggested that women can be linked to resources for additional

support in these areas of concern. In addition to resource supports, women also have a need to receive services to combat mental health concerns such as depression, post-traumatic stress disorder, anxiety, etc. Mental health concerns need to be addressed in a cohesive manner with additional resource supports provided to women. Even when a survivor of IPV is able to leave a violent situation, the mental health effects of the violence are often present for many years. Along with resource supports and mental health services, it is also suggested that a component of psycho-education about IPV be accessible to women in order to prevent repeated exposure and abuse. By integrating a combined treatment model program, women will be able to access the mental health services, psycho-education, and resources that would decrease levels of depression and help to impact lasting changes to end repeated exposure to violence.

CHAPTER THREE

CONCEPTUAL FRAMEWORK

Bronfenbrenner's Ecological Model

Urie Bronfenbrenner's (1974) ecological systems theory offers a framework of the complex systems of relationships that take place across multiple levels of the surrounding environments. Within the ecological theory model, Brofenbrenner identifies four primary components that influence human development. Bronfenbrenner studied the Process, Person, Context, and Time in the ecological model (Rosa & Tudge, 2013). Looking at intimate partner violence through the ecological lens can suggest and identify factors that oppress women in domestic violence situations. Brofenbrenner developed the idea of the process, specifically proximal processes, which relate to the interactions of children with their caregivers. Other processes include interactions with objects and people (Rosa & Tudge, 2013). Processes are most effective when they are consistent and occur over a large portion of the child's life. Proximal processes are the foundation or the building blocks of the individual's interaction with their environment. The proximal processes are often disrupted in families where there is IPV. When looking at this in an IPV situation, it would be necessary to see the proximal processes that were evident or lacking within that individual's family that may have altered their development.

The second area that Brofenbrenner studied was the person. This was the concept that changed his theory from the ecological model to the more refined bioecological model (Rosa, & Tudge, 2013). The latter model incorporates the person. This can include any personal characteristics that influence social interactions. A person's physical

appearance, including their age and gender will have an influence on their social interactions. The person and the personal characteristics influence how they respond to others and in return, how others respond to them. Other personal characteristics include IQ, ability to handle stress/emotions, and personality (Rosa, & Tudge, 2013). All these factors influence how one interacts with their environment and is unique to everyone. Within the IPV population, personal characteristics may be different for everyone. The woman's ability to handle stress or emotions is unique to her as an individual; however, due to IPV, her ability to handle stress may be diminished. Personal characteristics may also either hinder or promote interactions with her environment. Dependent on personal characteristics, including age or social economic status, a woman might have either more access or limited access to resources within her community and society.

Brofenbrenner described the third area as context. This area is the most well-known portion of Brofenbrenner's studies and involves looking at the various system levels. Brofenbrenner describes four systems within this domain: Microsystem, Mesosystem, Exosystem, and Macrosystem (Neal & Neal, 2013). As shown in Figure 1, the microsystem is the system level where family systems theory and bioecological theory can overlap with some congruency. The microsystem is described as the individual's family, friends, and the interactions with the most immediate people in the individual's life (Rosa & Tudge, 2013). This is the most influential level. Interactions at this level are bi-directional, meaning that how an individual treats someone else in this system directly affects how they treat the person in return. Reactions will affect how others treat the individual. Specifically, this can address multiple aspects of IPV because certain actions within the relationship set the stage for the reaction from the perpetrator.

For example, when the victim is walking on eggshells, trying not to upset the perpetrator, the interactions between both individuals often becomes strained. The cycle of violence can also be interwoven with this stage because the actions of the victim at various stages within the cycle of violence precipitate the reactions of the perpetrator (Focht, 2020). Implicit and explicit rules are also established within this level. These implicit and explicit rules may be examples of how the individual reacts and thus, interacts within the family (Murray, 2006). These rules which shape and dictate the interactions between family members establish a systemic emotional and behavioral homeostasis within the microsystem. Women in IPV situations often experience a dysfunctional homeostasis with consistent feedback loops that move the family farther away from a functional homeostasis.

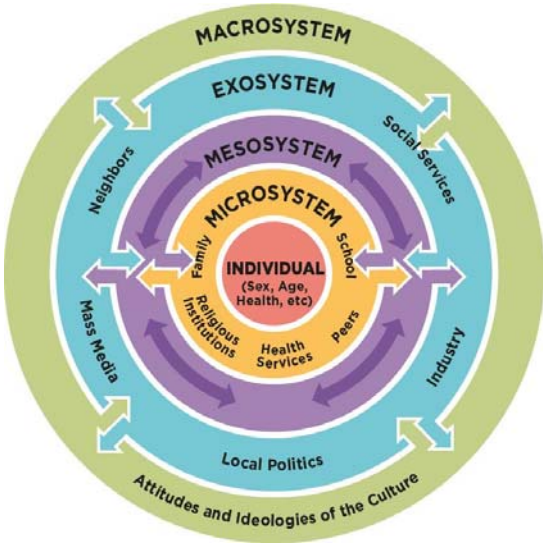


Figure 1. Bronfenbrenner's Ecological System Theory Wheel**.**
Note. Spellman, N. (2021). *Applying Bronfenbrenner's ecological systems theory*. Constant Contact. Retrieved April 5, 2022, from http://events.r20.constantcontact.com/register/event?llr=huuy6dbbb&oeidk=a07ehequq49e42b3bd

The second system level is the mesosystem. Brofenbrenner indentified the mesosystem as the interactions between different parts of an individual's microsystem (Rosa & Tudge, 2013). The mesosystem can be viewed as building a bridge between two or more of the microsystem. The individual has direct interactions with the mesosystem much like the microsystem; however, the difference is that the two microsystems have some form of connection in the mesosystem. Women in domestic violence situations often have limited mesosystems due to microsystems being purposefully separated from one another by the perpetrator, as an act of control, or by the victim to keep the IPV hidden (Machisa et al., 2018). The victim has diminishing interactions with some microsystems while being completely cut-off to other microsystems. Mental health effects of IPV may also hinder women to have multiple mesosystems and prevent the experiences, support, and interactions from the mesosystems they do have (Machisa et al., 2018). Providing women with access to social supports can have a profound effect in terms of gaining access to their mesosystems as well as access to mental health services and resources nested within them.

The third system level is the exosystem. This is an outside system that has an indirect effect on the individual. The individual does not directly interact with this system; however, the individual does experience its influence (Rosa & Tudge, 2013). An example within this level would be a husband's work. If work environment is punitive or toxic, it becomes a source of agitation or frustration for the husband, who takes his hostilities into the home. While the wife does not have any direct interactions with her husband's work, she is indirectly affected because of his mood when he returns home. In an IPV situation, this may look like walking on eggshells, trying to calm or appease the

husband, or attempting to not say anything that would make him mad (Focht, 2020). Another example of the exosystem within the context of IPV is through policy making of laws related to domestic violence. While the woman may have no direct interactions with the lawmakers, she is indirectly affected by the laws about domestic violence, domestic violence arrests, and policies that get put into place by the lawmakers. Teaching women through psycho-educational classes can offer education about the cycle of violence and laws/policies related to IPV.

Finally, there is the macrosystem. The macrosystem is defined as "the institutional systems of a culture or subculture, such as the economic, social, education, legal, and political systems" (Rosa & Tudge, 2013). The overarching belief system of the microsystem determines the effect of the macrosystem in a domestic relationship. Cultural values, health, and public laws can also be a part of the macrosystemand has top-down effects on all other system levels. Socio-economic status, ethnicity, and policy play a role in the macrosystem as it shapes and governs how exosystems, mesosystems, and microsystems behave. For example, laws on divorce shape what social services are offered to IPV victims (Exo), how others in the community and workplace view and treat an IPV victim who is divorcing her husband (Meso), and how the family views and utilizes divorce as an option within a relationship (Micro). Within the IPV situations, socio-economic status and ethnicity are factors that have led to higher rates of IPV. One example within the macrosystem could be how the cultural belief affects whether a woman should stay at home and take care of children or whether she should get a job to support her family. This influence of the macrosystem will have effects on all other system levels, specifically in the interaction the woman is able engage at each level such

as how she utilizes services to assist her work (e.g. babysitter) and how she interacts with her close proximal relationship (e.g. her conversations with her neighbors and peers are about work rather than her duties at home. The cultural environments are also significant within this level. If an individual lives in a low-income neighborhood with alcohol and drug use where domestic violence is commonplace, these factors will have substantial impact on the individual.

The last concept within Brofenbrenner's five systems is the chronosystem. The chronosystem is where time is incorporated as part of the environment for human development (Rosa & Tudge, 2013). Changes that occur over an individual's lifetime that are caused by experiences and life events are considered within this system. This could include typical individual development (puberty, becoming ill), the birth of a sibling, or could include the more traumatic experiences some families face of domestic violence. Women who are amidst the IPV are facing multiple changes within various levels. Women often must experience life transitions when exiting an IPV situation, which continues to add to her chronosystem of life events. Sociocultural events also have an impact on the chronosystem. The impact of the societal issues can affect the developing person.

Family Systems Theory

To understand the barriers women face within IPV situations it is necessary to observe IPV through the Family Systems Theory (Bowen, 1976) lens. Family systems theory is one lens in which to view intimate partner violence. Family relationships are intricately interwoven and bidirectional (Murray, 2006). Family system theory attempts

to address the circular causality in terms of behavioral and emotional interactions within the family. When looking at circular causality in IPV, partners get stuck in an abusive pattern that mutually reinforces each other negatively. Understanding the explicit and implicit rules within the family may help to identify relationship conflict patterns (Murray, 2006). Within family systems theory there are eight key Bowenian concepts (Bowen, 1985) that can be directly related to issues within intimate partner violence. Differentiation of self refers to one's ability to differentiate themselves from the family. An individual with low differentiation is dependent upon others within the family for approval, acceptance, and decision-making (Sauerheber, et al., 2014). While an individual may not have entered into the relationship with low differentiation, often times, low differentiation is developed over the course of the abusive relationship due to implicit and explicit rules that are established within the family system. A person with high differentiation can recognize they are part of the family system but still have the capacity to be their own person. In identifying and working with women in domestic violence situations, it is the goal to help establish higher differentiation with new implicit and explicit rules to create a healthy relationship and environment. Relationship interactions can also be influenced by the fact that individuals with low differentiation tend to be with those with similar levels of differentiation (Pollak, 2004). Research has shown that individuals will often choose a mate that resembles similar patterns of behavior to what they experienced in their upbringing (Pollak, 2004). Often, intimate partner violence or domestic violence is exacerbated in these low differentiated situations. In contrast, a person with high differentiation can recognize they are part of the family system but still have the capacity to be their own person within the family. In

identifying and working with women in domestic violence situations, it is the goal to help establish higher differentiation with new implicit and explicit rules to help create a healthy relationship and environment.

Another key concept is the triangle within the family system (Bowen, 1985). Within intimate partner violence the triangles may be with the abused woman being on the same side as her children creating alienation between the father and the children and simultaneously creating a division between the husband and wife. While the woman may not be doing this action overtly, she often spends her time and energy into another part of the family or possibly avoiding the high-conflict situation. In this example it is putting her time and energy into her children, instead of her husband. The shifting of the third person reduces the possibility of any one relationship 'overheating' (Sauerheber et al., 2014). While the conflict in an abusive relationship is between the husband and wife, some women try to spend their time and energy on the husband, in efforts to eliminate episodes of violence. The triangle in this situation might still be with the children; however, the dynamics look different. All the interactions within the family system are intricately connected and the experiences/relationship interactions with one part of the family system inherently affect other parts of the family system. When symptomatic behaviors are seen by the family system, some families respond in ways of support to lessen the stress and increase the coping ability of the symptomatic person (Micucci, 1995). For example, when a child acts out and draws attention away from the family conflict. Other families who are either overly involved/close or extremely distant respond to the emergence of symptoms in different ways. Those that are close may overreact to the symptomatic person because of the threat it would place on the relationship (Micucci,

1995). Distant families might notice symptoms less until there are effects that are seen outside of the family system (Micucci, 1995).

Within all family systems there is a nuclear family emotional system (Bowen, 1985). The nuclear family emotional system in a dysfunctional family typically has four main problem areas which include marital problems, dysfunction in one spouse, impairment of one or more children, and emotional distance. While some of these problems may exacerbate intimate partner violence, these areas are often a symptom related rather than causes for IPV. At the heart of the dysfunctional families and IPV is a phenomenon known as circular causality. Circular causality has significant impacting relation to marital problems and emotional distance. Intimate partner violence may lead to marital problems and emotional distance which, in turn, may lead to a self-perpetuating intimate partner violence cycle. Throughout the course of IPV, behavioral and emotional problems in one or more children may also become evident, leading to more disruption and deeper conflict within the family system. These specific areas will continue to affect and influence other areas within the nuclear family emotional system because the overall functioning of the family system is a determinant of the individual functioning of each person. The emotional atmosphere of the family has an effect on each individual person within the family unit (Sauerheber et al., 2014).

Family projections and multigenerational transmission process are interconnected when viewing in terms of intimate partner violence. Family projections look at the parent's projections of emotional issues on the children. Within intimate partner violence households, these may be projections of one or more of the parent's anxiety, stress, anger, fear, and even the use of violence in close relationships. One example could be identified

as a parent that is extremely anxious due to IPV. When talking with her children, her anxiousness is present, and she may become overly worried about the childrens' anxiousness and unintentionally transmit her anxiety to her children. This emotional difficulty continues with anxiety and anxiousness becoming more significant in the children's life as they take on their mother's anxiety and throughout their childhood and into their adult lives. The multigenerational transmission process relates to the projection concept as children often have emotional problems because of the parent's emotional issues. From a clinical standpoint, the multigenerational IPV tranismissionis visible within the family system, observed in their dysfunctional interaction, and emotional homeostasis. While a parent may live in intimate partner violence, the child sees the family interactions and views them as being 'normal' and 'acceptable'. After prolonged exposure, these dysfunctional emotional patterns transmit to children which include, "basic emotions, feelings, and subjectively determined values, attitudes, and beliefs" (Sauerheber et al., 2014, p. 22). Later in adulthood, the child will likely find a mate with similar emotional ussues or levels of differentiation and together, this couple will raise children with deep psychosocial impairment (Sauerheber, et al., 2014; Pollack, 2004).

One specific technique within family systems theory to examine, as well as address the multigenerational transmission of poor differentiation, is the genogram. Genograms allow the therapist to identify key people in the family and each individual's relationship within the family including death, stories of survival, divorce, marriages, etc (Sauerheber et al., 2014). Therapists are also able to identify and address key issues, concerns, and repeated patterns within the family system.

Emotional cut-off is an aspect of family systems theory that is applicable to IPV.

Women can either attempt to physically not be around their abuser by trying to work more or seek out friends and family or women are emotionally cut-off and try not to discuss or address any problems within the marriage (Sauerheber et al., 2014). Women who take this avoidant or cut-off approach often do so out of fear for further IPV. This approach can be traced to the first stage of the Cycle of Violence where the woman is trying to appease the abuser and eliminate as much conflict as possible (Focht, 2020). When looking, as well as intervening, the Cycle of Violence in families within a dysfunctional homeostasis, emotional and systemic changes needs to occur to attain a functional homeostasis. Functional changes can be categorized into two categories a) first order and b) second order change. First order change includes the superficial changes that don't affect the family system dynamic including reducing name calling or avoiding conflict (Guttman, 1991; Nichols & Shwartz 2005). Second order change, which includes philosophical changes, is beneficial within the family because it develops a change in the thinking and dynamics within the family system. Even if a partner learns new communication skills but still believes he has the power to make all the decisions for his partner, a new structure has not been attained (Murray, 2006). Being able to work toward building a relationship where both partners are mutually respected and share in decision making would be an example of second-order change, or changes within the dynamics and structure of the family (Murray, 2006).

Sibling position within the family system relates to the birth order and gender that may affect personalities and relationships. Depending on an individual's birth order and gender, they may have had different implicit and explicit rules within their family. This may lead to certain personality characteristics as a person develops over time. Some first-

born siblings develop the concept that others will listen to them and follow their lead. Some second-born siblings may develop personality characteristics of following along with others and not taking the lead. While these are merely examples, family systems theory identifies birth order and gender as a construct in which to view family problems. The last key concept is societal emotional process. This concept incorporates the idea that society interacts in much the same way as a family system. Demonstrated in the aforementioned example, various pieces of society are intricately connected as of that of the family. Family systems theory can help identify an individual's progressive and regressive interactions with their community.

Bronfenbrenner's Ecological Systems Theory integrated with Family Systems Theory can provide a valuable lens in which to view the problems of IPV. While these theories offer a lens to view the IPV problem, Cognitive Behavioral Therapy is a research-based intervention proven to be effective with this population of women IPV survivors, specifically in the areas of Post-Traumatic Stress Disorder (PTSD) and depression. Previous interpersonal traumas continue to effect IPV victims due to PTSD and depression (Iverson, et al. 2011). By treating PTSD and depression the risk for future IPV victimization can be minimized and the cycle of abuse can be interrupted (Ivreson, et al. 2011). Cognitive Behavioral Therapy is one of the most common interventions used to help reduce PTSD symptoms and depression. In the study completed by Iverson et al. (2011), reductions in PTSD and depression through the use of CBT intervention were associated with a decreased likelihood of IPV victimization. CBT attempts to change behavior by identifying the thoughts, feelings, and beliefs that are associated with a specific outcome. CBT is often a chosen intervention because of its effectiveness of

focusing on patterns of thinking and identifying beliefs, attitudes, and values of the IPV survivor.

Cognitive Behavioral Therapy

From a clinical standpoint, Cognitive Behavioral Therapy (CBT) can be useful as an intervention method when treating IPV family systems. Within family systems, there are observations, feedback, and intervention within the structure of the family unit. Patterson (2014) explains the areas where systems and CBT are complimentary. Some of these areas include the structure and organization of the system, contextuality, communication, and homeostasis (Patterson, 2014). Within family systems theory, the family unit is highly organized and can be considered functional or dysfunctional and open or closed. CBT can be utilized as an intervention tool within the family systems theory of women survivors of IPV because CBT involves identifying dysfunctional thinking, connecting them to behaviors, and modifying thinking that is more consistent with desired behaviors as well as its interplay with her immediate social environment (Patterson, 2014).

From an ecological perspective, CBT can be utilized as a framework to understand and utilize the larger social context in treatment. In both CBT and family systems theory, individuals are not seen in isolation but rather as part of an interconnected system that includes the environment in which they live. This is particularly relevant in an IPV situation where women live in extreme social environments that significantly impact their cognitive perceptions as well as behavior aspects. One example of such extreme social environments would be a low income and

high violent crime community. Thinking of both behavior and cognitions nested within family's larger social context is critical to understanding and promoting sustainable second order change. Communication, a target point of CBT's intervention connects it with family systems theory. In family systems theory, communication circularity and feedback loops are present within the family system. Looking at the components of communication, one action elicits the action of another. An example of this might be when the female tries to not do anything to upset her partner so attempts to say very little, the partner thinks that she is being standoffish and communicates with her in a mean tone. Because of the mean tone in communication, the female then says even less in order to avoid an argument. The action of the female influences the actions of her partner and the then the response of her partner influences her actions in return. By looking at communication and the behaviors that are elicited through communication, CBT and family systems align once again. The fourth are of complimentary alignment is through the concept of homeostasis. Homeostasis is an important foundational component of family systems theory and unfortunately, the homeostasis within an IPV situation is often dysfunctional. The perspective and intervention of CBT can support healthy development of a functional homeostasis because the systems-based approach of CBT "inevitably disrupts old patterns and aims directly at achieving a more functional balance within the system" (Patterson, 2014, p. 138). By focusing on some of these correlating components of CBT within the Family Systems Theory Framework, CBT can be a useful and functional intervention to support Family Systems Theory work within IPV survivors.

Family Systems Theory is one way to view domestic violence. Within family systems theory, families are seen as being intricately connected (Murray, 2006). Each

part of the family system, including parental, parent-child, and sibling subsystems affects other parts of the family system. Reciprocal influences have a meaning on every individual member in the family (Murray, 2006). Family theorists believe that there are multiple causes and effects that determine the outcomes of behaviors and actions, this is called circular causality. While one person's behavior may elicit another family member's responsive behavior, then that behavior creates additional behaviors in family members. The causality is not linear within family systems but rather an intricate web with multiple influences. Because of this factor, women in IPV situations must be viewed in relation to the entire family system and other social systems in which she is connected within, as well as outside her family. Within family systems there are also implicit and explicit rules within each family system. These implicit and explicit rules play an important role in the function those specific behaviors play within the system (Murray, 2006). Family theorists would say that the family is an emotional unit and that an individual cannot be understood in isolation from one another. In the same way the survivor of abuse should not be apart but rather nested within the larger system of abuse. Each family member's actions and behaviors contribute to the functioning of the family system and other family member's behaviors, including the violence that is occurring

The system of abuse, as well as, the intergenerational transmission of abuse is easily understood through genograms, a powerful clinical tool in psychotherapy. Genograms allow the therapist to identify key people in the family and everyone's relationship within the family. Therapists are also able to identify key issues, concerns, and repeated patterns within the family system. Family theorists attempt to identify everyone's role within the family. These defined roles can have a huge impact on the

functioning family system. Family system therapists often try to find ways to support the individual to help restore family relationships. This is only possible when looking at the family system as a whole and not the individual in isolation. When looking at the victim in an IPV situation, it is imperative to understand and identify her role within the family whether positive or negative and address the changes from a systemic lens. The targets of change within family systems therapy are the individual in relation to the family, the family as a whole, and creating first and second order change. Therapists look to help individuals make changes and ultimately achieve second order change within their family unit. First order change would be considered superficial changes that don't affect the family system dynamic (Guttman, 1991; Nichols & Shwartz 2005). Second order change is beneficial within the family because it develops a change in the thinking and dynamics within the family system.

Family Systems Theory also provides an understanding that as symptoms of IPV increase, individuals in the family tend to neglect other aspects of their lives (Micucci, 1995). Survivors often abandon other interests and activities as they put more of their effort and focus into the symptomatic person. Survivors may also stop attending activities or participate in other events in hopes of appeasing the abuser, which increases isolation and the potential possibility for sources of support. Likewise, external friends and family members may choose to distance themselves at the same time to avoid problems and conflict with the symptomatic individual. Often, outsiders may not even be aware of the abuse or symptomology at home; however, isolation for the victim is still felt.

Some of the criticism of family systems theory within domestic violence situations are the considerations of power within the family (possibly males having more

power than females), the neutral stance for violent behavior, and how circular causality places blame on the abused person for the abuse. On the same vein, another critique of family systems theory is that it de-emphasized the responsibility of the abuser on the family system. For example, Murray (2006) found evidence that family systems theory inadvertently excuses the violent behavior of the perpetrator because it overly attributes the abuse as we a result of circular causality in the family. Even with these critiques, family systems theory offers insight into domestic violence. Family Systems' theoretical framework and underlying concepts allow the clinician to address the socio-emotional system that underpins, shapes, and sustains any and all dysfunctional family dynamics. Programmatically, this framework program can allow for developers to not only avoid placing blam on the abused person but also avoid deemphasizing the responsibility of the perpetrator (Murray, 2006).

Integrated Model/Perspective

Taken together, the human ecological theory and family systems theory offers valuable insight into the treatment of IPV. Bronfenbrenner's ecological model explains the multiple system levels that can be affected when a woman is in an intimate romantic relationship. Whether the woman is experiencing difficulties within her microsystem, mesosystem, exosystem, or macrosystem, all system levels end up being affected because of the cycle of abuse occurring in her dyadic relationship with her abuser. When looking at the microsystem and the direct interactions and relationships in her social immediacy, the woman's interactions are affected by the intimate partner violence, whether that is with her family, health services, peers, or neighborhood. It is beneficial to keep a Family

Systems Theory perspective when looking at the relationships and interactions at all the ecological system levels as it permits seeing the abuse dynamic in motion. By understanding positive and negative feedback loops, it is possible to see how the various ecological levels become more oppressive for women in intimate partner violence. For example, as a woman become more entangled in an abusive relationship, she often becomes more controlled by her abuser. Limited access to friendships and social connections are frequent due to the abuser's desire for power and control. Women often talk less about their personal lives to friends and co-workers when they are experiencing abuse, which further separates them from this system of support. Because of the circular causality of the violence cycle in her relationship with her partner, a growing sense of entrapment of the women and her children, loss of personal agency, and overall dysfunctional family homeostasis, women are often unable to make the necessary changes within their social context of ecological system that would support a healthy environment. Looking at other aspects of Family Systems Theory such as triangles and emotional cut-off provides insight into why social ecological levels are often affected for women experiencing intimate partner violence. For example, women experiencing abuse may be emotionally cut-off from her family of origin. Triangles are also created within the immediate family system when children are involved by relieving tension between the partners and focusing more energy and time on the children. By looking at and supporting both the family systems theory concepts within the ecological systems theory, women can be supported across multiple ecological levels, increasing support systems and challenging family systems theories to create positive outcomes in their lives. Theoretically, if women can be supported in multiple ecological levels, there is a higher

likelihood for women to see the abuse and have the supports at various levels to make changes for a healthy environment.

Figure 3 depicts how Family Systems Theory is integrated within the Ecological levels as it relates to IPV. This graphic demonstrates that while IPV impacts various ecological levels, the level in which IPV is embedded is within the microsystem. Contributing factors for an individual such as personal mental health concerns, physical health concerns, personal vulnerabilities, age and gender, personal characteristics, personal vulnerabilities, personal resiliencies, and developmental stages all impact the interactions within IPV situations. The microsystem, where IPV is embedded, is where a Family Systems Theory lens can be meaningful. By looking at differentiation levels, intergenerational patterns, family structures, and other aspects within the microsystem, pertinent changes can be implemented to make changes within this system level. The mesosystem, the exosystem, and the macrosystem all have effects on the family struggling with IPV through increased tensions between microsystems, limited access to social services, societal transmissions, as well as many other aspects which oppress women in IPV situations.

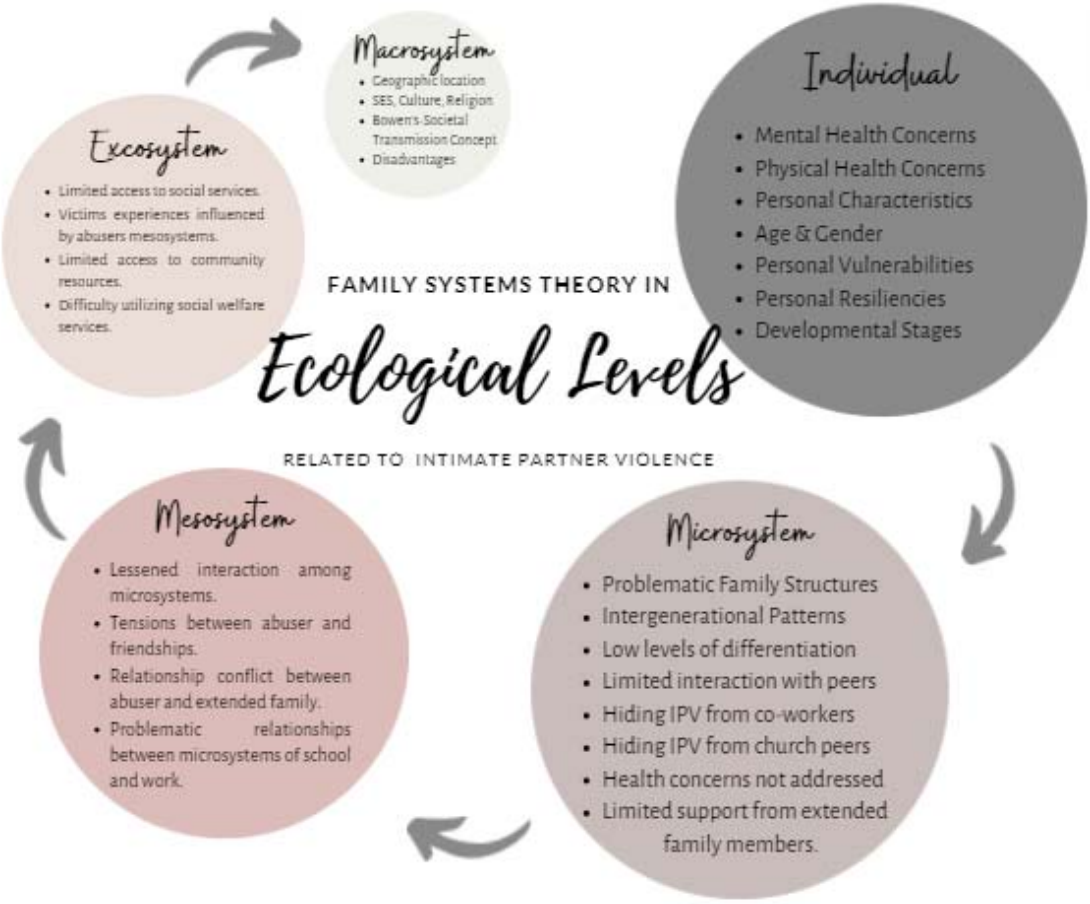


Figure 2. Family Systems Theory in Ecological Levels Related to IPV.

Together, Family Systems Theory and Bronfenbrenner's bioecological theory model work jointly in framing how the various systems in a survivor's life are interconnected within the intricate systems of the family that is nested within the larger social ecology. Within the macrosystem, the chronic anxiety at the societal level (wars, community violence, poverty, lack of education, food and housing insecurity, etc.) contributes to the anxiety and lack of differentiation in the family system. As we know, closed systems that have low differentiation often lead to dysfunctional family systems that may result in violence.

Elements of the REST (Resource, Education, Support, and Therapy) Program incorporate the above integrated model. To address the family system as well as individuals within it, psycho-educational lessons and therapy services that have a Family Systems Theory focus will be modified and applied. Lessons and activities will be developed that incorporate bringing awareness to the interconnected parts of the family system with the larger social ecology. The program will incorporate aspects of Family Systems Theory such as creating and evaluating genograms to help individuals identify intergenerational patterns, birth order, and aspects of family of origin. Lessons will focus on helping the participants understand concepts of family rules and roles and how the roles have come to be established within the family system. Learning about the patterns of interactions and identifying the goals of each person in the system can create awareness of the abusive patterns that the survivor encountered. Through lessons and interactions, subsystems such as children or extended families will be explored. Identification of the organization of the couples' relationship around the violence will be a priority, as well as, how the family responds to certain behaviors from the symptomatic individual. The program will focus on identifying personal levels of differentiation, specifically emotional self-regulation learning to balance individuality and togetherness in relationships (Priest, 2015).

The REST (Resource, Education, Support, and Therapy) program attempts to incorporate therapeutic services, psycho-educational/relational classes, and resource supports in order to address various components of the bioecological systems theory by supporting the women at various ecological levels. Treatment options offered provide support and psychological services to women to help them regain their mental health and

social supports to make choices that are productive to their life and the lives of their children. Providing intensive psychological support and treatment services for women in intimate partner violence situations can have a profound positive effect on the woman and any children within the family. Brofenbrenner's ecological systems theory can help explain the complex layers of interwoven systems that oppress victims of IPV as well as utilize the systems to foster enduring second order family system changes. Family systems theory addresses key concepts within family interactions that continue the violence. Identifying the various systems that impact womens' mental health and social support can provide a valuable framework when working with this specific population. Applying a family systems theory and an ecological systems theory perspective to the concepts of intimate partner violence within all system levels may help to explain and systemically treat the biopsychosocial and larger systemic challenges women face in IPV relationships.

CHAPTER FOUR

METHODOLOGY

Program Structure

The REST Program (Resources, Education, Support, and Therapy) is a combined treatment model that addresses and offers therapeutic services, psycho-educational/relational classes, resource supports, and family therapy to victims of intimate partner violence. According to the World Health Organization (2013), intimate partner violence often leads to Physical Trauma, Psychological Trauma/Stress, and Fear and Control. Physical Trauma could be in the form of musculoskeletal, soft tissue, genital trauma, or other. Physical Trauma would be addressed throughout the program by offering an initial evaluation form identifying the participant's current safety. A safety plan would also be created with this client. Psychological trauma/stress is the mental health issues that affect women in IPV situations. This can include Post Traumatic Stress Disorder, anxiety, depression, eating disorders, or suicidality. Psychological Trauma/Stress is addressed through multiple aspects of the program, primarily through therapeutic services. Psychological Trauma/Stress will be measured through the outcome objectives in this evaluation plan. Finally, Fear and Control may be limited to sexual and reproductive control and healthcare seeking. Victims of IPV may lack autonomy and have difficulty seeking care and other services. Due to fear and control, the victim may also lack a wide range of support at various systems levels. The program and evaluation plan are based on Brofenbrenner's Ecological Theory (Darling, 2007) with a Family Systems Theory foundation. The REST Program attempts to address concerns within the

womens' Microsystem (immediate environment), her Mesosystem (other connections), her Exosystem (indirect environment), her Macrosystem (social and cultural values), and her Chronosystem (changes over time). The evaluation plan attempts to address concerns at multiple ecological levels.

Program Overview

The REST Program (Resource, Education, Support, and Therapy) is a multi-faceted program comprised of four distinct components: Resource Supports (RS); Psycho-educational Groups on Domestic Violence (PG/DV); Support Groups (SG); and Individual Therapy (IP); and Family Therapy (FT), which is supported by a Logic Model. While each component has specific criteria for completion, individuals may access the components of the program based on individual need and individual circumstances. While some individuals may be able to start group psycho-educational classes right away, others may receive individual counseling while they are waiting for a class to open. When a participant is referred or connected to the program, their first point of contact will be with the Service Navigator. The role of the service navigator is to be connected with individual clients and gather background information in order to determine priority needs and services for each client. The service navigator will assist in administering preliminary assessments to help document the client needs through the process of enrollment in the program. The service navigator may also provide crisis counseling if necessary.

Resource support will be provided as needed. The role of the Resource Manager is to review initial assessments and collaborate with Service Navigator in order to connect participants with priority needs. Resource Manager establishes community

connections and discusses options with the participant in order to provide the services most correlated with specific needs. Some women need support and are not ready to make changes in living situation or court procedures at the beginning of the program, while other women need support and resources immediately. It is expected that women complete all the parts of the program (resource supports, psycho-educational classes, support groups, and therapy) prior to attending family therapy. It is the goal of the program to help women regain their own mental health so they can make better decisions while working on their relationships with their family/children. While most components offer fluidity between them, family therapy is the culminating piece of the program to really fully implement the recovery and connection of the program design.

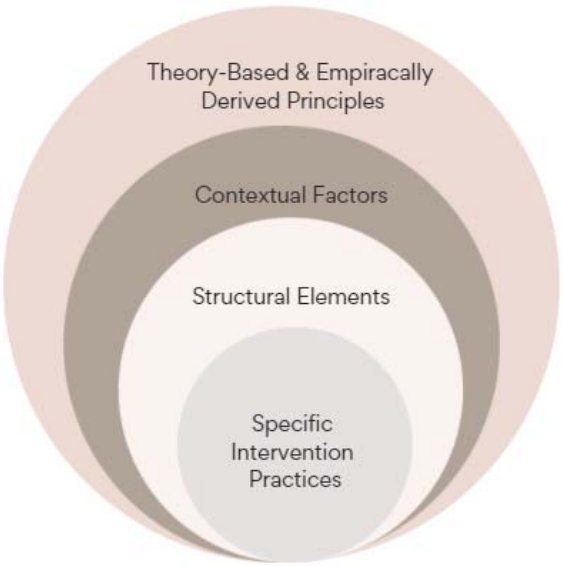


Figure 3. Program Foundations.

The REST program is designed for implementation for domestic violence shelters and therapy centers, which target women who have experienced intimate partner violence

or domestic violence within the household. The program is founded on psychoeducational lessons, individual counseling, case management, and family counseling. The REST program is designed to teach women about domestic violence and help them identify abusive situations, engage in support groups, connect with community resources, as well as provide counseling to women who have experienced trauma from intimate partner violence. It is the goal of the program to help women work through and reprocess past emotional trauma and memories in order to make more adaptive memory networks throughout the healing processes. Women will address negative cognitions that are present from early childhood trauma or from the current trauma of being exposed to domestic violence. Past emotional trauma is believed to cause more harm to women within intimate partner violence as their emotional and mental health continues to decline. Resource supports are an important component of the program because many women, of all education levels, do not know how to take action with the legal system, to find housing, attain employment and childcare, or make changes within the dysfunctional system in which they are living. The REST program incorporates family therapy to involve children who have experienced trauma due to domestic violence to rebuild the family system by establishing healthy rules and roles. As a combination of education, therapy, and resource supports, REST provides women with the information and the recovery resources to make changes to stop domestic violence before intergenerational components contribute to further dysfunction.

Key Interventions

The first key intervention within this program would be psycho-educational

classes. Women need to learn what domestic violence is and the effects it can have on her life and the lives of her children. Education must also address helping women understand they have been part of victimization, learn information about abuse tactics, create and develop safety and survival techniques, and learn to listen to their own intuition (Enache etal., 2019). Often women in intimate partner violence relationships have been putting aside their own needs and desires to keep the peace and not cause any problems that they are unable to know when there are red flags in a relationship. Psychoeducational classes would help women practice and be aware of the important messages her body sends her that she should pay attention to (Czerny & Lassiter, 2016). Part of education is also understanding the abuse tactics and learning to change the unconscious self- talk that may be happening after years of verbal or emotional abuse. Boundaries are another session topic that will be introduced. It is not until women are able to feel safe and secure in their environment can they move forward (Czerny & Lassiter, 2016). Setting boundaries both emotional and physical is one of the first steps in healing.

Psychoeducational classes within this program would attempt to aim for participants to attend a minimum of 8 of the 10 sessions. Individuals would also be able to access the material from the weeks missed if they were unable to attend. Groups for psychoeducational classes would include approximately 8-10 participants. The classes would be closed groups to facilitate client sharing and openness. The group psychoeducational classes would have a trained therapist to lead the curriculum, ask questions, and provide input on each session.

Another key intervention within the program is individual counseling. Research has found that intimate partner violence and poor health outcome for women have a

significant correlation (Walsh et al., 2015). In the study completed by Akyazi et al. (2018), 76.3% of the cases of women were diagnosed with at least one psychiatric disorder. Some of the astounding statistics included approximately half of the participants experienced PTSD. Over half of the women had attempted suicide at least once, with 66% of these individuals attempting suicide after the violence had begun (Akyazi, et al., 2018). As a result of domestic violence, other mental health issues such as depression, fear, anxiety, low self-esteem, sexual dysfunction, eating problems, obsessive-compulsive disorder, and PTSD can occur (Carretta, 2008). For most verbally abused women, after multiple experiences of verbal abuse, many women believe they are worthless (Zosky, 1999). Once women start to believe they are worthless, mental health becomes an even greater concern. Women are unable to make choices that will keep them and their children safe because their mental health is so impacted. Many women even have suicidal thoughts and want to give up on living all together. Prolonged exposure to domestic violence situations often has more significant effects on the woman's mental health. Treatment support and intensive psychological services for women would result with women regaining their mental health and making choices that are productive to their life and the lives of their children. Providing intensive psychological support and treatment services for women in domestic violence situations can have a profound positive effect on the woman and any children within the family and hopefully stop the intergenerational cycles that otherwise continue.

While each participant comes to the table with their own unique story and situation, it is the goal of this program for women to regain their mental health. While EMDR (Eye Movement De-Sensitization and Reprocessing) may not work for every

single survivor, it is suggested to be the first option used with domestic violence victims within this program. This form of therapy helps clients to access and process traumatic memories into adaptive memory pathways (Shapiro, 1989). EMDR is specifically useful for domestic violence victims because it helps them attune their awareness to feelings within their body. EMDR has also proved to be more effective than active listening or relaxation therapy, or no treatment (Maxfield, n.d.). Because women experiencing intimate partner violence often have symptoms of PTSD, it has been the chosen primary method of therapy for this program. PTSD symptoms were reduced dramatically in a study that used EMDR as the treatment method (Maxfield, n.d.). EMDR also allows clients to access memories that are early on in their life and reprocess those memories into adaptive networks. Individual counseling using EMDR is striving for true healing of domestic violence survivors. Another study showed that "psychological treatment designed to address women's mental health needs and promote access to resources would significantly reduce women's IPV victimization over time" (Miller, Howell, & Graham-Bermann, 2014). Individual counseling is imperative as it provides a plethora of positive effects including increasing assertive communication skills, positive self-talk, stress management, improvement of self-care, developing positive cognitions, awareness of behavioral patterns, and reduce the sense of responsibility for others' behaviors (Enache, et. al., 2019).

Individual counseling would be completed by a licensed therapist that is trained in EMDR therapy or trauma therapy. Participants would be expected to participate in individual counseling after or concurrent with psycho-educational courses. Woman may complete individual counseling during psycho-educational courses if desired or if

currently seeking crisis intervention. Individual counseling may vary for each participant and a set number of sessions would not be designated within the program.

The third phase of the program would be resource support meetings. This phase would incorporate connection and resources. Resource support meetings may be completed by someone who is a survivor of Intimate Partner Violence. Someone who has had similar experiences can be a valuable resource in ways to access support groups, community resources, and court system procedures. Advocacy efforts can also help survivors change their past experiences into 'opportunities to make a difference in the lives of others" (Murray, King, Crowe, & Flasch, 2015). "Survivor advocacy has the potential to be a therapeutic, empowering experience for clients" (Murray, et.al., 2015). While this phase of the program may be tailored more to meet the individual needs of the client, each client will be set up with a point of contact for resource support. Advocacy and resource support would be available to ask questions, provide community resources, connect to other local support groups, access information for the court system, and be a connection to the survivor who often feels they are alone in this process.

In closing, the four phases of the program are psychoeducational group class, individual counseling, resource supports, and family therapy. This program is structured following Herman's (1992) multistage model of recovery for trauma as occurring in three stages: establishing safety, remembrance and mourning, and reconnection (Johnson, Zlotnick, & Perez, 2011). The psychoeducational classes focus on physical and emotional safety as is the first tenant of Herman's (1992) recovery model. Remembrance and mourning are completed in the second phase of individual counseling; however, participants also get to move a step farther and reprocess any negative cognitions and

beliefs. The third and fourth phase offers connection through the resource support opportunities and family therapy. Participants have access to a point of connection through resource support meetings, which also has multiple resources available to assist the participant in reaching their individual goals for progress and change within their lives. These key interventions are the foundation for a program that aims to provide lasting positive changes for survivors of domestic violence.

Demographics

The target population for this evaluation is women, ages 18 and older, which are identified as either currently experiencing or previously experienced intimate partner violence, severe intimate partner violence, current intimate partner violence, or prior intimate partner violence

The demographic region for this evaluation is expected to initially start in the southern California region, particularly in the San Bernardino and Riverside counties. It is hopeful that the program development can eventually offer an online component for therapeutic services, psycho-educational/relational classes, and community supports. Online access would be significant for this target population because of the typical lack of access to outside support due to the perpetrator's power and control over the victim. Exclusion criteria for this program includes males, anyone under the age of 18, women victims experiencing suicidality, and non-English speaking.

Population – Inclusion/Exclusion Criteria

The population that the REST Program would serve includes women who either

are currently experiencing domestic violence/intimate partner violence or women who have previously been subjected to it. Inclusion criteria would be women of adult ages (age 18 or older) who have experienced or previously experienced domestic violence. While domestic violence does also have women perpetrators and male victims, it is the goal of this program to build trust and community among women victims. Exclusion for this program for the target population is male, anyone under the age of 18 years old, female victims experiencing suicidality, and non-English speaking individuals. The targeted women within this population would be expected to attend the educational sessions, individual therapy, resource support meetings, and family therapy. The REST Program individuals may be recommended to the program in the middle of the pscyhoeducational class sessions, they will be required to wait until a new class form to participate in psychoeducational classes. Individuals can access Individual Therapy and Resource Supports at any point throughout the program. Individuals may be put on a waiting list if space is not currently available for classes.

Participation and Implementation

Participation from group members would be expected for women attending the psycho-educational groups. It would be expected that the women complete all 10 weekly sessions including activities. If there is an emergency and a missed session occurs, the participant can receive the information and complete the activities independently for up to one session. Individual therapy is required for approximately 10-session at 45 minutes per session. If the therapist and participant agree that less than 10 sessions are adequate, adjustments can be made. The program recommends 10 sessions at minimum to address

past trauma and any current trauma. Resource support meetings offer three, one-hour long sessions with a support staff to ask questions about procedures, court regulations, resources, housing, and job opportunities. Resource support is a requirement for a staff member to learn about the participant and the unique situations of each case. Resource support is one aspect of the program that can be a change agent in the system to help bridge connections and community resources that will last long beyond the program. Lastly, family therapy is the final stage of the program. Family therapy is greatly dependent upon each individual case. While some families may be ready to complete family therapy after completing the other components of the program, other families may need a length of time before they are able to participate. Depending on the situation, the abuser may or may not be involved in the family therapy. Some suggestions for family therapy include PCIT, CPRT, and Circles of Peace. Therapists may work with families depending on the needs of each family.

Feasibility and Funding

The R.E.S.T. Program is one that is designed to be integrated into already established shelters or domestic violence organizations. Looking at the five areas of feasibility in relation to the program, the R.E.S.T. Program is a strong option to integrate and house within an already established organization. The first area of feasibility is the technical component and whether this program is technically possible. The program has few technical requirements. It would be beneficial to have access to a handful of computers or tablets for assessment ease. Online support groups would also be developed through a web-based system. In terms of economic feasibility and whether or not the

project can be afforded would be discussed through the percentage of therapist and staff time that must be taken into account to run the program. To run a single cohort, three times over the course of the year, it is estimated to take approximately 35% of the already staffed therapist's workload. Established organizations and shelters could consider if it would be beneficial to add a therapist to their organization and run two simultaneous sessions if there is enough interest in the program. Additional staffing time would be necessary from the organization in regards to scheduling and tracking both attendance and assessment data. By incorporating a program that has multiple measures of assessment across multiple life domains, funding opportunities for shelters and organizations are increased due to established program effectiveness and reliable data. Legality is another feasibility aspect; however, since the R.E.S.T. Program would be housed within an already established organization many legal components would fall under the parent corporation. Program staff would follow all confidentiality guidelines as expected by state licensing board. Operational components are considered by defining and developing a plan to create shared spaces for program operations. While therapists may already have designated space to run therapy, coordination of group therapy/psycho-educational class rooms will be necessary in order to avoid overlapping/overbooking available space. This component also looks into scheduling both of physical spaces and personnel necessary to run the R.E.S.T Program.

Specific assessment measures were chosen in order to create comprehensive data about the effectiveness of the program for funding purposes. The R.E.S.T. Program is intended to be incorporated into not-for-profit organizations. All efforts will be made when in collaboration with organizations to have copies of their 501(c)3 IRS

Determination Letter to make sure the considerations for eligibility are present. The R.E.S.T Program is an ideal way to access many grant opportunities because of the population it is serving, as well as the topic of intimate partner violence and mental health wellbeing. This program also addresses solutions and interventions for a widespread epidemic problem in many communities. Because many domestic violence organizations are already grant funded or grant supported, there is most likely a team of knowledgeable experts that can use the comprehensive data from the program to refine additional grant opportunities. Many other aspects of grant funding necessities will already be in place within the parent organization such as the board of directors, IRS 990 tax return, financial statements, operating budget, and year-end financial statement. By utilizing the program outcomes and assessment procedures listed in the program, staff are able to identify if program objectives and goals have been met. Identifying and portraying this multiple measure assessment data to funders provides evidence on how the target populations' lives will be better because of the implementation of the R.E.S.T. Program.

Resource Supports

All individuals involved within the REST Program would receive resource support (RS) meetings with staff. Frequently, women in intimate partner violence situations feel alone and unsupported while trying to make changes within their life. Resource support meetings would attempt to provide information and guidance to women needing additional information about the legal system (especially if children are involved), housing, job opportunities, childcare, and food resources. Having someone available to ask questions and provide insight on how the court system typically handles

situations may be the deciding factor for women to leave. Understanding and being given small pieces of guidance through advocacy services may provide enough support for women to leave the domestic violent situation in which they are living.

This component would incorporate connection and community resources. Resource support meetings may be facilitated by someone who is a survivor of Intimate Partner Violence themselves who has completed additional training. Someone who has had similar experiences can be a valuable resource in ways to access support groups, community resources, and court system procedures. Advocacy efforts can also help survivors change their past experiences into opportunities to give back to the community in a meaningful way while making the difference in the lives of women (Murray et al., 2015). "Survivor advocacy has the potential to be a therapeutic and empowering experience for clients" (Murray, et.al., 2015). While this aspect of the program may be tailored more to meet the individual needs of the client, each client will be set up with a point of contact for resource supports. Facilitators of resource supports would be available to ask questions, provide community resources, connect to other local support groups, access information for the court system, and be a connection to the survivor who often feels they are alone in this process. Women would also feel supported by being educated on government benefits that may be available to them. Many women are unaware of the benefits and services that they have access to. Resource support meetings would provide a minimum of three, one-hour sessions to discuss each participant's individual and unique situation. Additional resource support sessions may be considered on an at-need basis. The goal of resource support is to help connect women with other agencies and community resources that are available that will provide support long after

the participant has completed the program.

Psycho-Educational Groups

Within the psycho-education/personal growth groups there will be a limit of 8 to 12 participants to easily facilitate personal discussions, reflection, and follow recommendations for beneficial group size (Gladding, 2012). The psycho-education groups are closed groups to facilitate authenticity and trust among group members. A closed group format was also developed into the design of this program to build relationships and establish trust and rapport between participants. The therapist leads discussions and activities, which includes a 10-week curriculum that meets once a week. The psycho-educational groups would focus on multiple aspects associated with intimate partner violence and mental health.

Education must also address helping women understand they have been part of victimization, learn information about abuse tactics, create and develop safety and survival techniques, and learn to listen to their own intuition (Enache, Matei, & Tusa, 2019). Often women in intimate partner violence relationships have been putting aside their own needs and desires to keep the peace and not cause any problems. Being in these types of stressful situations makes it difficult to identify the red flags in relationships. Psycho-educational classes would help women practice and be aware of the important messages her body sends her that she should pay attention to (Czerny & Lassiter, 2016). Educational aspects also focus on understanding the abuse tactics within the relationship and learning to change the unconscious self- talk that may be happening after years of verbal or emotional abuse. Participants would learn and practice creating health

boundaries in relationships. Boundaries are necessary to create a safe and secure environment for the victims of IPV. It is not until women are able to feel safe and secure in their environment can they move forward and heal (Czerny & Lassiter, 2016). Setting boundaries that focus around emotional and physical aspects in the relationship is one step women learn to take in the healing process.

Lessons may include defining domestic violence/intimate personal violence, the effects of domestic violence on individuals and children, the cycle of violence, legal aspects of domestic violence, denial and red flags, learning what a healthy relationship looks like, creating boundaries and a safety plan, and planning for the future. Psycho-educational classes within this program would attempt to aim for participants to attend a minimum of 9 of the 10 sessions. Individuals would be able to access the material from the week missed if they were unable to attend. Groups for psycho-educational classes would include approximately 8-12 participants. These closed groups could start four times per year and adjust depending on the need and funding. The group psycho-educational classes would have a trained therapist to lead the curriculum, ask questions, and provide input on each session. Participants in the groups will be able to share personal experiences if willing. Sharing stories and listening to others in the group fosters personal awareness and self-reflection. Women also can find support through others who can easily relate to difficult domestic violent situations. Group members will also participate in therapist lead activities to foster learning and awareness of each lesson. The psycho-educational groups will be once a week for two hours a lesson.

Support Groups

The R.E.S.T. Program offers bi-weekly support groups for women to come together and participate in a social setting. Women are able to build relationships and connections with others while sharing information they may have identified. Being able to start building a social network is extremely important in the womens' healing process. Relationships can be built between cohort groups and allow participants to find others who would be willing to attend community events together. The program provides resources that are available through the community, churches, other local organizations; however, it may be difficult for women to take that initial step alone. By fostering these relationships, women have others who support and facilitate taking steps to be further connected in the community. Depending on the cohorts that choose to attend the support groups, some women may be more experienced in accessing the community supports and provide their knowledge to new participants of the support group. Participants also have access to an online support group of women who have completed the program. This is suggested to be contained to local regions of program implementation. Women will have access to communicate with other women about resources, building friendships, or even just sharing in life's accomplishments. Creating a shared space online that is not labeled as a domestic violence group, offers safety while also providing opportunities for meaningful friendships and connections.

Individual Therapy

The second component of the REST Program is individual therapy. Research has found that intimate partner violence and poor health outcome for women have a significant correlation (Walsh et al., 2015). While individuals may have received counseling and therapy in the past, therapy throughout this program will be implemented to specifically address past trauma. One suggested method to utilize within the program is Eye Movement Desensitization and Reprocessing (EMDR) because it has been proven to be extremely effective with individuals experiencing Post-Traumatic Stress Disorder (PTSD) (Yaggie et al., 2011). This form of therapy helps clients to access and process traumatic memories into adaptive memory pathways (Shapiro, 2018). Women who either currently experience or have previously experienced Intimate Partner Violence often exhibit PTSD. EMDR enables individuals to heal from the symptoms and the emotional distress of past traumas (Shapiro, 2018). EMDR does not use "traditional talk therapy, but instead relies on the individual's rapid, rhythmic eye movements to lessen the disturbance of the emotionally charged memories or traumatic experiences" (Shapiro, 2018). EMDR also attempts to build adaptive memory networks and turn negative cognitions into positive cognitions. Women within the program would be expected to start with a minimum of 10 individual therapy sessions focused on addressing past or current trauma. It is the goal of individual therapy to clear out past traumatic events and build adaptive memory networks and healthy cognitions. Through EMDR or trauma therapy the intent is to establish Adaptive Memory Networks, so women can heal and

recover from past traumatic experiences (Shapiro, 2018). It is also imperative for women to engage in individual therapy to process through emotions and past experiences that have become normalized within their own emotional distress. Healing from past trauma is the beginning of recovery and being able to heal to make healthier choices.

EMDR therapy requires therapist certification before administering the EMDR techniques. Additional training may be required for completing EMDR sessions with women who are still currently experiencing domestic violence traumas; however, EMDR is recommended specifically because of the success experienced for individuals with PTSD. Participants can participate in individual counseling at any time throughout the program. Women may complete individual counseling during psycho-educational courses if desired or if currently seeking crisis intervention prior to attending the classes. If EMDR is not appropriate for a specific participant, an alternative individual therapy technique will be used to address past trauma.

Family Therapy

The last component of the REST program is Family Therapy (FT). The focus of family therapy is the development of attachment problems that occur between parent and child throughout domestic violence situations (Levendoskyet al., 2011). The program recommends Parent-Child Interaction Therapy (PCIT) as the starting point for family therapy if there are behavioral concerns with children in the family. Young children who are exposed to domestic violence often exhibit extreme behaviors. PCIT attempts to address behavioral needs of children in two phases: by developing a relationship and helping the children feel calm and secure and by managing the behaviors while remaining

calm, confident, and consistent (Lieneman et al., 2017). Additional certification and training is necessary to administer PCIT. Other suggested family therapy could include an attachment-based therapy model called *Child-Parent Relationship Therapy (CPRT) Treatment Manual: A 10-Session Filial Therapy Model for Training Parent* (Bratton et al., 2006). This therapy also requires additional certification and training to teach the model. CPRT is recommended for children presenting with behavioral, emotional, social, and attachment disorders, which tend to be common for children exposed to domestic violence. CPRT can be an option when group family therapy is possible. This therapy is based on the concept that the relationship between parent and child is extremely important. The goal is to increase communication, positive interactions between parent and child, and to help parents learn to enjoy parenting. Often parent-child relationships are neglected when mothers are involved in domestic violence and this therapy can help repair and rebuild the connection between parent and child while fostering a secure attachment. Other family therapy models can be used at the discretion of the therapist. 'Circles of Peace' is a program that may be utilized if it is possible in logistics and safety for the abuser to attend therapy. 'Circles of Peace' uses a restorative justice circle approach in therapy which attempts to repair the harm that was caused by the abuse (Ortega et al., 2016). 'Circles of Peace' should be used with caution at the discretion of the therapist and the participant, making sure that it would be safe to consider this therapy model. Other family therapy models may include the participants' parents if the victim does not have any children. Often extended familial relationships are strained when domestic violence occurs. Working with a family systems lens to re-establish the roles and rules within the system would be helpful in rebuilding family relationships.

The therapy model used for family therapy will be at the discretion of the therapist; however, some research-based therapies have been suggested within the program. Family therapy attempts to reconnect parent and child relationships that may have been harmed throughout the trauma. Triangulation often occurs due to the tension between the husband and wife. Working with a therapist to identify this triangulation in hopes of changing the dynamic is important. If children are not involved, it allows the participant to rebuild relationships that may have been damaged due to domestic violence and make connections with other family members such as parents or siblings. Family therapy also provides continued support for families that can make positive, healthy changes and decide to stay together.

Logic Model

This logic model shows the necessary components of the REST program. It is the ultimate outcome goal of this program for women and children to no longer live in domestic violence situations, whether it is changes within their current situation or whether women choose to leave the relationship. To get to this outcome objective, education, therapy, and support are needed as women learn how to survive and regain their mental health. Women are often trying to just survive and not cause any tension in the relationship and often feel very alone. The REST program offers support through closed group sessions, individual therapy with focusing on past trauma, resource supports to help with community resources and supports for women, and family therapy to help rebuild connections and relationships with children or other family members.

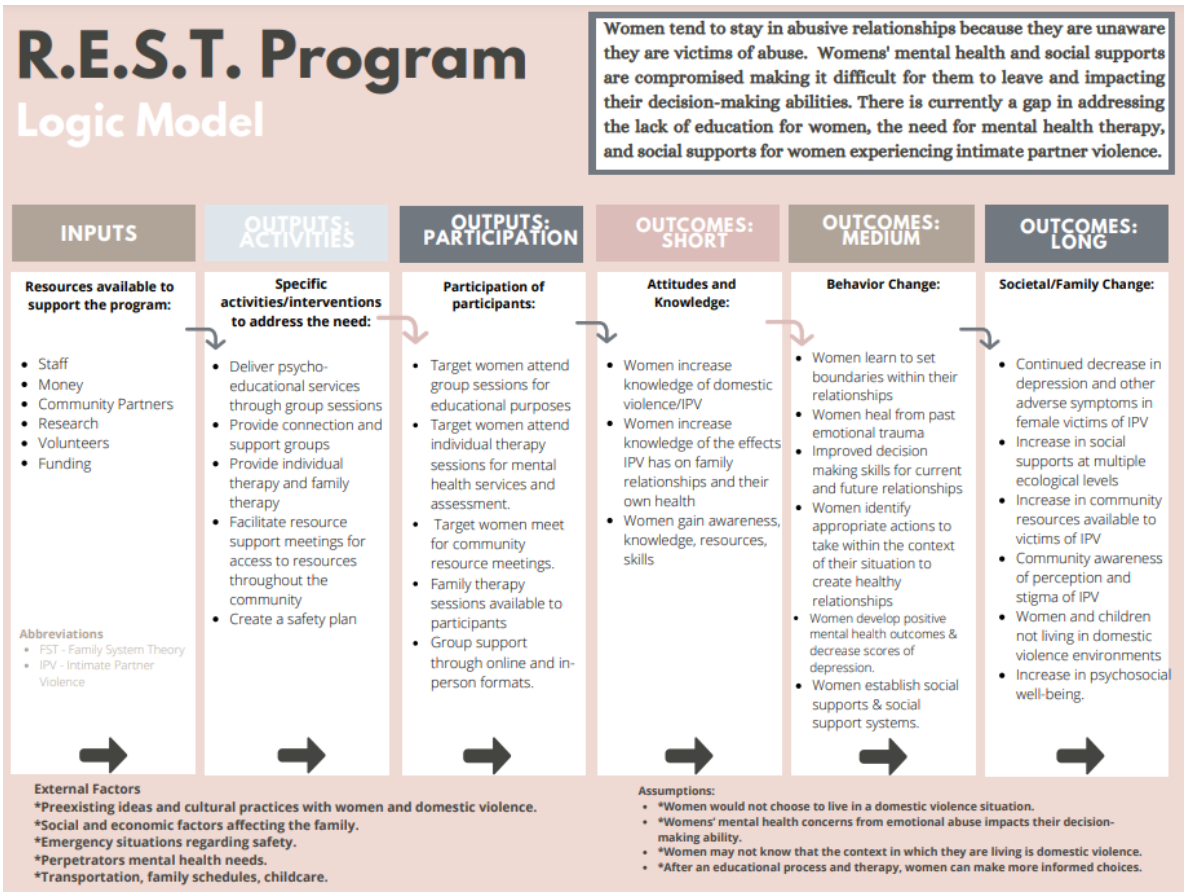


Figure 4. Logic Model.

The logic model of the REST program identifies the outcomes of the program, including the psycho-educational classes, group sessions, support groups, individual counseling/therapeutic services, safety plan, and community resources. The participation is listed within the logic model. Some of the short outcomes within the program include increasing womens' knowledge of intimate partner violence/domestic violence, increasing womens' knowledge of the effect it has on children and their own health, helping women create healthy boundaries, helping women heal from past emotional trauma, and to gain resources, knowledge, and skills. The medium outcomes for the program are to improve awareness of domestic violence and depression, improve

decision making skills for current and future relationships, identify appropriate actions that can be taken within specific situations, and developing positive mental health outcomes and social supports. The long-term outcomes are to decrease the number of women living in domestic violence situations (this may be either the women have learned to create healthy boundaries and the situation in the home has changed or the woman may have left the abusive situation). The second long-term outcome goal is to decrease depression in women who have experienced IPV while increasing her social supports and resources. It is the goal of the REST program to have lasting changes within families and individuals. The model attempts to help victims heal from both past and current traumas to create healthy lives of those who participate in the program.

Theory of Change

The conceptualization of this problem is the continual perpetuation of intimate partner violence because women are not aware that the situation, they are experiencing is considered abuse. Other women may understand that they are living in an abusive situation but do not have the resources or support available to leave. Many women may know about physical abuse; however, they are not aware of emotional, verbal, and economic abuse. The health effects, both physical and mental, that are associated with living under these conditions are many. Intimate partner violence perpetuates because of womens' lack of education about the topic, lack of resources and support, other factors such as cultural and religious viewpoints, and the lack of second order change within the family system.

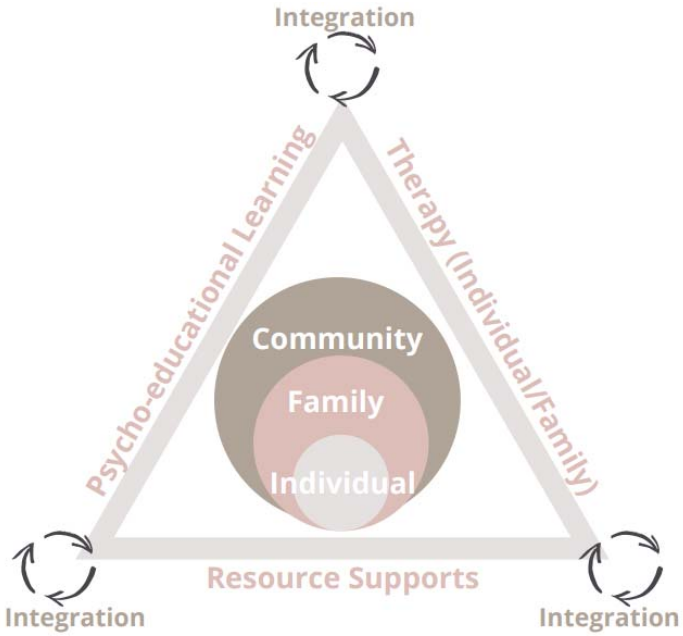


Figure 5. Theory of Change.

The theory of change within this program is to develop womens' education and supports to create a first order change prior to creating a second order change. With this first order change of regaining womens' mental health, building up support systems and treatment options, second order change can be made possible. The rules of interaction within intimate partner violence situations will not be positively disrupted if the woman's mental health is so significantly impacted from the abuse. Only once a woman regains her mental health and has the supports, she needs can she go into the IPV situation and uphold new rules of interaction. Homeostasis for domestic violence is one that is dysfunctional. There is often a great deal of negative feedback loops from the system to bring the system back to the comfortable way of doing things. Once a woman has been educated about what abuse is and how it affects her and her family, she can then provide positive feedback loops within the system to initiate new rules of interactions. Certain

behaviors from the perpetrator will no longer be acceptable within the family system. She may even have a 'line drawn in the sand' (theoretically) if certain behaviors occur then she will leave. Because of her mental health and clarity, along with the educational component and supports/resources available, she can make more informed choices for her and her family. Second order change is imperative in this situation because if the woman has regained her mental health but then enters back into the same system, it is likely that her mental health will decline again. Establishing a new 'normal' and new rule of interactions and boundaries is imperative to systemic change for domestic violence. Women also need their mental health and education in the future if they choose to enter a healthy relationship and not continue to repeat patterns. Even if the perpetrator isn't on board enough to receive mental health services himself, if the woman is able to establish new rules for the system there is a chance at creating a new functional homeostasis within the family system. If a new homeostasis is not found, it is likely that the system will break. This may lead to the family breaking apart, but it also might be the only solution to keep all the members of the family safe.

The purpose of the theory of change is to educate women and help them regain their mental health to have first order change. With this regained mental health, education, and support, it is the primary goal to create a second order change within the family system. Even though it is known for victims to return to the abuser multiple times; it is the hope of this theory of change that the woman will tolerate less and create more healthy boundaries with the abuser. The ultimate outcome would be either to create a new functional homeostasis with new rules of interaction or for the woman to leave the intimate partner violence and build a new, safe way of living.

Process and Outcome Objectives

In order to determine if the program is doing what it is intended to do, process goals have been developed. The process goals for the REST program include two goals related to program implementation. The first goal is to implement the sessions for the program as directed in the manual. Objective for this goal would be by the end of Year 1, 100% of participants (in fully completed groups) complete the educational reading material, the ten psycho-educational group sessions, a resource support meeting, and an individual therapy session. The second process goal is to use the curriculum and assessment measures as directed by the program manual. The objective for this goal is by the end of Year 1, 100% of participants who have entered the program, with enough time to complete in entirety, have been given ten session/packet materials as indicated by program manual and taken all performance and outcome evaluation measures as indicated in the program manual.

The performance goals for the REST program include two primary goals in the areas of psycho-education and advancement in knowledge, decreasing depression, and increasing social supports. Goal one is to increase the knowledge base and education of participants in Intimate Partner Violence. The objective for this goal is by the end of Year 1, participants will increase their scores and conceptual understanding on the knowledge-based assessments by 75%. Goal two is to provide resource support meetings and individual/family therapy to all participants in the program. The objective for goal two is by the end of Year 1, 75% of the participants enrolled in the REST program will decrease their scores on the BDI while increasing their scores on the MOS-SSS Surveys.

The outcome goals for the REST program include two primary goals in the areas

of psycho-education and the advancement in knowledge and in the areas of decreased depression and increased social supports. A third indirect outcome goal is in changing societal perception and stigma. Outcome goal number one is to increase overall education and knowledge-base of participants in the REST program. The objective for this goal is by the end of Year 1, participants in the program can pass the intimate partner knowledge curriculum with 80% accuracy. Goal number two is to decrease participants' depression while increasing social support at multiple ecological levels. The objective for this goal is by the end of Year 1, 85% of participants who have completed the program will have a decrease in score on the Beck Depression Inventory and an increase on the MOS-SSS Survey. The third indirect goal is to create and promote social justice and public awareness of intimate partner violence by changing the perception and stigma associated with IPV through increasing social support and connections of victims. The objective for this goal is by the end of year 1, the REST program will increase community partnerships for victims by 50%. By incorporating multiple measures, the program is able to determine effectiveness through outcome goals that demonstrate a decrease in symptoms while creating positive outcomes for the participants.

Evaluation Measures

The evaluation measures chosen for this project include Implementation /Process Evaluation and Outcome Evaluation. The implementation/process evaluation is a quantitative measure of identifying adherence to the program standards, dosage (number of psycho-educational classes and therapeutic sessions attended), quality of delivery, participant responsiveness, and program differentiation. The information gathered from a

survey for implementation evaluation would be considered quantitative. When identifying the participant responsiveness and the program differentiation, a mixed methods model would be utilized to obtain qualitative data for informational and evaluative purposes. Another component of the implementation/process evaluation is identifying the material/curriculum used and determining if the participants are comprehending the material, personalizing the material, and retrieving the material when needed. At the beginning of each psycho-education class there will be a pre-test to identify prior knowledge on the topics being covered in that class session. At the end of each class session there will also be a post-test to help identify gained knowledge from the psycho-educational lesson. This evaluation piece is partially used as an intervention to help participants be cognizant of the topics and areas of concern on the tests. Psycho-educational lessons will teach participants multiple components about intimate partner violence. Within the psycho-educational lessons there are pre/post-tests that address the 10 topics covered over the 10 weeks.

Additional process evaluations would include the Vulnerability and Mental Health Scale (VMHS). This scale is modified from the Abusive Behavior Inventory (ABI), the Depression, Anxiety, and Stress Scale (DASS), and incorporates questions relating to the 'Cycle of Violence'. This measure would also be imperative to give at the beginning of the program and at the end of the program. The questions about mental health and the Cycle of Violence help women be aware of behaviors that fall into these categories. An example is reading the questions about whether the participant feels like they are walking on eggshells may help the participant understand that is not a feeling that would be present in a healthy relationship.

The second area of evaluation within the REST Program is the outcome evaluations. The outcome evaluations attempt to determine if the program met its overall goals and objectives. The primary goals of the REST Program are to decrease depression and increase social supports and community resources for women in Intimate Partner Violence. To decrease depression, the program offers psycho-education, resource supports, and therapeutic services. Social supports are addressed through the program's use of social groups within the psycho-educational classes, and community resources. The primary evaluation measures that are utilized to determine if the outcome goals have been met are the BDI (Beck Depression Inventory) (Appendix B), the SF-36 (36 Item Short Form Survey) (Appendix B) and the MOS-SSSI (Medical Outcome Study – Social Support Survey Instrument) (Appendix B).

Depression was the measure chosen to indicate outcomes of the program through the BDI and the SF-36 because it is a significant and prevalent factor for women in intimate partner violence. According to NCADV (2015), seven out of ten women who are psychologically abused, display symptoms of PTSD and/or depression. Depression has a significant effect on the victim of IPV and her immediate environment, including her family, her children, and others that live with her. Depression also affects the victim and the way she interacts, or lacks interaction, with other systems she is connected. She may have less interactions in her mesosystem and not seek outside activities whether it be physical exercise, church activities, or social engagements. The victim's interactions with her exosystem and macrosystem may also be impacted by depression as she has less desire to interact with her indirect environment. Perceptions of social and cultural values may change due to the depressive state the victim experiences. Measuring depression at

the entrance of the program, midway through the program, and at the end of the program can provide information on the program's effectiveness and the progress of the participant. The BDI is a quick measure to get quantitative information about the participants' level of depression (Kroenke et al., 2001). The SF-36 was a tool specifically chosen to measure symptoms in women because of the ability to look eight health domains. The SF-36 can give evaluative data on the participants' physical function, bodily pain, vitality, role-emotional, role-physical, general health, social function, and mental health. By monitoring this information at the beginning of the program and at the completion of the program, it is possible to determine the program effectiveness and the impact on participant lives in multiple areas.

The MOS-SSSI and the SF-36 were the measures chosen to indicate outcomes of the program in relation to social support and community supports (Moser et al., 2012). These areas are addressed through the program by incorporating psycho-educational classes about healthy relationships and unhealthy relationships, red flags, boundaries, etc. Therapeutic services may also address social supports that the victim may be lacking and address underlying reasons why this may be happening. Through the therapeutic process, participants are expected to work on past trauma. Therapy can help with facilitation of mending familial relationships that have been damaged due to factors of IPV in order to build or re-build social supports for the participant. Community support is specifically implemented within the REST Program to facilitate interactions between the victim and the systems beyond her microsystem. By working with the program facilitators, the participant can access community resources in a variety of ways, including financial assistance, employment assistance, connections to faith/religion groups, support groups,

exercise and physical well-being activities. Offering and connecting women to activities and community supports can be the change agent for creating and developing social supports for women in IPV situations. The MOS-SSSI was chosen as the outcome evaluation measure for social support because it identifies supports in four areas: 1. Emotional/Information Support where the victim receives empathy and encouragement through situations, 2. Tangible Support where the victim may receive behavioral help or monetary assistance, 3. Positive Social Interaction where the participant has outside interactions that are positive, and 4. Affective Support where the participant receives expressions of love and affection from another individual (Moser, et. al., 2012). The MOS-SSI is a scale that easily contributes to the ecological framework of the program and evaluation because it looks at social supports that are within the participants' microsystem, mesosystem, and exosystem. The participant is also asked questions about tangible support that could be coming from a macro level of government assistance. Many system levels within Brofenbrenner's ecological model can be addressed through the MOS-SSI.

Timing

The timing for the evaluations varies depending on whether they are process/implementation oriented or whether they are outcome oriented. For the purposes of this program the process evaluations would be taken at different intervals depending on what they are measuring. The pre and post tests would be brief 5 minute or less questions at the beginning and end of each psycho-educational class session. The satisfaction and engagement questionnaire would be completed once at the end of the

program. The program will be different lengths for different participants, depending on the number of therapeutic services and community resources that are necessary for each participant in addition to the psycho-educational classes. At the end of the program, the participant will be emailed an exit survey, asking questions about satisfaction and engagement. It would be the goal of the program to complete quarterly focus groups for participants that have exited the program. For participants that have exited the program early, a shortened version of the exit survey will be emailed to the participant to determine the reason for leaving. Information from the early exit survey will be crucial for making any possible changes to reduce the rates of non-completion of the program.

The outcome evaluations will be completed at the beginning of the program and serve as a baseline measure of the participants' depression and social support. The same measures (BDI, the SF-36, and the MOS-SSI) will be administered once the participants have completed half of the psycho-educational classes and at least one therapeutic session. The last administration of the BDI, SF-36, and the MOS-SSSI will be completed once the participant has completed all ten psycho-educational classes and at minimum two total therapeutic sessions.

Pre and post tests for curriculum measures will be brief paper and pencil tests at the beginning and end of each psycho-educational class. All other surveys will be emailed to the participant so they will be able to take the questionnaire or survey at their own convenience and on their own device (smartphone or computer). Surveys and questionnaires will be formatted to utilize Qualtrics to compute and analyze the data compiled from the surveys. Participant email addresses and phone numbers will be collected during the program registration to facilitate survey distribution through email.

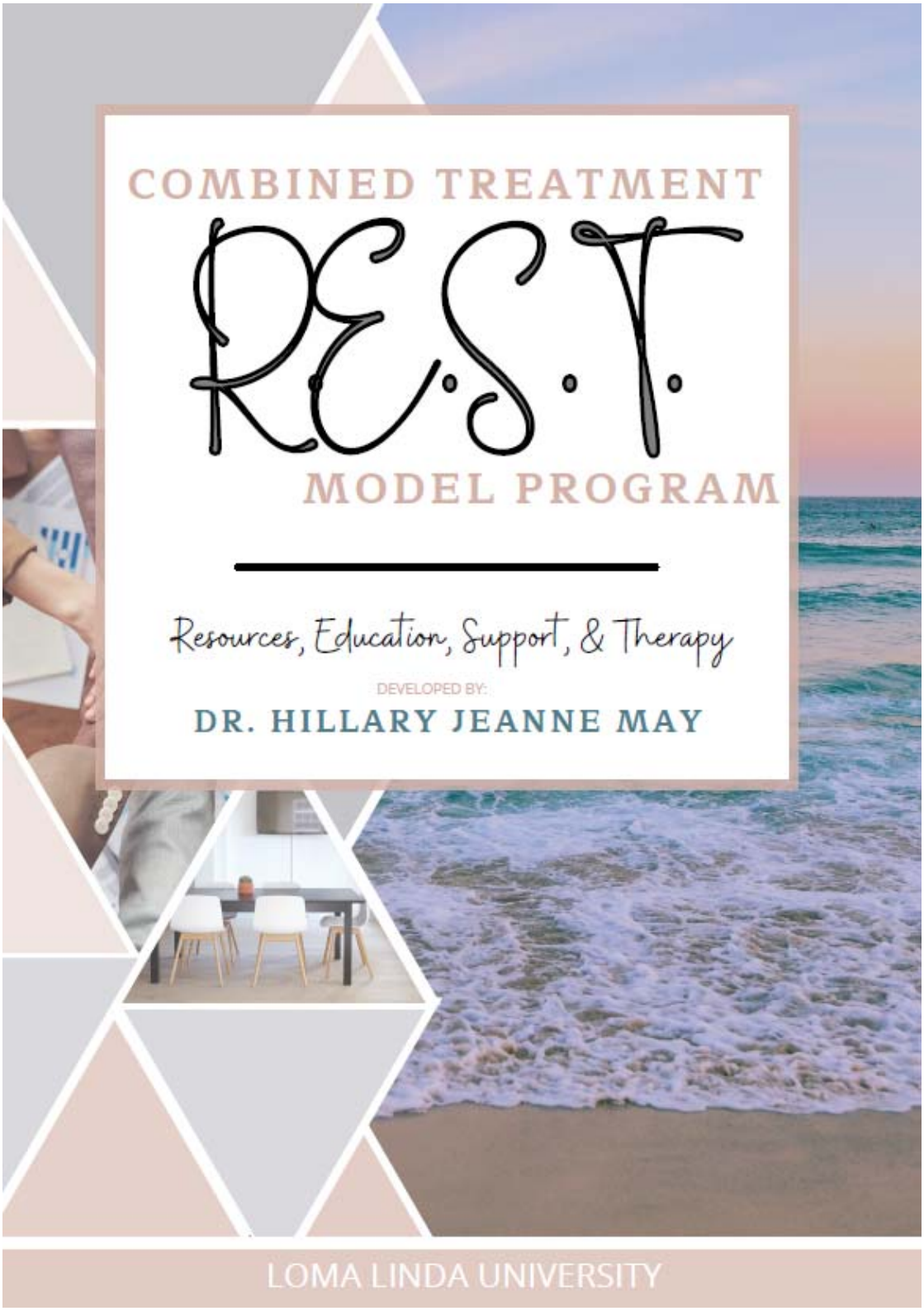
Participants will be the primary individuals completing the surveys. In addition to the participants, the psycho-educational class group leader and mentors/advocates providing community resources may also complete the process evaluation measures. The data and information from the surveys will be used to address any concerns in the program and to evaluate whether the program is meeting the outcome goals in relation to depression and social supports for women of intimate partner violence. Semi-yearly the program leaders will meet to discuss the evaluation measures and make accommodations and changes to the program as needed. Aggregate data and information will be used to enhance certain aspects of the program and address any procedural recommendations made on the exit surveys. The data will be collected in the snowball sampling method because as the program continues in duration, increasing data will be collected and added to the already compiled data as more groups complete the program. Information will be documented and graphed to present the evaluation measure outcomes to the staff. Potentially, the overall levels of aggregate data on depression and social supports may be graphed as well for participants to see the reduction in depression and the increase in social supports after completing the program and throughout the duration of the program.

The purpose of this evaluation plan is to determine whether the program is meeting the outcome goals defined in the logic model (Appendix X). This evaluation plan also addresses evaluation process and implementation components to determine if the program is being implemented as designed. Determining the baseline level of depression of women in an intimate partner violence situation when she enters the program is significant when determining if a decrease in depression has occurred. It is important to consider that women are often going through many other life changes throughout the

period when they are enrolled in a program (i.e., changes in employment, changes in housing, loss of insurance, new cities, changes for their children, etc.). Identifying the amount of, if any, social supports a woman has is a key factor in helping victims. Understanding the emotional aspects of the domestic violence situation and facilitating psycho-educational/relational classes about trauma bonding and emotional attachments is imperative for long-term change. Helping the participants build/re-build familial relationships that have been broken and developing additional social supports through various system levels can provide the support a woman needs to make informed decisions about her life. Through the evaluation process, women can quantify a level of depression and see indications that their situation is improving. Providing access to social support and measuring changes within a woman's support system also establishes a multi-level system of support. Developing social supports for women within domestic violence situations can foster a community of support, encouragement, and understanding. Increasing social supports and mental health for women in intimate partner violence situations can create the foundation for positive change in the life of the victim.

CHAPTER FIVE

PROJECT OUTCOME



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INTRODUCTION

Letter

The purpose of the REST program is to provide women who have experienced intimate partner violence a comprehensive approach to mental health services and education with the goal of connecting women with community-based supports and ongoing care. The program's priority is to offer comprehensive services at one location to better address the care of those in need. It is the goal of the program to ensure access to resources and treatment options in order to fully heal from the traumatic experiences of intimate partner violence and the effects it has on the survivors' social lives and social environments.

The REST program services women who are impacted by intimate partner violence. The client is paired with a Service Navigator who will assist in determining the priority needs for each individual client and work toward removing barriers in receiving care and support.

Hillary May

Hillary May
Author & Editor

MISSION & VISION statements

MISSION

The REST Program aims to promote healthy relationships for women survivors of intimate partner violence through social and emotional support, psycho-education, and empowerment. Through these services women survivors regain their mental health and build a lasting system of supports across system levels that encourages healthy relationships.

VISION

Striving for healthy and safe relationships for all women.

The REST program's objectives offer aspects of providing knowledge, skills, healing, and resources that allow for women survivors to have healthy transitions through the next chapter of their life. Focusing on women survivors while promoting healthy relationships, resources, support, and individual wellness is a key component of the REST program.

POPULATION, PROBLEM & *program purpose*

POPULATION

The population the REST Program serves includes women who are currently experiencing domestic violence/intimate partner violence or women who have previously been subjected to it. Inclusion criteria would be women of adult ages (age 18 or older) who have experienced or previously experienced domestic violence. It is the goal of this program to build trust and community among women victims. Exclusion for this program for the target population is male, anyone under the age of 18 years old, female victims experiencing suicidality, and non-English speaking individuals (at this time). The targeted women within this population would be expected to attend 90% of the educational sessions, individual therapy, resource support meetings, and family therapy.

The REST Program individuals may be referred to the program in the middle of the pscyho-educational class sessions, they will be required to wait until a new class forms to participate in psychoeducational classes. Individuals can access Individual Therapy and Resource Supports at any point throughout the program. Individuals may be put on a waiting list if space is not currently available for classes.

PROBLEM

On average 1 in 4 women will experience some form of domestic violence within their lifetime (National Domestic Violence Hotline, 2019). Many victims experience psychological trauma and provide input that it is more traumatic than physical violence; however, this type of violence is unable to be readily seen by society (Drieskens et al., 2017). This may be one of the reasons that domestic violence continues on a societal level with limited solutions that work toward a systemic and enduring solution.

Research has found that intimate partner violence and poor health outcomes for women have a significant correlation (Walsh et al., 2015). Approximately half of the participants of the study experienced PTSD and over half of the women had attempted suicide at least once, with 66% of these individuals attempting suicide after the violence had begun (Akyazi, et al., 2018).

Survivors of intimate partner violence have a variety of psychosocial needs that are rarely met. Some of these needs include "long-term safety and healing, housing, economic stability, health and well-being, and community connection" (Sullivan & Goodman, 2019).

PROGRAM PURPOSE

Provide a combined treatment model program to women survivors of intimate partner violence.

This program seeks to fill a void in the domestic violence social service field by providing a combined treatment model program to address the needs of survivors of intimate partner violence. As such, the primary purpose of this project is the development of a treatment program with services that are easily accessible by survivors. Additionally, REST is designed to be easily installed and implemented in shelters or agencies that have contact with this population of women. This program offers a means to engage an underserved and invisible population to prevent recurrent intimate partner violence traumatic experiences.

GOALS & objectives

OUTCOME GOALS

Outcome goal number one is to increase overall education and knowledge-base of participants in the REST program.

The objective for this goal is by the end of Year 1, participants in the program can pass the intimate partner knowledge curriculum with 80% accuracy.

Goal number two is to decrease participants' depression while increasing social support at multiple ecological levels.

The objective for this goal is by the end of Year 1, 85% of participants who have completed the program will have a statistically significant decrease in score on the Beck Depression Inventory and the SF-36 while having an increase on the MOS-SSS Survey (see assessment section for description of assessments).

The third indirect goal is to create and promote social justice and public awareness of intimate partner violence by changing the perception and stigma associated with IPV through increasing social support and connections of victims.

The objective for this goal is by the end of year 1, the REST program will increase community partnerships for victims by 50%.

By incorporating multiple outcome and program monitoring measures, the program is able to determine effectiveness through outcome goals that demonstrate a decrease in adverse symptoms while creating positive outcomes for the participants.

THEORETICAL foundations

BRONFENBRENNER'S ECOLOGICAL SYSTEMS THEORY

Treatment options offered provide support and psychological services to women to help them regain their mental health and social supports in order to make choices that are productive to their life and the lives of their children.

Brofenbrenner's ecological systems theory can help explain the complex layers of interwoven systems that oppress victims of IPV.

At the individual level there are personal characteristics that play a role in how the individual is able to handle certain situations in their life, including their personality and sense of self. In an IPV situation, the frequency of interactions of the individual with their microsystems may be diminished, over time as their primary microsystems, their home, batters the woman. If women begin with strong social supports at the beginning of experiencing IPV, it is usually diminished after a period of time. Women in domestic violence situations often have limited mesosystems due to microsystems being purposefully separated from one another by the perpetrator, as an act of control, or by the victim in an effort to keep the IPV hidden (Machisa et al., 2018).

Mental health effects of IPV may also hinder women to have multiple mesosystems and prevent the experiences, support, and interactions from the mesosystems they do have (Machisa et al., 2018). Providing women with access to increase their mental health and increase social supports can have a profound effect in relation to women being able to access and interact with their mesosystems. It is the goal of the REST program to incorporate and build supports at every ecological level in order to dismantle the systems that oppress women survivors of IPV.

THEORETICAL *foundations*

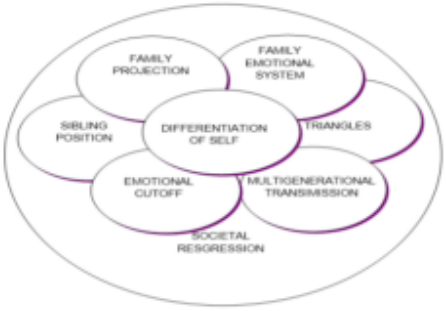
FAMILY SYSTEMS THEORY

To understand the barriers women face within IPV situations it is necessary to observe IPV through the Family Systems Theory lens. Family relationships are intricately interwoven and bidirectional within the larger social environment (Murray, 2006). Family system theory attempts to address the circular causality within the family in instances of IPV. When looking at circular causality in IPV, partners get stuck in a pattern that mutually reinforces each other negatively. The families have repeating interaction patterns, which influence each others' behaviors. Understanding the explicit and implicit rules within the family may help to identify relationship conflict patterns (Murray, 2006). Within family systems theory there are eight key Bowenian concepts that can be directly related to issues within intimate partner violence.

One concept to understand within FST is differentiation. In identifying and working with women in domestic violence situations, it is the goal to help establish a higher differentiation for the program participant with new implicit and explicit rules to create a healthy relationship and environment.

Conceptualizing first and second order change is imperative in making a healthy relationship dynamic

First order change, such as reducing name-calling, would be considered superficial changes that don't affect the family system dynamic (Guttman, 1991; Nichols & Shwartz 2005). Second order change, such as challenging the rules of the system, is beneficial within the family because it develops a change in the thinking and dynamics within the family unit. Being able to work toward building a relationship where both partners are mutually respected and share in decision making would be an example of second-order change, or changes within the dynamics and structure of the family (Murray, 2006). These are some of the foundational concepts that are discussed and learned throughout the REST program. Giving women the knowledge to understand the complexity of the interactions within the family system provides an increased awareness to family dynamics.



LOGIC *model*

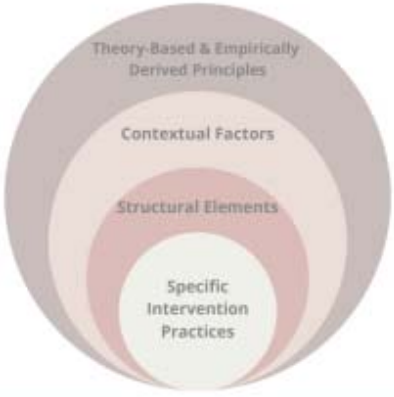
R.E.S.T. Program
Logic Model

Women tend to stay in abusive relationships because they are unaware they are victims of abuse. Womens' mental health and social supports are compromised making it difficult for them to leave and impacting their decision-making abilities. There is currently a gap in addressing the lack of education for women, the need for mental health therapy, and social supports for women experiencing intimate partner violence.

INPUTS	OUTPUTS: ACTIVITIES	OUTPUTS: PARTICIPATION	OUTCOMES: SHORT	OUTCOMES: MEDIUM	OUTCOMES: LONG
Resources available to support the program:	**Specific activities/interventions to address the need:**	**Participation of participants:**	**Attitudes and Knowledge:**	**Behavior Change:**	**Societal/Family Change:**
• Staff • Money • Community Partners • Research • Volunteers • Funding	• Deliver psycho-educational services through group sessions • Provide connection and support groups • Provide individual therapy and family therapy • Facilitate resource support meetings for access to resources throughout the community • Create a safety plan	• Target women attend group sessions for educational purposes • Target women attend individual therapy sessions for mental health services and assessment. • Target women meet for community resource meetings. • Family therapy sessions available to participants • Group support through online and in-person formats.	• Women increase knowledge of domestic violence/IPV • Women increase knowledge of the effects IPV has on family relationships and their own health • Women gain awareness, knowledge, resources, skills	• Women learn to set boundaries within their relationships • Women heal from past emotional trauma • Improved decision making skills for current and future relationships • Women identify appropriate actions to take within the context of their situation to create healthy relationships • Women develop positive mental health outcomes & decrease scores of depression • Women establish social supports & social support systems.	• Continued decrease in depression and other adverse symptoms in female victims of IPV • Increase in social supports at multiple ecological levels • Increase in community resources available to victims of IPV • Community awareness of perception and stigma of IPV • Women and children not living in domestic violence environments • Increase in psychosocial well-being

External Factors
- ***Preexisting ideas and cultural practices with women and domestic violence.**
- ***Social and economic factors affecting the family.**
- ***Emergency situations regarding safety.**
- ***Perpetrators mental health needs.**
- ***Transportation, family schedules, childcare.**

Assumptions:
- ***Women would not choose to live in a domestic violence situation.**
- ***Womens' mental health concerns from emotional abuse impacts their decision-making ability.**
- ***Women may not know that the context in which they are living is domestic violence.**
- ***After an educational process and therapy, women can make more informed choices.**



PROGRAM facilitators

Service Navigator

The role of the service navigator is to be connected with individual clients and gather background information in order to determine priority needs and services for each client. The service navigator will assist in administering preliminary assessments to help document the client needs through the process of enrollment in the program. The service navigator may also provide crisis counseling if necessary.

Resource Manager

The role of the Resource Manager is to review initial assessments and collaborate with Service Navigator in order to connect participants with priority needs. Resource Manager establishes community connections and discusses options with the participant in order to provide the services most correlated with specific needs.

Lesson Facilitator

The role of the Lesson Facilitator is to Provide Pre/Post-Test for participants, review content of each lesson with participants, allow for fluid conversations related to topic, redirect conversation back to objectives and lesson content when necessary, note any questions from participants that are unable to be answered immediately with a follow-up response to participants, and guide participants through the lesson activity together.

Licensed Therapist

The role of the licensed therapist is to provide individual counseling services to the participants. Therapist may also participant and conduct family therapy sessions. Therapist may use a variety of modalities throughout their sessions. Therapists are specifically trained to treat Trauma.

SERVICE navigator

The role of the service navigator is to be connected with individual clients and gather background information in order to determine priority needs and services for each client. The service navigator will assist in preparing preliminary assessments to help document the client needs through the process of enrollment in the program.

Service Navigator coordinates initial intake assessments for participants:

- *Vulnerability & Mental Health Scale (VMHS)*
- *Beck Depression Inventory (BDI)*
- *MOS Short Form Health Survey (SF-36)*
- *Social Support Survey Instrument (MOS-SSSI)*

Completes:

- Initial Intake Assessment
- Background Information
- Service Plan
- Session Sign-Ups
- Connection Groups

Creates service plan and coordinates services for participant.

Intake Interview Prompts

"Thank you for sharing your story with me. I'm sorry you are experiencing this challenge in your life. I would like to ask you a few questions, so I can provide you with the most appropriate services."	Again, thank them for sharing their story with you. Individuals are vulnerable during this time and they are taking a risk by sharing personal information before they even know if you will be able to help.
Participant First & Last Name	You might not think having the last name of the participant is important but most nonemergency programs can serve many people at once. It's likely that many people will have the same first name.
"Are you interested in getting connected with services soon or what is your desired timeframe?"	Not everyone is in an emergency situation and might want time to make arrangements. This also allows you the opportunity to: ▪ safety plan ▪ discuss resources in the community ▪ give an idea of what to expect at an appointment ▪ get documents ready if needed ▪ get childcare if needed ▪ work around their work schedule
We want to keep your connection with us as confidential as possible so I would like to go over the best ways to connect with you by phone. "	If the caller says it's ok for you to call them it's important to discuss safety planning while using the phone. It's also important to know if the abuser is still in the home and may answer the phone.

Intake Interview Prompts

Safe Phone Number with Area Code "Is it okay to leave messages?"	Make the distinction of calling vs. leaving a message. It might be ok to call the phone but not leave a message. Area codes are important with cell phones. Not everyone is local and you will need the area code to call them back.
"If yes, what specifically should the message say?"	The caller might want you to have a secret phrase planned. For example: "Hi this is Sandy from Avon; the knitting group on Pike; or the local yoga class. I will call back tomorrow."
"Who else might answer your phone?"	The caller might not think that someone else will answer their phone so it's always good to get clarification and plan for all possibilities
"Is the abusive partner living in the home?"	This question will help you understand why the caller might be speaking quietly and/or not engaging with you at the time of your call.

Intake Interview Prompts

"What is your relationship with the abuser?"	It's helpful to know what role the abusive person plays in the life of the caller. The abuser could control when the caller leaves the house and/or how they get to their appointments. You should be prepared to provide some helpful tips and safety planning on how to get to your office.
"Is it still okay to call the safe number provided?"	Why ask this again? After the previous questions the caller may have decided that it's not a good idea for you to call back. Now is the time to talk about a safe way to communicate.
"Our program provides many different services. Can you share with me what services you might be interested in first?"	After sharing what services you provide it's a good idea to uncover what the caller might be interested in. They might be able to connect to other resources before coming to the appointment.
"We have childcare while you attend our program, will you be bringing any children with you?"	Sharing that you have childcare for kids might be the deciding factor for an individual to be able to participate in the program (specifically the psycho-educational classes and the individual therapy components).

SERVICE navigator

Introductions & Overview of Program | Let us get to Know you Better | We Want to Help Support You

Introductions & Overview of Program

Name: _____
Date of Birth: _____
Age: _____
Date of Intake: _____
Address: _____
Safe Contact #: _____
Email address: _____

Tip: Please familiarize yourself with the Intake questions ahead of time. This is a tool to assist you in understanding the needs of the participant so that you are equipped to provide the appropriate support.

Welcoming statement: "I hope we will be able to provide you with the resources you need and if not, guide you in the right direction. Our program welcomes you – and we open our doors to individuals who reach out to us from different cultures, race and ethnicities, from a variety of religious backgrounds, individuals with hidden or visible disabilities, individuals who have substance use challenges, individuals with money or no money – just like the world around us."

Tip: Whenever possible, before you begin the paperwork, give the participants and their children an overview of the program and facilities. Provide them with an opportunity to get acquainted with an unfamiliar place. Share the highlights of the R.E.S.T. program before you get to the personal questions on your form. This allows individuals time to get comfortable and appreciate the goal of your program.

Accessibility within our Facilities: Did you notice anything on our tour that might prevent you from getting around? Do you have any concerns or hesitations about using our program? Do you have any access needs that we should know about?

☐ No ☐ Yes Please describe: _____

SERVICE navigator

Let us get to Know you Better

Tip: Shifting the conversation – sharing the story "The next question is focused on sharing what brought you to our program. Please take your time and feel free to stop if you need to take a break. Please share whatever you feel comfortable with, all your answers are voluntary. We keep this information confidential and we don't share it with anyone without your permission. Except, if you tell us that you want to hurt yourself or someone else, or you tell us that your child has directly experienced abuse."

I know this is a difficult time for you, and when you feel comfortable, I am ready to hear about the events that led you to this program.

Remember that many women may not understand that they are experiencing abuse and may just know they are distressed. Provide an open-ear to hear how they are being affected by what has happened to them.

SERVICE navigator

We Want to Help Support You

Tip: Once trust has been established, and because we want to provide the best services remind participants to share whatever they feel comfortable with, all their answers are voluntary.

Can you share what your relationship is with the person who is harming you?
Spouse Boyfriend/Girlfriend Ex-Boyfriend/Ex-Girlfriend Partner Other relationship _____

Tip: Time to check-in and let the participant know that you be asking them to describe their experience of living with abuse. Let the participant know that you are happy to take a break and return to this conversation.

Can you describe your experience of abuse?
Emotional Abuse: _____
Physical Abuse: _____
Sexual Abuse: _____
Other tactics/ways you felt hurt: _____

We would like to get to know your children. Can you share their names and any particular needs that we can support you with?
Name:_____ Gender:_____ DOB:_____ Age:_____ Grade:_____
Name:_____ Gender:_____ DOB:_____ Age:_____ Grade:_____
Name:_____ Gender:_____ DOB:_____ Age:_____ Grade:_____
Name:_____ Gender:_____ DOB:_____ Age:_____ Grade:_____
Name:_____ Gender:_____ DOB:_____ Age:_____ Grade:_____

Experiencing abuse can be extremely difficult to live with and sometimes it can lead to people harming themselves to ease the pain. Have you ever thought about harming yourself?
☐No ☐ Yes Please describe: _____
How often in the last week? _____
How often in the last month? _____

Have you ever done anything to hurt yourself?
☐No ☐ Yes Please describe: _____

While you are with us, if you are feeling like you might want to harm yourself the supports that would most help me are:

- ☐ Have some call me
- ☐ Listening to music
- ☐ Going outside
- ☐ Journaling
- ☐ Meet with a counselor
- ☐ Texting with someone
- ☐ Talking to a friend
- ☐ Doing some kind of art

Have you been using drugs or alcohol?
☐No ☐ Yes, What drugs/amount per week? _____

SERVICE navigator

We Want to Help Support You

Do you take medication? ☐ No ☐ Yes, what is the medication for?_____

Do you or your children have any concerns about health or medical related issues that you would like to address?
☐ No ☐ Yes Please describe: _____

Are the important religious practices that you engage in?
☐ No ☐ Yes Please describe: _____

Can you share what specific cultural, ethnic groups or communities you identify with?
Race: African American, Asian, Native American, Alaska Native, Pacific Islander, White, Multiracial, Other _____

Ethnicity: Non-Hispanic/Non-Latino Hispanic/Latino Other _____

Can you share what is your main source of income?
☐ TANF_____ If not on TANF, eligible? _____ ☐ SSI_____ ☐ Worker's Compensation_____ ☐ None
☐ Unknown ☐ Unemployment _____ ☐ Veteran's Disability_____ ☐ GA_____ ☐ Unable to Work_____
☐ Other: _____

Has participant ever received information on applying for TANF? _____ * If NOT on TANF and possibly eligible, give information NOW on how to apply.

Our program works within our community to connect you to services to support you and your family. Let's discuss some of these programs and see if you might be interested in their services.

Community Advocacy	Drug/Alcohol Counseling	Legal Advocacy	Food/Clothing
Group Support	Court Advocacy	Childcare/Respite Care	Interpreter Services
Education	Shelter	ESL	Housing
Address Confidentiality	Financial Assistance	Healthcare/Medication	Transportation
Parent-Skill Counseling	DV Education	Employment/Vocational Counseling or Training	
Culturally Appropriate Services			

Emergency Contact Information _____
(In case of an emergency is there anyone you would like for us to contact?)

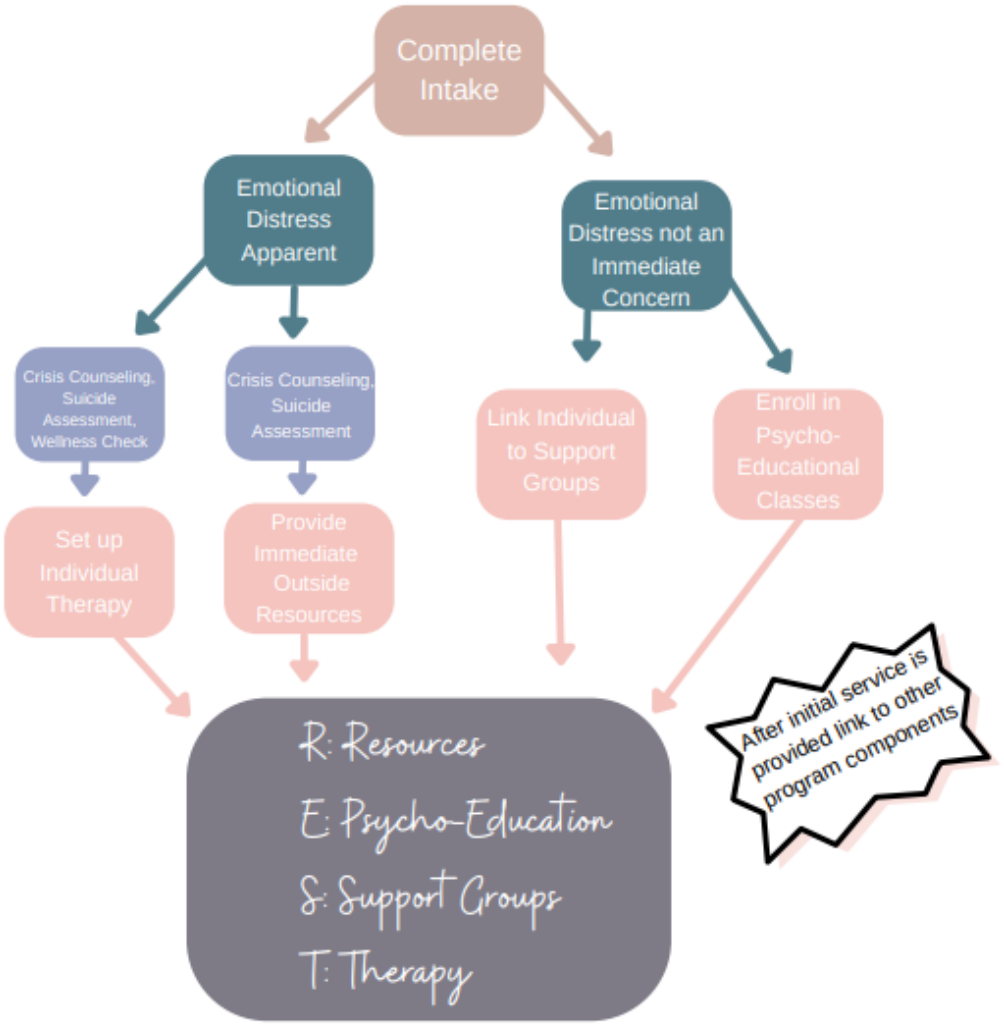
Safety Planning: Safety planning is an ongoing conversation with a survivor and may or may not be a formal or written plan. Safety planning strategies should be relevant to the survivors' priorities, decisions and risks. The planning process should be dynamic and flexible to meet the survivors' changing circumstances. (Davies, J. Domestic Violence Advocacy: Complex Lives/Difficult Choices,2, second edition, 2014)

_____
_____
Thanks for your patience with all these questions. Now it is your turn, do you have any questions for me?
_____
_____
_____

SERVICE navigator

Participant Recommendations

Tip: Review all three parts of the service navigator packet. Follow flow chart to help make recommendations for components of the program that are most necessary immediately for the participant.



RESOURCE *manager*

The role of the Resource Manager is to review initial assessments and collaborate with Service Navigator in order to connect participants with priority needs. Resource Manager establishes community connections and discusses options with the participant in order to provide the services most correlated with specific needs.

Resource Manager will hold a minimum of two resource meetings with participant.

Resource Meetings:

- Food Resources
- Physical Health Resources
- Employment Resources
- Housing Resources
- Medical Resources
- Activity Resources
- Community Event Resources

Completes:

- Resource Meeting Tracker with participant
- Connects participants with other participants with similar needs
- Links participant with needed resources
- Connects participant with community-based services

RESOURCE meetings

Resource meetings would incorporate connections to community-based services and resources. Resource support meetings may be completed by someone who is a survivor of Intimate Partner Violence. Bringing survivors together when connecting them to social and legal resources can promote social support through their shared experiences of resource exploration and fortification.

Advocacy efforts can also help survivors change their past experiences into 'opportunities to make a difference in the lives of others" (Murray, et al., 2015).

"Survivor advocacy has the potential to be a therapeutic, empowering experience for clients" (Murray, et.al., 2015). While this component of the program may be tailored more to meet the individual needs of the client, the service navigator will be aware of the outcomes of the resource support meetings. Advocacy and resource support would be available to ask questions, provide community resources, connect to other local support groups, access information for the court system, and be a connection to the survivor who often feels they are alone in this process.

Resource meetings will create lasting connections to community-based resources for participants in the program.

COMMUNITY RESOURCES

This section will be different for each shelter that is implementing the REST program. Resources are any and all community based services that could be offered as an outside connection to the participant. This ranges from food and medicals needs to gym memberships and church connection groups. Every community will have different resources available and every participant will have a different priority of needs.

Participants will meet individually with a resource meeting specialist that will coordinate community resource connections with the participant.

RESOURCE SHEET

It is expected that the resource meeting specialist has the comprehensive list of available community connections and discusses options with the participant in order to provide the services best fitting with specific needs.

The following page is a resource meeting tracker. Information about specific community connections can be written down. A copy can be given to participant so the participant has access to the information as well.

Resource meeting specialist should be cognizant to coordinate participants that know each other that may need the same community resources in order to provide connection with each other, support, and a higher likelihood of accountability.

RESOURCE MEETING TRACKER

PHYSICAL NEEDS	EMOTIONAL NEEDS	OTHER

1ST MEETING DATE	2ND MEETINGS DATE	FOLLOW-UP

PHONE NUMBERS TO NEEDED RESOURCES	COMMUNITY CONNECTIONS

FIRST STEPS	NEXT STEPS
☐ _____	☐ _____
☐ _____	☐ _____
☐ _____	☐ _____
☐ _____	☐ _____

NOTES

PSYCHO-EDUCATION *classes*

Psycho-education/personal growth groups will be a 10-week long, closed group that will have a limit of 8 to 12 participants in order to easily facilitate personal discussions, reflection, and to follow recommendations for beneficial group size (Gladding, 2012). A closed group format is critical to developing psychological authenticity, social support, and group cohesion, all of which are critical to resiliency and well-being.

- 8-12 Participants
- Closed group format
- 10 Sessions, 2 hours in length
- Therapist Facilitated

Group Structure:
Intro/Welcome: 15 minutes
Pre-Test: 5 minutes
Weekly Lesson: 60 minutes
Activity: 20 minutes
Closing/Post-Test: 20 minutes

Unit 1: Intimate Partner Violence
4 Sessions

Unit 2: Family Systems
3 Sessions

Unit 3: Healthy Relationships
3 Sessions

FACILITATOR instructions

This program manual is designed to be the main resource for running the REST Program psycho-educational classes. Within each lesson, the objectives for the lesson are listed, an introduction time to take the pre-test is noted, all of the information about the content of the lesson is prepared, an activity for the lesson is designated, and a time for the post-test is noted.

All of the worksheets for participants are within the activities section of this manual. The purpose behind the lesson content is to give the facilitator information and comprehensive background knowledge on the topics being taught. It is the goal of the program to provide psycho-education on specific topics but also allow for fluidity of on-topic conversation by participants. The goal is to review the lesson content thoroughly. The guide can help the facilitator stay on track with the discussions as they progress through the lesson. A streamlined PowerPoint of the main topics of each lesson is available for facilitator use.

Facilitator Goals:

- **Provide Pre/Post-Test for Participants**
- **Review content of each lesson with participants.**
- **Allow for fluid conversations related to objectives.**
- **Redirect conversation back to objectives and lesson content when necessary.**
- **Note any questions from participants that are unable to be answered immediately and provide follow-up when needed.**
- **Guide participants through the lesson materials, discussion, and activity.**

UNIT 1 IPV 1.1

SESSION 1: WHAT IS DOMESTIC VIOLENCE?

OBJECTIVES

- Understand the definition of Intimate Partner Violence
- Differentiate between abusive and non-abusive behaviors
- Learn about types of abuse
- Identify the phases of the Cycle of Violence
- Identify patterns of abuse experienced

INTRO/WELCOME: 15 MINUTES

Facilitator is present to welcome individuals into the group. This time is spent with the purpose of connecting with others in the group and building relationships. Short check-ins can be done by going around the table and asking individually how each person's week has been. Be aware to keep this contained to a brief check-in with each person.

PRE-TEST: 5 MINUTES

Hand out Pre-Test for Lesson 1 (see Pre/Post Test Section).

LESSON 1:

Intimate Partner Violence or Domestic Violence :
Cruel or violent behavior (abuse) perpetrated against an intimate partner or former intimate partner. Domestic violence (also referred to as intimate partner violence (IPV), dating abuse, or relationship abuse) is a pattern of behaviors used by one partner to maintain power and control over another partner in an intimate relationship (National Domestic Violence Hotline, 2019).

Abusive Conflict vs. Non-Abusive Conflict:
In all relationships there will be times when there are differing perspective, disagreements, and negative emotions. Expressing negative emotions, disagreeing, or requesting a partner change a behavior are not necessarily abusive behaviors. The context and underlying intention of the person displaying the behavior ultimately determines whether the behavior is abusive (National Domestic Violence Hotline, 2019).

Abusive Conflict involves cruel or violent behavior motivated by the desire to hurt, control, manipulate, scare, intimidate, humiliate, disrespect, or devalue that person. Abusive behavior is based on a foundational belief in superiority and authority over the other partner, a belief that the other partner must obey the demands of the abusive partner (National Domestic Violence Hotline, 2019).

Non-Abusive conflict involves respectful behavior motivated by a desire to communicate one's own point of view as well as understand the other person's point of view. Non-abusive behavior is based on a foundational belief in freedom of both partners to decide what they will do, or not do, to resolve the conflict (National Domestic Violence Hotline, 2019).

Patterns of Abuse:
Not all violence is the same. While some individuals experience one type of violence, others may experience something different. Family violence researchers and clinicians have found that while IPV patterns vary, they roughly fall into three common patterns of violence explained below. (Note: The term 'violence' used below refers to physical, sexual, and psychological violence).

Coercive Controlling Violence
Coercive control is a form of domestic abuse, or intimate partner violence. It describes a pattern of behaviors a perpetrator uses to gain control and power by eroding a person's autonomy and self-esteem. This can include acts of intimidation, threats, and humiliation (National Domestic Violence Hotline, 2019).

Research into coercive control suggests that this type of abuse often predicts future physical violence. Anyone in any type of intimate relationship can experience coercive control. Some research suggests that it is mainly women who experience it, while other studies suggest that the rates for men and women are similar.

Situational Couple Violence:
Situational couple violence is the most common form of intimate partner violence and is characterized by conflicts that escalate on occasion to a point where one or both partners react in a violent way as a result of poor communication, self-control or conflict resolution skills (National Domestic Violence Hotline, 2019).

Abusive behaviors used in Situational Couple Violence may resemble those of Coercive Controlling Violence (i.e. cursing, yelling, name-calling, accusations of infidelity), but the abuse in Situational Couple Violence is not part of a relationship-wide pattern of seeking power and control over the other partner. Rather, in Situational Couple Violence one or both partners seek to gain control in a specific situation regarding a particular issue. Additionally, neither partner typically reports feeling afraid of the other, whether perpetrator, mutual combatant, or victim of this kind of violence.

Violent Resistance

Violent Resistance refers to the type of violence an abused partner uses in response to an initial attack by a Coercive Controlling Violent partner. This includes two main types of violent resistance:

- Self-Defense: violence used as a means to protect oneself or others from injury.
- Retaliation: violence that is not required for immediate self-defense, but rather is the act of responding to abusive behavior with retaliation – as a means of standing up for oneself.

*It may be helpful to offer participants a highlighter in order to highlight the abuse tactics that they have experienced in their relationship. (See additional resources section for copies of the wheel)

Domestic Abuse Intervention Programs
202 East Superior Street
Duluth, Minnesota 55802
218-722-2781
www.TheDuluthModel.org

Types of Abuse (National Domestic Violence Hotline, 2019):
Physical abuse is intentional bodily injury. Some examples include slapping, pinching, choking, kicking, shoving, or inappropriately using drugs or physical restraints. Signs of physical abuse.

Sexual abuse is nonconsensual sexual contact (any unwanted sexual contact). Examples include unwanted touching, rape, sodomy, coerced nudity, sexual explicit photographing. Signs of sexual abuse.

Mental mistreatment or emotional abuse is deliberately causing mental or emotional pain. Examples include intimidation, coercion, ridiculing, harassment, treating an adult like a child, isolating an adult from family, friends, or regular activity, use of silence to control behavior, and yelling or swearing which results in mental distress. Signs of emotional abuse.

Exploitation occurs when a vulnerable adult or his/her resources or income are illegally or improperly used for another person's profit or gain. Examples include illegally withdrawing money out of another person's account, forging checks, or stealing things out of the vulnerably adult's house. Signs of exploitation.

Neglect occurs when a person, either through his/her action or inaction, deprives a vulnerable adult of the care necessary to maintain the vulnerable adult's physical or mental health. Examples include not providing basic items such as food, water, clothing, a safe place to live, medicine, or health care. Signs of neglect.

Self-neglect occurs when a vulnerable adult fails to provide adequately for themselves and jeopardizes his/her well-being. Examples include a vulnerable adult living in hazardous, unsafe, or unsanitary living conditions or not having enough food or water. Signs of self-neglect.

Abandonment occurs when a vulnerable adult is left without the ability to obtain necessary food, clothing, shelter or health care. Examples include deserting a vulnerable adult in a public place or leaving a vulnerable adult at home without the means of getting basic life necessities.

SESSION 1

1.1

ACTIVITY: 20 MINUTES

Hand out in Activity Section in manual for Lesson 1. Activity for this session includes taking a closer look at the Cycle of Violence. The cycle of abuse is a social cycle theory developed in 1979 by Lenore E. Walker to explain patterns of behavior in an abusive relationship (Walker, 1979).

Participants will identify situations in their own relationship that follows the cycle of violence.

CLOSING/POST-TEST: 20 MINUTES

Hand out Post-Test for Lesson 1 (see Pre/Post Test Section).

UNIT 1 IPV 1.2

SESSION 2: EFFECTS OF DOMESTIC VIOLENCE

OBJECTIVES

- Understand the effects of domestic violence on participants
- Understand the effects of domestic violence on children
- Identify strategies to effectively cope with anxiety

INTRO/WELCOME: 15 MINUTES

Facilitator is present to welcome individuals into the group. This time is spent with the purpose of connecting with others in the group and building relationships. Short check-ins can be done by going around the table and asking individually how each person's week has been. Be aware to keep this contained to a brief check-in with each person.

PRE-TEST: 5 MINUTES

Hand out Pre-Test for Lesson 2 (see Pre/Post Test Section).

LESSON 2:

Effects of Domestic Violence on Participant and Children:
Violence against women can cause long-term physical and mental health problems. Violence and abuse affect not just the women involved but also their children, families, and communities. These effects include harm to an individual's health, possibly long-term harm to children, and harm to communities such as lost work and homelessness (Goldstein, et al., 2021).



What are the short-term effects of violence?

The short-term physical effects of violence can include minor injuries or serious health conditions. They can include bruises, cuts, broken bones, or injuries to organs and other parts inside of your body. Some physical injuries are difficult or impossible to see without scans, x-rays, or other tests done by a doctor or nurse (Fisher, 1999).

Short-term physical effects of sexual violence can include:

- Vaginal bleeding or pelvic pain
- Unwanted pregnancy
- Sexually transmitted infections (STIs), including HIV
- Trouble sleeping or nightmares

If you are pregnant, a physical injury can hurt you and the unborn child. This is also true in some cases of sexual assault.

If you are sexually assaulted by the person you live with, and you have children in the home, think about your children's safety also. Violence in the home often includes child abuse. Many children who witness violence in the home are also victims of physical abuse.

What are the long-term effects of violence?

Violence against women, including sexual or physical violence, is linked to many long-term health problems. These can include:

- Arthritis
- Asthma
- Chronic pain
- Digestive problems such as stomach ulcers
- Heart problems
- Irritable bowel syndrome
- Nightmares and problems sleeping
- Migraine headaches
- Sexual problems such as pain during sex
- Stress
- Problems with the immune system

Many women also have mental health concerns after violence. To cope with the effects of the violence, some women start misusing alcohol or drugs or engage in risky behaviors, such as having unprotected sex. Sexual violence can also affect someone's perception of their own bodies, leading to unhealthy eating patterns or eating disorders. If you are experiencing these problems, know that you are not alone. There are resources that can help you cope with these challenges (Fisher, 1999).

What are the mental health effects of violence?

If you have experienced a physical or sexual assault, you may feel many emotions — fear, confusion, anger, or even being numb and not feeling much of anything. You may feel guilt or shame over being assaulted. Some people try to minimize the abuse or hide it by covering bruises and making excuses for the abuser (Scrafford, et al., 2019).

If you've been physically or sexually assaulted or abused, know that it is not your fault. Getting help for assault or abuse can help prevent long-term mental health effects and other health problems.

Long-term mental health effects of violence against women can include:

- Post-traumatic stress disorder (PTSD). This can be a result of experiencing trauma or having a shocking or scary experience, such as sexual assault or physical abuse.6 You may be easily startled, feel tense or on edge, have difficulty sleeping, or have angry outbursts. You may also have trouble remembering things or have negative thoughts about yourself or others. If you think you have PTSD, talk to a mental health professional.
- Depression. Depression is a serious illness, but you can get help to feel better. If you are feeling depressed, talk to a mental health professional. Some common signs of depression include feelings of sadness, tearfulness, emptiness or hopelessness, angry outbursts, irritability or frustration, even over small matters, loss of interest or pleasure in most or all normal activities, such as sex, hobbies or sports.
- Anxiety. This can be general anxiety about everything, or it can be a sudden attack of intense fear. Anxiety can get worse over time and interfere with your daily life. If you are experiencing anxiety, you can get help from a mental health professional.

(National Domestic Violence Hotline, 2019).

Other effects can include shutting people out, not wanting to do things you once enjoyed, not being able to trust others, and having low-esteem.1

Many women who have experienced violence cope with this trauma by using drugs, drinking alcohol, smoking, or overeating. Research shows that about 90% of women with substance use problems had experienced physical or sexual violence.

Substance use may make you feel better in the moment, but it ends up making you feel worse in the long-term. Drugs, alcohol, tobacco, or overeating will not help you forget or overcome the experience. Get help if you're thinking about or have been using alcohol or drugs or food to cope.

What are other effects of violence against women?
Violence against women has physical and mental health effects, but it can also affect the lives of women who are abused in other ways:

- **Work.** Experiencing a trauma like sexual violence may interfere with someone's ability to work. Half of women who experienced sexual assault had to quit or were forced to leave their jobs in the first year after the assault. Total lifetime income loss for these women is nearly $250,000 each.
- **Home.** Many women are forced to leave their homes to find safety because of violence. Research shows that half of all homeless women and children became homeless while trying to escape intimate partner violence.
- **School.** Women in college who are sexually assaulted may be afraid to report the assault and continue their education. But Title IX laws require schools to provide extra support for sexual assault victims in college. Schools can help enforce no-contact orders with an abuser and provide mental health counseling and school tutoring.
- **Children.** Women with children may stay with an abusive partner because they fear losing custody or contact with their children.
(National Domestic Violence Hotline, 2019).

Sometimes, violence against women ends in death. More than half of women who are murdered each year are killed by an intimate partner. One in 10 of these women experienced violence in the month before their death.

ACTIVITY: 20 MINUTES

Hand out Activity for Session 2 (see Activity Section). The activity for this session helps participants identify things that make them feel anxious. Participants are encouraged to write down changes they feel and identify coping strategies.

CLOSING/POST-TEST: 20 MINUTES

Hand out Post-Test for Session 2 (see Pre/Post Test Section).

UNIT 1 IPV 1.3

SESSION 3: DENIAL & CO-DEPENDENCY

OBJECTIVES

- Understand that denial is a coping mechanism and identify its purpose.
- Identify the four levels of denial.
- Understand the definition of co-dependency.
- Identify the symptoms of co-dependency
- Identify steps to take to stop the co-dependency.

INTRO/WELCOME: 15 MINUTES

Facilitator is present to welcome individuals into the group. This time is spent with the purpose of connecting with others in the group and building relationships. Short check-ins can be done by going around the table and asking individually how each person's week has been. Be aware to keep this contained to a brief check-in with each person.

PRE-TEST: 5 MINUTES

Hand out Pre-Test for Lesson 3 (see Pre/Post Test Section).

LESSON 3:

Denial:

Denial helps us cope and focus on what we must in order to survive. Denial also harms us when it causes us to ignore problems for which there are solutions or deny feelings and needs that if dealt with would enhance our lives. Often times, when someone is in denial, they are completely unaware that they are in denial (Prosman, et al., 2014).

Degrees of Denial:

First Degree: Denial that the problem, symptom, feeling or need exists.
Second Degree: Minimization or rationalization about it.
Third Degree: Admitting it, but denying the consequences.
Fourth Degree: Unwilling to seek help for it.

Reasons for Denial:
Denial is a defense that helps us. There are many reasons we use denial, including avoidance of physical or emotional pain, fear, shame or conflict.

Denial can be adaptive when it helps us cope with difficult emotions, such as in the initial stages of grief following the loss of a loved one, particularly if the separation or death is sudden. Denial allows our body-mind to adjust to the shock more gradually.

It's not adaptive when we deny warning signs of a treatable illness or problem out of fear. Many women delay getting help when in abusive situations out of fear of the abusive person. Applying the various degrees above, we might deny that we are in an abusive relationship; next rationalize that it's probably just due to financial or work stresses; third, admit that it could be or actually is abusive, but deny that it is harmful to yourself or your children; or admit all of the above and still be unwilling to seek help or support (Dziegielewski, et al., 2005).

Inner Conflict:
We might not look at the abusive situation because that might mean that we leave the relationship, the children might not have their father living with them, more financial burdens are placed on the survivor. Sometimes there are aspects that the abused person just does not want to face as a reality.

Frequently, partners of abusers are on the continual cycle of denial. The abuser can be loving and even responsible at times and promise to stop their abuse, but soon it returns breaking trust and promises. Apologies and promises are made and the abused individual chooses to forgive and move on because they love their partner (Lancer, 2019).

Familiarity:
Sometimes problems become so familiar we don't recognize them as problems. We grew up with them and don't see that something is wrong. Sometimes, if we were emotionally abused as a child, we wouldn't see the emotional abuse from a spouse as something wrong.

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We might acknowledge that our spouse is verbally abusive, but minimize or rationalize. Some women state that even though they know their husbands are verbally abusive, they also know their husbands love them. Most victims of abuse experience third degree denial, meaning that they don't realize the detrimental impact the abuse is having on them – often leading to PTSD long after they've left the abuser. If they faced the truth, they'd be more likely to seek help (Lancer, 2019).

Denial of needs is a major reason people remain unhappy in relationships. They deny problems and deny that they're not getting their needs met. They might feel guilty and lack the courage to ask for what they need or know how to get their need met. Learning to identify and express our feelings and needs is a major part of recovery and is essential to well-being and enjoying satisfying relationships.

Some signs you may be in denial (Lancer, 2019):

1. Think about how you wish things would be in your relationship?
2. Wonder, "If only, he (or she) would . . ."?
3. Doubt or dismiss your feelings?
4. Believe repeated broken assurances?
5. Conceal embarrassing aspects of your relationship?
6. Hope things will improve when something happens (e.g., a vacation, moving, or getting married)?
7. Make concessions and placate, hoping it will change someone else?
8. Feel resentful or used by your partner?
9. Spend years waiting for your relationship to improve or someone to change?
10. Walk on egg-shells, worry about your partner's whereabouts, or dread talking about problems?

Moving Past Denial:

When faced with an overwhelming event(s), it's OK to say, "I just can't think about all of this right now." You might need time to work through what's happened and adapt to new circumstances. But it's important to realize that denial should only be a temporary measure — it won't change the reality of the situation.

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What is Co-Dependency?

Codependency refers to a mental, emotional, physical, and/or spiritual **reliance** on a partner, friend, or family member. Codependency refers to an imbalanced relationship pattern where one person assumes responsibility for meeting another person's needs to the exclusion of acknowledging their own needs or feelings (Bornstein, 2006).

9 Signs of Co-Dependent Behavior:

1. People Pleasing

We all want people to like us but there is a difference between some of the normal tendencies of the desire for people to like us and being a people pleaser all of the time. Feeling like you have no choice but to help others and keep them happy is often how a people pleaser feels. Typically, a people pleaser doesn't like to say no even if it interferes with their own wants and needs.

2. Lack of Boundaries

People in both roles in a codependent relationship tend to have problems recognizing, respecting, and reinforcing boundaries. Having boundaries simply means you respect the other person's right to his or her own feelings and autonomy. It also means recognizing that you aren't responsible for the other person's happiness. People in codependent relationships tend to have a problem where one person doesn't recognize boundaries and the other person doesn't insist on boundaries. Thus, one person is controlling and manipulative, and the other person is compliant and fails to assert his or her own will (Dutton, 2007).

3. Poor Self-Esteem

Typically, neither person in a codependent relationship has very good self-esteem. One person in the relationship often needs validation and approval of the other person in order to feel needed. The other person has low self-esteem due to having to depend on someone else to meet material needs and needing validation from that person. The dependent person is often controlling out of a basic sense of insecurity that the other person might leave.

4. Caretaking

A major sign of codependency is when you feel like you have to take care of everyone all the time. If you feel like everything will go terribly wrong if you don't take care of everyone, you might be experiencing codependency.

5. Reactivity
When your identity is based on pleasing others and you feel responsible for everyone's wellbeing, you might find yourself reacting to situations rather than acting out of your own volition. You might find yourself being defensive or easily internalizing criticism. It is also partly a result of your inability to set boundaries so that you feel responsible for someone else's feelings (Dutton, 2007).

6. Poor Communication
Communicating effectively is difficult with a codependent mindset. The caregiver is often unaware of her own wants and needs and when she is aware of them, she may be reluctant to express them. She may fear upsetting the other person by asserting herself. In order to break the co-dependency patterns, both people have to learn to communicate honestly and effectively.

7. Lack of Self-Image
The caregiver may lack a positive self-image. If the caregiver defines herself specifically around her role in the relationship, this might be a sign of codependency.

8. Dependency
Each person needs the other for something. One person needs his emotional needs to be met because other issues have impeded his autonomy. The other person needs validation and a sense of purpose from taking care of someone. In a way, it's a tradeoff, but it also limits both people involved.

9. Relationship Stress
As you might expect, any of these factors can put a lot of stress on a relationship. When you can't communicate or respect boundaries, you're bound to have problems. While one partner feels stresses about trying to do everything right, the other partner often feels insecure about the relationship. Both individuals in the relationship suffer when there is codependency.

SESSION 3

1.3

Avoiding Co-Dependency in your Relationship:

Follow COURAGE to avoid codependency in your relationship.

C: Communicate your feelings, be confident
O: Overcome obsessions, offer healthy support
U: Unconditional self-acceptance, love yourself and accept your flaws
R: Reject what you don't deserve
A: Ask for help, explore alternate options
G: Go for the best for yourself
E: End the unhealthy relationship

Codependent Relationships	Healthy Relationships
• Intense attraction – feel anxious	• Friendship begins – feel comfortable
• Idealize each other and ignore differences	• Get to know each other
• Fall in love and make commitments	• Acknowledge differences (or leave)
• Get to know each other	• Grow to love each other
• Become disappointed	• Make commitments
• Cling to romantic fantasy of love	• Negotiate and compromise needs
• Try to change partner into ideal	• Love and acceptance of each other deepens
• Feel resentful and unloved	• Feel supported and loved

ACTIVITY: 20 MINUTES

Hand out Activity for Session 3 (see Activity Section). The activity for this session helps participants identify the severity of any co-dependent symptoms they may be experiencing. Participants can rate the severity of the symptom presence. They could rate with a different color pen in the future to monitor progress.

CLOSING/POST-TEST: 20 MINUTES

Hand out Post-Test for Session 3 (see Pre/Post Test Section).

UNIT 1 IPV 1.4

SESSION 4: RED FLAGS & SAFETY PLANNING

OBJECTIVES

- Learn some of the red flags of abusive relationships
- Identify any red flags in current relationship
- Create a personalized safety plan
- Plan ahead for technology safety
- Identify personal goals and dreams

INTRO/WELCOME: 15 MINUTES

Facilitator is present to welcome individuals into the group. This time is spent with the purpose of connecting with others in the group and building relationships. Short check-ins can be done by going around the table and asking individually how each person's week has been. Be aware to keep this contained to a brief check-in with each person.

PRE-TEST: 5 MINUTES

Hand out Pre-Test for Lesson 4 (see Pre/Post Test Section).

LESSON 4:

Why Recognizing Warning Signs Is Important:

Recognizing the red flags or warning signs in a relationship is important because it may have a lasting negative impact on a person's emotional and mental state. You may have an idea of the warning signs of an abusive person, but when you're in the situation, you may be too blind to see it. It may be easy to miss out on abuse when you're blinded by love, especially when the abuser is your romantic partner.

Some warning signs can be as little as controlling what to wear, where to go, or the friends you hang out with. These warning signs can be easily detected in a person's word, behavior, and action. It may start as verbal abuse, and as you tolerate it, it may turn into emotional abuse, mental abuse, or physical abuse. Learning the warning signs can keep women aware before they are so deep in a romantic relationship where it becomes more difficult to leave (Hayduk, 2017).

SESSION 4

1.4

It's not always easy to tell at the beginning of a relationship if it will become abusive. In fact, many abusers may seem absolutely perfect on the surface — as if they are the dream partner — in the early stages of a relationship. Possessive and controlling behaviors don't always appear overnight, but rather emerge and intensify as the relationship grows.

If you're beginning to feel as if your partner or a loved one's partner is becoming abusive, there are a few behaviors that you can look out for. Watch out for these red flags (National Domestic Violence Hotline, 2019).

- Embarrassing or putting you down
- Looking at you or acting in ways that scare you
- Controlling who you see, where you go, or what you do
- Keeping you or discouraging you from seeing your friends or families
- Taking your money or refusing to give you money for expenses
- Preventing you from making your own decisions
- Telling you that you are a bad parent or threatening to harm or take away your children
- Preventing you from working or attending school
- Blaming you for the abuse, or acting like it's not really happening
- Destroying your property or threatening to hurt or kill your pets
- Intimidating you with guns, knives or other weapons
- Shoving, slapping, choking or hitting you
- Attempting to stop you from pressing charges
- Threatening to commit suicide because of something you've done
- Threatening to hurt or kill you
- Pressuring you to have sex when you don't want to or do things sexually you're not comfortable with
- Pressuring you to use drugs or alcohol
- Preventing you from using birth control or pressuring you to become pregnant when you're not ready

Domestic violence doesn't look the same in every relationship because every relationship is different. But one thing most abusive relationships have in common is that the abusive partner does many different kinds of things to have more power and control over their partners.

Safety Planning:

WHAT IS A SAFETY PLAN?

A safety plan is a set of actions that can help lower your risk of being hurt by your partner. It includes information specific to you and your life that will increase your safety at school, home, and other places that you go on a daily basis.

HOW DO I MAKE A SAFETY PLAN?

Take some time to go through each section of the safety planning tool. You will be asked a series of questions to help you identify your safety options. You can use this tool on your own, or you can use it with a friend or an adult you trust.

You will also be given a pocket-sized emergency contact card (index card may be used) that you can fill out with phone numbers and keep with you at all times so you always know how to contact the most important people.

KEEP IN MIND:

- For this safety plan to work for you, the information you fill in must be honest and accurate.
- Once you complete your safety plan, be sure to keep it in an accessible but secure location. You should also consider giving a copy of your safety plan to someone that you trust.
- If you don't feel safe keeping the printed safety plan or emergency contact card with you, then you can still use the safety tips. Try to memorize at least one phone number of someone you can call any time.
- You know your situation better than anyone else; trust your judgment and weigh your options before taking any steps.

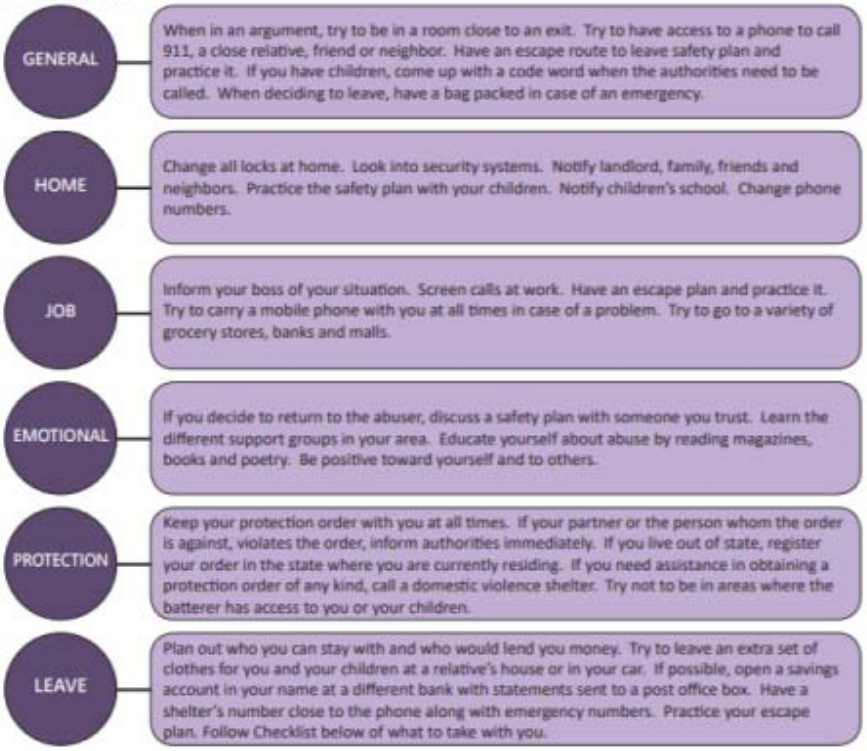


SESSION 4

1.4

Safety Planning

Leaving the abuser is the most dangerous time for a victim of domestic violence. Seventy five percent (75%) of domestic violence related homicides take place when one partner in a relationship tries to leave. Please note the following guidelines to insure both your safety while you are still living with the abuser and when you decide to leave.



Graphic from Turning Point
Services to End Domestic and Sexual Violence

Ways to get help:

- If you need help in a public place, yell "Fire!" People respond more quickly to someone yelling "fire" than to any other cry for help.
- If you can, always have a phone where you know you can get to it. Know the numbers to call for help such as 911 or the National Domestic Violence Hotline at 1-800-799-SAFE (7233). Know where the nearest pay phone is in case you have to run out of the home without your cell phone. Know your local battered women's shelter number.
- Let friends and neighbors who you trust know what is going on in your home. Make up a signal with a trusted neighbor, like flashing the lights on and off or hanging something out the window, which will alert him/her that you need help.
- Make a habit of backing the car into the driveway (so you can quickly pull out) and having a full tank of gas. Keep your car keys in the same place so you can easily grab them. If you would be leaving by yourself (if you don't have children), you might want to even keep the driver's door unlocked (and the other car doors locked) so that you are prepared to make a quick escape if you have to.
- Think of several reasons for leaving the house at different times of the day or night that the abuser will believe, in case you feel that the violence is about to erupt and you need an excuse to get out.

ACTIVITY: 20 MINUTES

Hand out Activity for Session 4 (see Activity Section). The activity for this session helps participants create a personalized safety plan. By working together as a group, participants can collaborate on phone numbers and safety plan ideas.

CLOSING/POST-TEST: 20 MINUTES

Hand out Post-Test for Session 4 (see Pre/Post Test Section).

UNIT 2

Family Systems 2.1

SESSION 5: INTRODUCTION OF FAMILY SYSTEMS

OBJECTIVES

- Basic understanding of Family Systems Theory
- Summarize 8 key concepts of Family Systems Theory
- Recognize family patterns
- Understanding of a genogram

INTRO/WELCOME: 15 MINUTES

Facilitator is present to welcome individuals into the group. This time is spent with the purpose of connecting with others in the group and building relationships. Short check-ins can be done by going around the table and asking individually how each person's week has been. Be aware to keep this contained to a brief check-in with each person.

PRE-TEST: 5 MINUTES

Hand out Pre-Test for Lesson 5 (see Pre/Post Test Section).

LESSON 5:

What is Family Systems Theory?

Family systems theory is an approach to understand human functioning that focuses on interactions between people in a family and between the family and the context(s) in which that family is embedded.

Family relationships are intricately interwoven and bidirectional (Murray, 2006). Family system theory attempts to address the circular causality within the family. When looking at circular causality in IPV, partners get stuck in a pattern that mutually reinforces each other negatively. Understanding the explicit and implicit rules within the family may help to identify relationship conflict patterns (Murray, 2006).

If there is access to video viewing, the YouTube video from the Bowen Center quickly describes some important components of this lesson.
https://www.youtube.com/watch?v=-GK7LaT5rxY

SESSION 5 2.1

Within family systems theory, families are seen as being intricately connected to one another (Murray, 2006). Each part of the family system affects other parts of the family system. Reciprocal influences have meaning on each individual's behavior within the family as well (Murray, 2006). Family theorists believe that there are multiple causes and effects that determine the outcomes of behaviors and actions, this is called circular causality. While one person's behavior may elicit another family member's responsive behavior, then that behavior creates additional behaviors in family members. The causality is not linear within family systems but rather an intricate web with multiple influences.

Implicit and Explicit Rules:

Within family systems there are also implicit and explicit rules within each family system. These implicit and explicit rules play an important role in the function that specific behaviors play within the system (Murray, 2006). Family Theorists would say that the family is considered to be an emotional unit and that an individual cannot be understood in isolation from one another. In the same way the survivor of abuse should not be viewed in isolation from the family and system where the abuse occurred as well as the other systems in which she interacts. Each family member's actions and behaviors contribute to the functioning of the family system and other family member's behaviors. Birth order and roles within family of origin can play a factor in the family systems rules and interactions.

*Discuss some of the implicit and explicit rules in families.

The 8 Key Components of Bowen Family Systems Theory:

1. Triangles
2. Differentiation of Self
3. Nuclear Family Systems
4. Family Projective Process
5. Multigenerational Transmission Process
6. Emotional Cut-Off
7. Sibling Position
8. Societal Emotional Process

Eight Components Defined:

(Information from https://www.thebowencenter.org)

1. Triangles – A triangle is a three-person relationship system. It is considered the building block or "molecule" of larger emotional systems because a triangle is the smallest stable relationship system. A two-person system is unstable because it tolerates little tension before involving a third person.
2. Differentiation of Self – Differentiation involves a capacity to manage one's own anxieties and to resist reacting to anxiety in others. Bowen theorized that more highly differentiated individuals can mindfully engage the thinking and feelings systems that govern behavior.
3. Nuclear Family Systems – The concept of nuclear family emotional process describes four basic relationship patterns that govern where problems develop in a family. People's attitudes and beliefs about relationships play a role in the patterns, but the forces primarily driving them are part of the emotional system.
   a. Marital conflict
   b. Dysfunction in a spouse
   c. Impairment of one or more children
   d. Emotional distance
4. Family Projective Process – The family projection process describes the primary way parents transmit their emotional problems to their children. This projection process can impair the functioning of the children and also increase their vulnerability to clinical symptoms (Bowen, 1978).
5. Multigenerational Transmission Process – The concept of multigenerational transmission process describes how small differences in the levels of differentiation between parents and their offspring lead over many generations to marked differences in differentiation among the members of an extended family.
6. Emotional Cut-Off – The concept of emotional cutoff describes how people manage their unresolved emotional issues with parents, siblings, and other family members by reducing or totally cutting off emotional contact with them.
7. Sibling Position – The Bowen family systems theory concept of Sibling Position asserts that people who grow up in the same sibling position in families tend to have important common characteristics.
8. Societal Emotional Process – Each concept in Bowen theory applies to such nonfamily groups as work and social organizations. The concept of societal emotional process describes how the emotional system governs behavior in whole societies.

Genograms:

Some specific practices within family systems theory are genograms. Genograms allow the therapist to identify key people in the family and each individual's relationship within the family. Therapists are also able to identify key issues, concerns, and repeated patterns within the family system. Family theorists attempt to identify each individual's role within the family. These defined roles can have a huge impact on the functioning family system. Family system therapists often try to find ways to support the individual in order to help restore family relationships. This is only possible when looking at the family system as a whole and not the individual in isolation (Hurley, 1982).

According to Bowen, a family is a system in which each member had a role to play and rules to respect. Members of the system are expected to respond to each other in a certain way according to their role, which is determined by relationship agreements.

When looking at the victim in an IPV situation, it is imperative to understand and identify her role within the family whether positive or negative and address the changes from a systemic lens. The targets of change within family systems therapy is the individual in relation to the family, the family as a whole, and creating first and second order change. Therapists look to help individuals make changes and ultimately achieve second order change within their family unit. First order change would be considered superficial changes that don't actually affect the family system dynamic (Guttman, 1991; Nichols & Shwartz 2005).Second order change is beneficial within the family because it is developing a change in the thinking and dynamics within the family system.

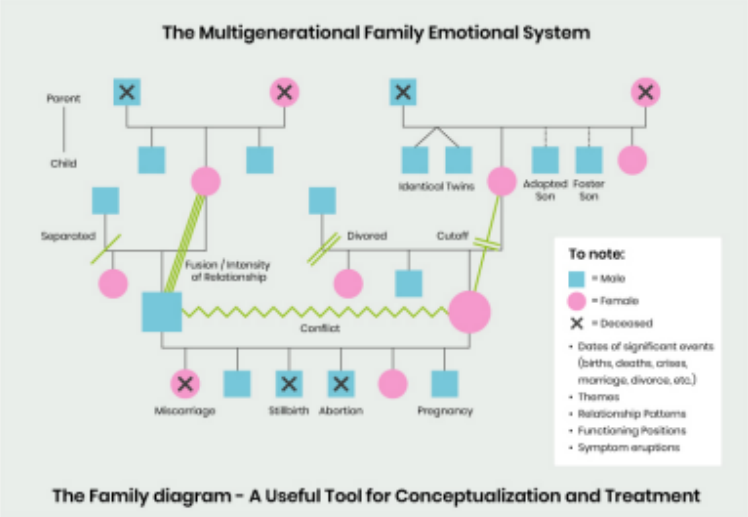
Circular Causality:

Circular causality focuses on the reciprocal relationship between two events. The perspective of reciprocal relationships stems from the idea that one system impacts another system. A reciprocal perspective moves away from the mechanical way of viewing systems (individualistic) toward a relational viewpoint with a focus on interactional patterns between individuals.

SESSION 5

2.1

Genogram:
A genogram is a picture of a person's family relationships and history. It goes beyond a traditional family tree allowing the creators to visualize patterns and psychological factors that affect relationships. A genogram offers a pictorial representation of the patterns and/or conflict in the family. A sample genogram to discuss is placed below.



The Family diagram - A Useful Tool for Conceptualization and Treatment

ACTIVITY: 20 MINUTES

Hand out Activity for Session 5 (see Activity Section). The activity for this session helps participants relate to the 8 key components of family systems theory. It also allows them to create a personal genogram to identify patterns with the family and different triangles that may be present.

CLOSING/POST-TEST: 20 MINUTES

Hand out Post-Test for Session 5 (see Pre/Post Test Section).

UNIT 2

Family Systems 2.2

SESSION 6: DEEPER DIVE INTO FST PART 1

OBJECTIVES

- Understand what anxiety can do within the family system
- Differentiate between the 'Feeling Guidance System' and the Intellectual Guidance System'
- Understand feedback loops within the family system

INTRO/WELCOME: 15 MINUTES

Facilitator is present to welcome individuals into the group. This time is spent with the purpose of connecting with others in the group and building relationships. Short check-ins can be done by going around the table and asking individually how each person's week has been. Be aware to keep this contained to a brief check-in with each person.

PRE-TEST: 5 MINUTES

Hand out Pre-Test for Lesson 6 (see Pre/Post Test Section).

LESSON 6:

Anxiety:
Bowen's focus was on patterns that develop in families in order to **defuse anxiety**. A key generator of anxiety in families is the perception of either too much closeness or too great a distance in a relationship. The degree of anxiety in any one family will be determined by the current levels of external stress and the sensitivities to particular themes that have been transmitted down the generations. If family members do not have the capacity to think through their responses to relationship dilemmas, but rather react anxiously to perceived emotional demands, a state of chronic anxiety or reactivity may be set in place.

Anxiety is used in Bowen Theory as a general term for emotional tension or stress. Anxiety impairs our ability to think and reason. Anxiety moves through the family system from one person to the next.

ANXIETY / **RELATIONAL TENSION** = **PRESENTING PROBLEM**

Many presenting problems are a result of anxiety/relational tension. "When aroused, the emotional system of the anxious individual tends to override the cognitive system and behaviour becomes increasingly automatic.....As the tension or anxiety mounts, the manifestations of togetherness and loss of individuality increase." (Papero 1990)

Togetherness vs Separateness

There are constantly two opposing forces of togetherness and separateness. The togetherness force compels us to be with others, seek approval, and attach with others while the separateness force compels us to be independent, have our own beliefs, and to not be overtaken by others.

Bowen asserted that we strive for a balance between togetherness and separateness.

If we are able to balance this well, we can be close to our loved ones without losing a sense of our individuality. "The emotional system operates as if it is governed by the interplay of two counterbalancing 'life forces'... defined as individuality and togetherness." (Kerr & Bowen, 1988).

"When it is possible to observe the details of family interactions without being seduced into an undue focus on certain details, then it can be seen that what family members think, feel, say, and do reflects an emotional process that pertains to the family as a whole. This emotional process is assumed to be regulated by the interplay of a force that inclines people to follow their own directives, to be independent (individuality), and a force that inclines them to respond to directive from others, to be connected (togetherness)." (Kerr & Bowen, 1988).

2.2

Feeling Guidance System

The 'Feeling Guidance System' involves emotions, automatic reactions, knee-jerk reactions, feeling, instincts, and urges.

INTELLECTUAL GUIDANCE SYSTEM

The 'Intellectual Guidance System' involves thinking, judgement, logic, reasoning, and rational thought.

FUNCTIONAL DECISIONS

In order to make functional decisions, we need access to both guidance systems and we need to be able to differentiate between them.

Homeostasis:
The concept of homeostasis means that the family system seeks to maintain its customary organization and functioning over time. It tends to resist change.

Homeostasis describes an ongoing process of system-level monitoring and adjustment that occurs in systems to maintain balance and order. Within family systems, homeostasis refers to unique behavioral, emotional, and interactional patterns developed and maintained by systems to enhance stability.

Homeostasis is not a fixed process. Instead, systems constantly use feedback, or information about the system, to monitor and self-correct. If movement beyond tolerable levels is detected, homeostatic actions are activated to restore stability to the system.

A system develops into a reliable and predictable way of being. The pull of this developed system is to maintain and not change. Any effort to change in this state creates anxiety in the system. Change and adaptation create a temporary disequilibrium but then settle into a new homeostatic state.
*Discuss the current homeostasis in a family system experiencing IPV.

SESSION 6

2.2

Feedback Loops:
The concept of ***feedback loops*** is used to describe the patterns or channels of interaction and communication that facilitates movement.

Negative feedback loops are those patterns of interaction that maintain stability or constancy while minimizing change. Negative feedback loops help to maintain homeostasis. Negative feedback loops are associated with patterns of interaction and communication that keep the family system functioning in its current way.

Positive feedback loops, in contrast, are patterns of interaction that facilitate change or movement toward either growth or dissolution. Although the words negative and positive are used within systems theory, it is not meant to characterize the communication as good or bad. Positive feedback loops would be patterns of interaction and communication that emerge as a result of the need for change.

As complex interactive systems, families are seen as being goal oriented. Families strive to reach certain objectives and goals. Through patterns of interactions, such as negative and positive feedback loops, the achievement of the goals becomes more or less attainable.

ACTIVITY: 20 MINUTES

Hand out Activity for Session 6 (see Activity Section). The activity for this session helps participants identify situations or events where they have used their 'Feelings Guidance System' or their 'Intellectual Guidance System'. Individuals are also encouraged to look at feedback loops that they can identify within their own relationships.

CLOSING/POST-TEST: 20 MINUTES

Hand out Post-Test for Session 6 (see Pre/Post Test Section).

UNIT 2

Family Systems 2.3

SESSION 7: DEEPER DIVE INTO FST PART 2

OBJECTIVES

- Understand what differentiation is in an individual in family systems theory
- Understand triangles within the family system
- Be able to explain the differences between first order change and 2nd order change

INTRO/WELCOME: 15 MINUTES

Facilitator is present to welcome individuals into the group. This time is spent with the purpose of connecting with others in the group and building relationships. Short check-ins can be done by going around the table and asking individually how each person's week has been. Be aware to keep this contained to a brief check-in with each person.

PRE-TEST: 5 MINUTES

Hand out Pre-Test for Lesson 7 (see Pre/Post Test Section).

LESSON 7:

Differentiation:

Differentiation of self refers to one's ability to differentiate themselves from the family. An individual with low differentiation is dependent upon others within the family for approval, acceptance, and decision-making (Sauerheber, et al. 2014). While an individual may not have entered into the relationship with low differentiation, often times, low differentiation is developed over the course of the abusive relationship due to implicit and explicit rules that are established within the family system.

A person with high differentiation is able to recognize they are part of the family system but still have the capacity to be their own person. In identifying and working with women in domestic violence situations, it is the goal to help establish higher differentiation with new implicit and explicit rules to create a healthy relationship and environment. Relationship interactions can also be influenced by the fact that individuals with low differentiation tend to be with those with similar levels of differentiation (Pollak, 2004).

SESSION 7

2.3

If someone is differentiated they can do two things well. Differentiated people are able to differentiate between their emotional guidance system and their reasoning guidance system and they are able to differentiate between themselves and others. These individuals don't get wrapped up in other people's emotions. They can be intimate with others while still remaining separated and individual.

Differentiated Person

DIFFERENTIATED

- Low Reactivity
- Calm Emotions
- Thoughtful Decisions
- Don't give in on pressure from others
- Low physical/social/emotional problems
- Not vulnerable to stress
- Independent
- Low (less prone) to Triangulation
- Low emotional entanglement
- Closeness with others/more fulfilling relationships

UNDIFFERENTIATED

- High Reactivity
- Less thoughtful decisions
- Can't say no
- Critical & judgmental
- Dependent
- High Triangulation
- Difficulty with decisions
- High physical/social/emotional problems
- Difficulty communicating
- Repeat problematic relationships

GROWTH!

The best way to work on increasing your differentiation level is to manage your 'Reactivity'.

Triangles:

Another key concept is the triangle within the family system. Within intimate partner violence the triangles may be with the abused woman being on the same side as her children creating alienation between the father and the children and simultaneously creating a division between the husband and wife. While the woman may not be doing this action overtly, she often spends her time and energy into another part of the family or possibly avoiding the high-conflict situation. In this example it is putting her time and energy into her children, instead of her husband (Willis, et al., 2021).

The shifting of the third person reduces the possibility of any one relationship 'overheating' (Sauerheber et al., 2014).While the conflict in an abusive relationship is between the husband and wife, some women try to spend their time and energy on the husband, in efforts to eliminate episodes of violence. The triangle in this situation might still be with the children; however, the dynamics look different. All of the interactions within the family system are intricately connected and the experiences/relationship interactions with one part of the family system inherently affect other parts of the family system. When symptomatic behaviors are seen by the family system, some families respond in ways of support in order to lessen the stress and increase the coping ability of the symptomatic person (Micucci, 1995).

Dysfunctional Triangles - Perpetuate the Problem
Functional Triangles - Resolve the Problem

First Order Change and Second Order Change:

First-order changes can create a temporary shift in systemic dynamics that can set the stage for more sustainable second-order changes. Second-Order Change. Second-order changes involve not just changes in behavior, but changes (or "violations") of the rules of the system itself (Guttman, 1991; Nichols & Shwartz 2005).

SESSION 7 2.3

When looking at the cycle of violence and the patterns of interactions within a dysfunctional homeostasis, change needs to occur in order to attain a functional homeostasis. First order change would be considered superficial changes that don't actually affect the family system dynamic (Guttman, 1991; Nichols & Shwartz 2005).

Second order change is beneficial within the family because it is developing a change in the thinking and dynamics within the family system. Even if a partner learns new communication skills but still believes he has the power to make all the decisions for his partner, a new structure has not been attained (Murray, 2006). Being able to work toward building a relationship where both partners are mutually respected and share in decision making would be an example of second-order change, or changes within the dynamics and structure of the family (Murray, 2006).

First Order Change

VS.

SECOND ORDER CHANGE

"A system which may run through all its possible internal changes without effecting a systemic change, i.e., second-order change, is said to be caught in a Game Without End. It cannot generate from within itself the conditions for its own change; it cannot produce the rules for the change of its own rules." (Watzlawick, et al.1974)

ACTIVITY: 20 MINUTES

Hand out Activity for Session 7 (see Activity Section). The activity for this session helps participants identify the level of differentiation they currently have.

CLOSING/POST-TEST: 20 MINUTES

Hand out Post-Test for Session 7 (see Pre/Post Test Section).

UNIT 3

Healthy Relationships 3.1

SESSION 8: BOUNDARIES & EQUALITY WHEEL

OBJECTIVES

- Discuss ways that we respect ourselves and others
- Identify appropriate boundaries for time, emotions, knowledge, and bodies.
- Understand and be able to utilize the 'Equality Wheel'.

INTRO/WELCOME: 15 MINUTES

Facilitator is present to welcome individuals into the group. This time is spent with the purpose of connecting with others in the group and building relationships. Short check-ins can be done by going around the table and asking individually how each person's week has been. Be aware to keep this contained to a brief check-in with each person.

PRE-TEST: 5 MINUTES

Hand out Pre-Test for Lesson 8 (see Pre/Post Test Section).

LESSON 8:

Creating healthy boundaries is empowering. By recognizing the need to set and enforce limits, you protect your self- esteem, maintain self-respect, and enjoy healthy relationships. Unhealthy boundaries cause emotional pain that can lead to dependency, depression, anxiety, and even stress-induced physical illness.

Learning to set boundaries can be a valuable skill that helps you heal and enriches your relationships in the future. Boundaries help us be aware of ourselves and our relationships. They're important for self-care and making yourself a priority.

Boundaries can be defined as the limits we set with other people, which indicate what we find acceptable and unacceptable in their behavior towards us.

SESSION 8

3.1

BOUNDARIES

What are boundaries?

Boundaries are the non-negotiable lines that are established with your partner to make sure that you feel safe and respected in the relationship. Boundaries are extremely important whether the relationship is new or has been a part of your life for many years. Women should know their boundaries and how to express them. Boundaries protect our personal goals, dreams, values, autonomy and self-worth. Some boundaries to consider and make sure you have evaluated include (Kippert, 2022):

Physical Boundaries: Think about how and when you feel comfortable being physical in a relationship. Remember, your body is your own; no one else's! You should never feel pressured into being physical whether it is because you have been taken out to eat or because you feel like you 'should'.

Physical boundaries also include violent behavior. Some partners may think that a playful shove or more aggressive bedroom behavior is acceptable but if it makes you uncomfortable, then it is important to speak up and express this as a boundary.

Emotional Boundaries: Similar to your body, your emotions are your own to feel. No one else should be telling you that you should or shouldn't be feeling a certain way at any given time. Often our body has certain feelings as a warning sign or a way to be aware of something. Listen to your feelings. A boundary with emotions is being able to state how you are feeling and letting them know that you don't appreciate them trying to persuade you from feeling a certain way.

Another emotional boundary might be emotional separation. A boundary for yourself might be being aware that it is not your responsibility to make someone else happy. Think about when you are comfortable expressing intimate emotions with your partner and make sure you establish a boundary on this expression (such as 'I love you') that you are comfortable with.

Material Boundaries: Think about what you feel comfortable in sharing with your partner. Obviously, when we were kids we were taught that sharing is important, but as an adult you are able to decide what and how much you are comfortable sharing. Think about if you feel comfortable lending your partner your car, money, phone, etc.?

Spiritual Boundaries: Think about your spiritual beliefs and how much you feel comfortable sharing with your partner. Are you comfortable having different beliefs? Is your boundary that your partner respect your beliefs, even if they differ?

Mental Boundaries: Be aware of your own opinions, thoughts, and feelings. Sometimes, women in domestic violence situations are easily swayed by others. You may have a difficult time standing your ground, which means you need to take even more time to really think about your mental boundaries. Think about how you want to react to gaslighting or blame if your partner tends to use either of those tactics with you.

While determining boundaries may be hard, the hardest part of creating boundaries is actually sticking to them and enforcing them.

Many women in domestic violence situations tend to draw a 'line in the sand' of where their boundary is and their partner stays right around that line, steps on it, or may even cross over it a little. It is important to be aware that many individuals that cross one 'line in the sand' will also cross another. Be cognizant to not keep moving your figurative 'line in the sand'. Stick to your boundaries. Write them down. Practice saying them.

BOUNDARY *examples*

- I will have my own career and my partner will support it.
- I will spend time with my family because they are important to me.
- I will have my own friends and you may (or may not) be a part of that circle.
- I can change my mind for any reason and you will respect this freedom.
- I am proud of my appearance and you will not try to change it.
- I decide what is important to me.
- I have the right to desire my own goals.
- I have the right to seek professional help, if I choose to.
- I create my own priorities.
- I have a right to privacy.
- I have the right to not be responsible for other people's feelings.
- I have a right to set my own boundaries.
- I have a right to have my boundaries respected.

SESSION 8

3.1

Development of boundaries, if you weren't fortunate enough to have learned good ones in your family of origin or if yours were eroded, is a process. It takes time and work to find those 'muscles' and learn how to use them in ways that promote your personal growth, development, and safety.

The Equality Wheel

(USE IN CONJUNCTION W/ POWER & CONTROL WHEEL)

The 'Equality Wheel' has corresponding opposites to the 'Power and Control Wheel'. This wheel has been helpful for women who have been experiencing domestic abuse as they know what a relationship looks like that uses power and control; however, many women are unaware of what a healthy relationship with equality may look like. This wheel allows both women and men to understand the difference between a violent relationship and one that was healthy and supportive for both individuals.

*Individuals may highlight with the same color they used on the power and control wheel any items in the equality wheel that they experience with their partner. They can then use a different color to highlight the aspects of a relationship on the equality wheel that are most important to them. (See additional resources section for copies of both wheels).

Domestic Abuse Intervention Programs
202 East Superior Street
Duluth, Minnesota 55802
218-722-2781
www.TheDuluthModel.org

ACTIVITY: 20 MINUTES

Hand out Activity for Session 8 (see Activity Section). The activity for this session helps participants create boundaries in multiple areas of their lives.

CLOSING/POST-TEST: 20 MINUTES

Hand out Post-Test for Session 8 (see Pre/Post Test Section).

UNIT 3

Healthy Relationships 3.2

SESSION 9: COMMUNICATION

OBJECTIVES

- Understand the pragmatics of communication.
- Identify key factors in communication
- Identify ways to help promote effective communication
- Identify pitfalls that lead to ineffective communication

INTRO/WELCOME: 15 MINUTES

Facilitator is present to welcome individuals into the group. This time is spent with the purpose of connecting with others in the group and building relationships. Short check-ins can be done by going around the table and asking individually how each person's week has been. Be aware to keep this contained to a brief check-in with each person.

PRE-TEST: 5 MINUTES

Hand out Pre-Test for Lesson 9 (see Pre/Post Test Section).

LESSON 9:

Communication :

Similar to setting boundaries, communication is like a muscle. The more you use it the more it develops. By applying certain principles and seeking to improve your communication, improvement is possible with practice.

Without communication, couples have no room to compromise. If you can't meet in the middle over certain issues in your marriage, you are essentially invalidating each others' wants, needs, and feelings. This can be very dangerous to the success of a relationship.

If you have opened the doors of effective communication with your spouse, you are more likely to experience a happy and peaceful relationship. Better communication means better satisfaction in a relationship in which you discuss everything with each other and thus lessen fights or quarrels.

SESSION 9

3.2

COMMUNICATION

The 5 AXIOMS of communication (Montes, 2021):

1.Cannot NOT Communicate

- Every behavior is a kind of communication.
- As long as two parties are in presence of each other they are communicating and thus being interpreted by the other.
- Even the behavior of 'not talking' is still communicating to your partner.

2. Content and Relationship

- Content includes the actual words being said in the conversation.
- Meta-communication is one's relationship to the content (this includes the relationship between the communicators)
- The content being said is also in relationship to the communicators and other contexts that are present.

3. Punctuation

- Punctuation is how each party interprets the particular sequence of interaction to make meaning.
- How we punctuate the communication determines how we make meaning of the information.
- How does one group the messages to make meaning through the sequence of interactions? (For example: if a child barges into the room to give the parent an idea about something and the parent gets angry at the child; will the child interpret the anger at the idea or will the child interpret the anger to be at the interruption?)

4. Digital and Analog

- Digital – are discrete defined elements of communication (what the words actually mean).
- Analogic – are the meanings that we give those words/gestures/interactions.
- Modalities – includes the types or sorts of information being transferred.

5. Symmetric or Complementary

- Symmetric communication means it is equal from a power perspective.
- Complementary communication is when one where there is unequal power.
- Be aware of the type of relationship present.
- How it may or may not be functional (i.e. if parent/child are communicating with symmetric communication).

SESSION 9

3.2

The tragedy of common communication patterns is when someone is in pain they tend to either withdraw or lash out. What this means is that when they most need others' care, love, support, and concern is when they tend to act in ways that make it least likely that they will receive care, love, support, and concern from others.

*In no way is this statement incorporated to place any blame on the survivor, but rather help the survivor have insight into the perpetrator's unhealthy communication pattern.

On the other hand, domestic violence is different from many other kinds of violence in that it often occurs at home — the place where we are supposed to be safest. And it occurs between loved ones — people who in principle are there to care for and protect each other. Because domestic violence happens in a home environment — and between people who usually have had some sort of emotional closeness — the level of broken trust can greatly amplify the pain.

PRACTICAL TIPS

Some general tips to think about for communication with partners include:

- Process your feelings first - (remember..... about being differentiated)
- Think about timing - maybe give your partner a heads up that you would like to talk to them about something.
- Start with "I" statements and feelings - make sure you state how you are feeling and try not to place blame.
- Focus on being heard and on listening - try to understand their point of view.
- Make compromise and resolution the goal - try to find something that is a solution for both partners.
- Set clear boundaries - possibly any purchase over $500 should be discussed.
- Leave your partner notes - in efforts of communication.
- Check-in throughout the day when possible to let your partner know how you are feeling.

SESSION 9

3.2

Pitfalls TO AVOID

- The silent treatment - remember, even not talking is communicating to your partner.
- Bringing up past mistakes - this can be counterproductive and make your partner more defensive.
- Yelling or screaming - this will usually escalate the problem far beyond where the actual problem started.
- Walking away - or stonewalling is not effective and leaves the argument unresolved.
- Sarcasms or put-downs - these do not contribute to conflict resolution.
- Disrespectful non-verbal behavior - looking at your phone or not giving your full attention can be interpreted as disrespectful.

Effective communication is the foundation of a successful relationship, but that doesn't mean it's always easy. Remember, you are only responsible for you! You cannot control how someone else chooses to act.

ACTIVITY: 20 MINUTES

Hand out Activity for Session 9 (see Activity Section). The activity for this session helps participants create boundaries in multiple areas of their lives.

CLOSING/POST-TEST: 20 MINUTES

Hand out Post-Test for Session 9 (see Pre/Post Test Section).

UNIT 3

Healthy Relationships 3.3

SESSION 10: PLANNING FOR THE FUTURE

OBJECTIVES

- Participants will know how to set and make plans to attain personal goals and dreams.
- Identify the various ecological levels within their life.
- Determine what ecological levels may need more supports.
- Know how to create a SMART goal.

INTRO/WELCOME: 15 MINUTES

Facilitator is present to welcome individuals into the group. This time is spent with the purpose of connecting with others in the group and building relationships. Short check-ins can be done by going around the table and asking individually how each person's week has been. Be aware to keep this contained to a brief check-in with each person.

PRE-TEST: 5 MINUTES

Hand out Pre-Test for Lesson 10 (see Pre/Post Test Section).

LESSON 10:

Looking beyond the present:

While it is difficult to look beyond the present when there are emotional and traumatic experiences currently happening, it is important to try to look beyond the current situation. It is important to plan ahead for attaining your life goals and dreams you have for your future. This can include personal goals, relational goals, professional goals, spiritual goals, etc. If we don't actively identify our goals and make a plan to work toward them then we can get caught just living in our current situation. Now is the time to ask yourself the questions and determine if changes need to be made in order to attain your dreams and desires.

3.3

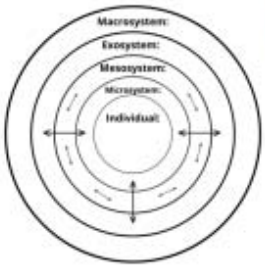
ASK YOURSELF THESE

questions...

- What are my professional goals? What career or job might I be interested in pursuing? What education would I need to attain my dream job? How can I work toward these goals?
- What are my goals in the area of physical health? How can I work toward these goals?
- What are my goals in the area of mental and emotional health? Where do I see myself in one year from now mentally/emotionally? How can I work toward these goals?
- Wat are my goals in the area of parenting my children? Do I need support in order to reach this goal? How can I work toward these goals?
- What are my goals in the area of developing and nurturing relationships with family, friends, a romantic relationship, etc.? Where do I want to be in one year when I think of these relationships? How can I work toward these goals?
- What are my goals in the area of spirituality? How can I work toward these goals?
- What are the potential barriers to reaching my goals? How can I overcome these barriers?
- What are my fears about the future? What coping skills have I learned to manage these fears?
- What support will I need moving forward? (family, friends, therapist, community resources, etc.)

ECOLOGICAL LEVELS

Looking at intimate partner violence through the ecological lens can suggest and identify factors that oppress women in domestic violence situations.



Personal Characteristics
Microsystem
Mesosystem
Exosystem
Macrosystem
Chronosystem

A person's physical appearance, including their age and gender will have an influence on their social interactions. The person and the personal characteristics influence how they respond to others and in return, how others respond to them. Other personal characteristics include IQ, ability to handles stress/emotions, and personality (Rosa, & Tudge, 2013). All of these factors influence how one interacts with their environment and is unique to each individual.

Within the IPV population, personal characteristics may be different for each individual. The woman's ability to handle stress or emotions is unique to her as an individual; however, due to IPV, her ability to handle stress may be diminished. Personal characteristics may also either hinder or promote interactions with her environment. Dependent on personal characteristics, including age or social economic status, a woman might have either more access or limited access to resources within her community and society.

Brofenbrenner describes four systems within this domain: Microsystem, Mesosystem, Exosystem, and Macrosystem (Neal & Neal, 2013).

Microsystem

- The microsystem is the system level where family systems theory and bioecological theory can overlap with some congruency. The microsystem is described as the individual's family, friends, and the interactions with the most immediate people in the individual's life (Rosa & Tudge, 2013). This is the most influential level. Interactions at this level are bi-directional, meaning that how an individual treats someone else in this system directly affects how they treat the person in return. Reactions will affect how others treat the individual. Specifically, this can address multiple aspects of IPV because certain actions within the relationship set the stage for the reaction from the perpetrator. The cycle of violence can also be interwoven with this stage because the actions of the victim at various stages within the cycle of violence precipitate the reactions of the perpetrator (Focht, 2020). Implicit and explicit rules are also established within this level. These implicit and explicit rules may be examples of how the individual interacts within the family (Murray, 2006).These rules and bi-directional interactions establish a homeostasis within the microsystem. Women in IPV situations often experience a dysfunctional homeostasis with consistent feedback loops that move the family farther away from a functional homeostasis.

Mesosystem

- The second system level is the mesosystem. Brofenbrenner indentified the mesosystem as the interactions between different parts of an individual's microsystem (Rosa & Tudge, 2013).The mesosystem can be viewed as building a bridge between two of the microsystem. The individual has direct interactions with the mesosystem much like the microsystem; however, the difference is that the two microsystems have some form of connection in the mesosystem. Women in domestic violence situations often have limited mesosystems due to microsystems being purposefully separated from one another by the perpetrator, as an act of control, or by the victim in an attempt to keep the IPV hidden (Machisa et al., 2018). Mental health effects of IPV may also hinder women to have multiple mesosystems and prevent the experiences, support, and interactions from the mesosystems they do have (Machisa et al., 2018). Providing women with access to increase their mental health and increase social supports can have a profound effect in relation to women being able to access and interact with their mesosystems.

Exosystem

- The third system level is the exosystem. This is considered to be an outside system that has an indirect affect on the individual. The individual does not directly interact with this system; however, the individual does experience its influence (Rosa & Tudge, 2013). An example within this level would be a husband constantly coming home angry or agitated due to his work situation. While the wife does not have any direct interactions with her husband's work, she is indirectly affected because of his mood when he returns home. In an IPV situation, this may look like walking on eggshells, trying to calm or appease the husband, or attempting to not say anything that would make him mad (Focht, 2020). Another example of the exosystem within the context of IPV is through policy making of laws related to domestic violence. While the woman may have no direct interactions with the lawmakers, she is indirectly affected by the laws about domestic violence, domestic violence arrests, and policies that get put into place by the lawmakers. Teaching women through psycho-educational classes can offer education about the cycle of violence and laws/policies related to IPV.

Macrosystem

- Finally, there is the macrosystem. The macrosystem is defined as "the institutional systems of a culture or subculture, such as the economic, social, education, legal, and political systems" (Rosa & Tudge, 2013). The overarching belief system of the microsystem determines the effect of the macrosystem. Cultural values, health, and public laws can also be a part of the macrosystem. The principles of the macrosystem have effects on all other system levels. Socio-economic status, ethnicity, and policy play a role in the macrosystem. Within the IPV situations, socio-economic status and ethnicity are factors that have lead to higher rates of IPV. One example within the macrosystem could be how the belief system of the macrosystem affects whether a woman should stay at home and take care of children or whether she should get a job to help support the family. This influence of the macrosystem will have effects on all other system levels, specifically in the interaction the woman is able engage at each level. The cultural environments are also significant within this level. If an individual lives in a low-income neighborhood with alcohol and drug use where domestic violence is commonplace, these factors will have substantial impact on the individual.

Chronosystem

- The last concept within Brofenbrenner's five systems is the chronosystem. The chronosystem is where time is incorporated as part of the environment for human development (Rosa & Tudge, 2013). Changes that occur over an individual's lifetime that are caused by experiences and life events are considered within this system. This could include typical individual development (puberty, becoming ill), the birth of a sibling, or could include the more traumatic experiences some families face of domestic violence. Women who are amidst the IPV are facing multiple changes within various levels. Women often have to experience life transitions when exiting an IPV situation, which continues to add to her chronosystem of life events. Sociocultural events also have an impact on the chronosystem. The impact of the societal issues can affect the developing person.

SESSION 10

3.3

GOALS

Goals are part of every aspect of business/life and provide a sense of direction, motivation, a clear focus, and clarify importance. By setting goals, you are providing yourself with a target to aim for. A SMART goal is used to help guide goal setting. SMART is an acronym that stands for Specific, Measurable, Achievable, Realistic, and Timely. Therefore, a SMART goal incorporates all of these criteria to help focus your efforts and increase the chances of achieving your goal (Poe, et al., 2021).

SMART goals are:

- Specific: Well defined, clear, and unambiguous
- Measurable: With specific criteria that measure your progress toward the accomplishment of the goal
- Achievable: Attainable and not impossible to achieve
- Realistic: Within reach, realistic, and relevant to your life purpose
- Timely: With a clearly defined timeline, including a starting date and a target date. The purpose is to create urgency.

ACTIVITY: 20 MINUTES

Hand out Activity for Session 10 (see Activity Section). The activity for this session helps participants identify interactions and supports they have at the various ecological lives in their lives. It also helps them identify personal characteristics.

CLOSING/POST-TEST: 20 MINUTES

Hand out Post-Test for Session 10 (see Pre/Post Test Section).

SUPPORT groups

Support groups offer meeting times for participants who have experienced similar situations to connect and build friendships. Bi-weekly support groups are scheduled within the program in order to offer less structured time for women to build relationships and support one another. Support is also offered through link women who have given consent to be part of an online group (through group messaging and group functions on social media sites) in order to be support throughout the week and when women are not attending other program components.

BI-WEEKLY SUPPORT GROUP SESSIONS

- Build Relationships
- Make Connections
- Networking Opportunity

Facilitator will be available during the support group sessions. Participants can ask questions or share personal experiences. The focus is on building system level supports.

ONLINE SUPPORT GROUPS

- Group messaging
- Joining a cohort social media 'group'
- Access to individual connections in cohort
- Connections online

Online supports are available for those who give consent in order to support individuals throughout the week who choose to explore this component. The groups are cohort and cross-cohort based and other participants that are known personally from other components of the program. There will be a moderator and admin within the groups.

INDIVIDUAL *Therapy*

Ten sessions of Individual therapy is designed within the program in order to help women learn ways to cope with traumatic experiences of intimate partner violence. Depression, anxiety, and PTSD (Post-Traumatic Stress Disorder) are common among this population. Women will participate in individual therapy in order to improve their mental health for themselves and their families.

Women will connect with a therapist for individual therapy. Together, the therapist and participant will determine the course of treatment. EMDR (Eye-Movement Desensitization and Reprocessing) is available for clients who would like to create adaptive memory networks in their healing journey.

Therapists will provide opportunities for coping strategies to be worked on throughout the week with individualized suggested activities for healing progress.

FAMILY Therapy

Family therapy is offered within the program design in order to help facilitate parent-child relationships that have been strained. This component is malleable to the participant and their individual situation. The focus of family therapy is the development of attachment problems that occur between parent and child throughout domestic violence situations. The program recommends Parent-Child Interaction Therapy (PCIT) as the starting point for family therapy if there are behavioral concerns with children in the family.

PARENT-CHILD INTERACTION THERAPY

PCIT attempts to address behavioral needs of children in two phases: by developing a relationship and helping the children feel calm and secure and by managing the behaviors while remaining calm, confident, and consistent (Lieneman et al., 2017).

CHILD-PARENT RELATIONSHIP THERAPY

Other suggested family therapy could include an attachment-based therapy model called Child-Parent Relationship Therapy (CPRT) Treatment Manual: A 10-Session Filial Therapy Model for Training Parents (Bratton et al., 2006). CPRT is recommended for children presenting with behavioral, emotional, social, and attachment disorders, which tend to be common for children exposed to domestic violence.

PRE/POST-TEST worksheets

At the beginning of each psycho-education class there will be a pre-test to identify prior knowledge on the topics being covered in that class session. At the end of each class session there will also be a post-test to help identify gained knowledge from the psycho-educational lesson. This evaluation piece is partially used as an intervention in order to help participants be cognizant of the topics and areas of concern on the tests.

Psycho-educational lessons will teach participants multiple components about intimate partner violence. Within the psycho-educational lessons there are pre/post-tests that address the 10 topics covered over the 10 weeks.

Pre/Post-Test Worksheets can be printed and reproduced. The format was created in order to make copies and cut each Session Pre/Post-Test in half. Facilitator will give participants Pre-Test at the beginning of the session and Post-Test at the end of the session.

PRE/POST-TEST

Pre-Test

Session 1

Name:

MOOD:

T/F IPV is cruel or violent behavior (abuse) perpetrated against intimate partner or former intimate partner.

T/F Physical, Sexual, Emotional, Exploitation, Neglect, Self-Neglect, Abandonment are all types of abuse.

T/F The Cycle of Violence has a Tension Building phase, a Violent Episode, and a Honeymoon Phase.

T/F The patterns of abuse are the same for all people.

T/F If you have never experienced physical abuse then it is not IPV.

T/F Non-abusive conflict is when there is a desire to communicate one's own point of view and understand the other person's PoV through respectful behavior.

Post-Test

Session 1

Name:

MOOD:

T/F IPV is cruel or violent behavior (abuse) perpetrated against intimate partner or former intimate partner.

T/F Physical, Sexual, Emotional, Exploitation, Neglect, Self-Neglect, Abandonment are all types of abuse.

T/F The Cycle of Violence has a Tension Building phase, a Violent Episode, and a Honeymoon Phase.

T/F The patterns of abuse are the same for all people.

T/F If you have never experienced physical abuse then it is not IPV.

T/F Non-abusive conflict is when there is a desire to communicate one's own point of view and understand the other person's PoV through respectful behavior.

Session 2

Pre-Test

Name:

MOOD:

T/F Violence against women can cause long-term physical and mental health problems.

T/F There are short-term effects of violence on children but no long-term effects.

T/F Digestive problems, heart problems, IBS, chronic pain, and migraines are some of the long-term physical health effects of IPV.

T/F PTSD, Depression, and Anxiety are some of the most common mental health effects on women in IPV situations.

T/F Women who experience IPV typically do not have any effects on their work/employment.

T/F The effects of IPV go beyond the home life and relationships within the home.

Session 2

Post-Test

Name:

MOOD:

T/F Violence against women can cause long-term physical and mental health problems.

T/F There are short-term effects of violence on children but no long-term effects.

T/F Digestive problems, heart problems, IBS, chronic pain, and migraines are some of the long-term physical health effects of IPV.

T/F PTSD, Depression, and Anxiety are some of the most common mental health effects on women in IPV situations.

T/F Women who experience IPV typically do not have any effects on their work/employment.

T/F The effects of IPV go beyond the home life and relationships within the home.

PRE/POST-TEST

Session 3

Pre-Test

Name:

MOOD:

T/F Denial is extremely detrimental because it will cause a victim to remain in an abusive relationship.

T/F Rationalizing abuse is one of the levels of denial.

T/F The inherent problem of codependency is that the individual loses their true sense of self since they're pouring so much into someone else.

T/F A sense of "walking on eggshells" to avoid conflict with the other person is a common characteristic of co-dependency.

T/F Codependency only refers to a physical reliance on a partner, friend, or family member.

T/F Co-dependency can only happen in a romantic relationship.

Session 3

Post-Test

Name:

MOOD:

T/F Denial is extremely detrimental because it will cause a victim to remain in an abusive relationship.

T/F Rationalizing abuse is one of the levels of denial.

T/F The inherent problem of codependency is that the individual loses their true sense of self since they're pouring so much into someone else.

T/F A sense of "walking on eggshells" to avoid conflict with the other person is a common characteristic of co-dependency.

T/F Codependency only refers to a physical reliance on a partner, friend, or family member.

T/F Co-dependency can only happen in a romantic relationship.

Session 4

Pre-Test

Name:

MOOD:

T/F Frequent lying and constant put-downs are red flags in a relationship.

T/F Having red flags means that the relationship will turn abusive.

T/F Sometimes women don't see the red flags in a relationship because they are blinded by love.

T/F Only women who are being physically abused should create a personalized safety plan.

T/F Leaving the abuser is the most dangerous time for the person being abused.

T/F Safety plans should start from the assumption that an abuser is dangerous and try to help the survivor identify the circumstances under which the abuser typically becomes violent

Session 4

Post-Test

Name:

MOOD:

T/F Frequent lying and constant put-downs are red flags in a relationship.

T/F Having red flags means that the relationship will turn abusive.

T/F Sometimes women don't see the red flags in a relationship because they are blinded by love.

T/F Only women who are being physically abused should create a personalized safety plan.

T/F Leaving the abuser is the most dangerous time for the person being abused.

T/F Safety plans should start from the assumption that an abuser is dangerous and try to help the survivor identify the circumstances under which the abuser typically becomes violent

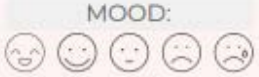
PRE/POST-TEST

Session 5

Pre-Test

Name:

MOOD:



T/F There are 8 key components of Family Systems Theory.

T/F It is better to be less differentiated in a relationship.

T/F Learning about Family Systems Theory can help me better understand the patterns of relationships in my own family.

T/F In Family Systems Theory it is believed that all parts of the family system are interconnected.

T/F A systems' behavior affects its environment but the environment does not affect the system.

T/F The behavior of individuals cannot be understood without reference to the systems to which they belong.

Post-Test

Name:

Session 5

MOOD:

T/F There are 8 key components of Family Systems Theory.

T/F It is better to be less differentiated in a relationship.

T/F Learning about Family Systems Theory can help me better understand the patterns of relationships in my own family.

T/F In Family Systems Theory it is believed that all parts of the family system are interconnected.

T/F A systems' behavior affects its environment but the environment does not affect the system.

T/F The behavior of individuals cannot be understood without reference to the systems to which they belong.

PRE/POST-TEST

Session 6

Pre-Test

Name:

MOOD:

T/F If family members react anxiously to perceived emotional demands, a state of chronic anxiety or reactivity may be set in place.

T/F Many presenting problems are a result of anxiety/relational tension.

T/F You should have togetherness or separateness in a relationship, but not both.

T/F The goal of Family Systems Theory is to focus on patterns that develop in families in order to defuse anxiety.

T/F The 'Feeling Guidance System' is responsible for thinking, judgement, reasoning, rational thought, and logical thinking.

T/F Functional decisions require access to both the 'Feeling Guidance System' and the 'Intellectual Guidance System'.

Session 6

Post-Test

Name:

MOOD:

T/F If family members react anxiously to perceived emotional demands, a state of chronic anxiety or reactivity may be set in place.

T/F Many presenting problems are a result of anxiety/relational tension.

T/F You should have togetherness or separateness in a relationship, but not both.

T/F The goal of Family Systems Theory is to focus on patterns that develop in families in order to defuse anxiety.

T/F The 'Feeling Guidance System' is responsible for thinking, judgement, reasoning, rational thought, and logical thinking.

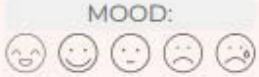
T/F Functional decisions require access to both the 'Feeling Guidance System' and the 'Intellectual Guidance System'.

Session 7

Pre-Test

Name:

MOOD:



T/F If you are differentiated you should have a low reactivity, calm emotions, thoughtful decisions, and independence.

T/F Individuals typically have similar differentiation levels to their family of origin.

T/F Partners often have very different levels of differentiation.

T/F A functional triangle will perpetuate a problem within the system.

T/F A triangle may occur between a husband, wife, and child or a husband, wife, and therapist.

T/F One way to help increase differentiation is to work on managing 'reactivity'.

Session 7

Post-Test

Name:

MOOD:

T/F If you are differentiated you should have a low reactivity, calm emotions, thoughtful decisions, and independence.

T/F Individuals typically have similar differentiation levels to their family of origin.

T/F Partners often have very different levels of differentiation.

T/F A functional triangle will perpetuate a problem within the system.

T/F A triangle may occur between a husband, wife, and child or a husband, wife, and therapist.

T/F One way to help increase differentiation is to work on managing 'reactivity'.

Session 8

Pre-Test

Name:

MOOD:

T/F Boundaries are typically difficult to keep until you have practiced establishing them for a while.

T/F You need someone else's approval before you establish boundaries of your own.

T/F Your partner should have a say on what boundaries you put into place.

T/F You should have boundaries for different areas of your life.

T/F The 'Equality Wheel' shows aspects of a healthy relationship and can be looked at in conjunction with the 'Power and Control Wheel.'

T/F Everyone deserves to have their boundaries respected. Everyone deserves to have a healthy relationship and be treated with respect.

Session 8

Post-Test

Name:

MOOD:

T/F Boundaries are typically difficult to keep until you have practiced establishing them for a while.

T/F You need someone else's approval before you establish boundaries of your own.

T/F Your partner should have a say on what boundaries you put into place.

T/F You should have boundaries for different areas of your life.

T/F The 'Equality Wheel' shows aspects of a healthy relationship and can be looked at in conjunction with the 'Power and Control Wheel.'

T/F Everyone deserves to have their boundaries respected. Everyone deserves to have a healthy relationship and be treated with respect.

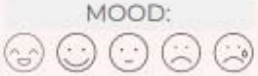
PRE/POST-TEST

Session 9

Pre-Test

Name:

MOOD:



T/F Giving the silent treatment is not a form of communication.

T/F In a partner relationship there should be symmetric communication.

T/F Communication involves the meaning we gives the words we say, as well as, the way the other person interprets what we say.

T/F Only one person needs to use active listening during communication.

T/F It is helpful to give your partner a heads up when you have something you would like to discuss with them.

T/F Yelling, screaming, and put-downs during a conversation are never acceptable.

Session 9

Post-Test

Name:

MOOD:

T/F Giving the silent treatment is not a form of communication.

T/F In a partner relationship there should be symmetric communication.

T/F Communication involves the meaning we gives the words we say, as well as, the way the other person interprets what we say.

T/F Only one person needs to use active listening during communication.

T/F It is helpful to give your partner a heads up when you have something you would like to discuss with them.

T/F Yelling, screaming, and put-downs during a conversation are never acceptable.

PRE/POST-TEST

Pre-Test

Name:

Session 10

MOOD:

T/F It takes a lot of courage to move out of a familiar situation with a partner even though it is damaging and hurtful.

T/F I can create goals and dreams and create a plan for attaining them.

T/F I will need support in multiple levels of my life to make difficult changes.

T/F I only need to address my mental health while I am in an abusive relationship.

T/F I know steps I can take to access supports and mental health help.

T/F It is important to be connected to people I can relate with and build relationships with.

Post-Test

Name:

Session 10

MOOD:

T/F It takes a lot of courage to move out of a familiar situation with a partner even though it is damaging and hurtful.

T/F I can create goals and dreams and create a plan for attaining them.

T/F I will need support in multiple levels of my life to make difficult changes.

T/F I only need to address my mental health while I am in an abusive relationship.

T/F I know steps I can take to access supports and mental health help.

T/F It is important to be connected to people I can relate with and build relationships with.

ACTIVITY worksheets

The activity worksheets that correlate with each lesson are created to help the participants relate the information to their own personal situations. Being able to personalize the information, makes it more meaningful and more likely to have an impact. The activities also make it possible to create authentic discussions within the group setting.

Facilitator will lead the activities that correlate with each session. The activities section of the program manual can be reproduced for the psycho-educational classes.

Allow time for participants to complete the activity in chunks, breaking to have discussion about the various sections within the activity. Some participants may have questions or wish to share about personal experience. Be cognizant to keep the activity focused on the content of the activity/session.

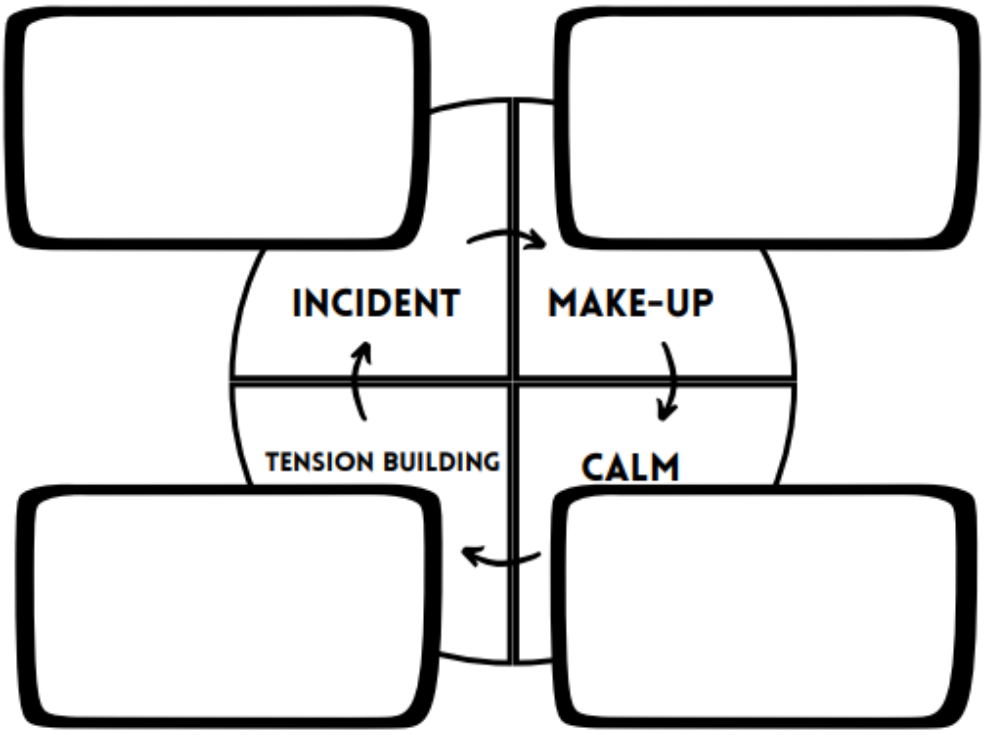
Each activity worksheet correlates with the Unit and Session Number. Additional resources that may correlate with multiple sessions are in the Additional Resources section.

Session 1

The Cycle of Abuse

This worksheet is a simplified version of the Cycle of Abuse. The theory of the abuse cycle was posited by Lenore E. Walkers in 1979.

Think about an incident that has happened in your past. Describe each phase in the Cycle of Abuse in your own personal life in the boxes surrounding the circle.



Why is abuse a cycle?

Session 2

COPING WITH ANXIOUS FEELINGS

Some things that make me feel anxious are:

Anxious

1. _____
2. _____
3. _____
4. _____

These changes happen when I feel anxious:

CHANGES IN MY BODY:	THOUGHTS I HAVE:	THINGS I DO:

When I feel anxious, I can cope by:

Check all of the coping skills that might be helpful. Use the blank space to write in your own.

- ☐ DEEP BREATHING
- ☐ USING POSITIVE SELF-TALK
- ☐ MEDITATING OR RELAXING
- ☐ TALKING TO A FRIEND
- ☐ TALKING TO ANOTHER ADULT
- ☐ LISTENING TO MUSIC
- ☐ GOING FOR A WALK
- ☐ WRITING IN A JOURNAL
- ☐ PRACTICING MINDFULNESS
- ☐ THINKING HAPPY THOUGHTS
- ☐ KEEPING MYSELF BUSY
- ☐ EXERCISING
- ☐ HELPING A FRIEND
- ☐ READING A BOOK
- _____
- _____
- _____
- _____

Session 3

Co-Dependency Symptoms

Symptoms of Co-Dependency	Rate the severity of the symptom presence in you. 1=low severity, 10= high severity
☆Unable to make a decision in the relationship.	1 2 3 4 5 6 7 8 9 10
☆Obsessive need for approval.	1 2 3 4 5 6 7 8 9 10
☆Difficulty identifying your feelings.	1 2 3 4 5 6 7 8 9 10
☆Difficulty communicating in a relationship.	1 2 3 4 5 6 7 8 9 10
☆Valuing the approval of others more than valuing yourself.	1 2 3 4 5 6 7 8 9 10
☆Lacking trust in yourself.	1 2 3 4 5 6 7 8 9 10
☆Have poor self-esteem.	1 2 3 4 5 6 7 8 9 10
☆Feel like you can't live without the other person.	1 2 3 4 5 6 7 8 9 10
☆Have fears of abandonment.	1 2 3 4 5 6 7 8 9 10
☆Unhealthy dependency on the relationship.	1 2 3 4 5 6 7 8 9 10
☆Having an exaggerated sense of responsibility for the actions of the other person.	1 2 3 4 5 6 7 8 9 10
☆You have a lack of boundaries.	1 2 3 4 5 6 7 8 9 10
☆If you have boundaries, you often don't stick to them.	1 2 3 4 5 6 7 8 9 10
☆You want to please everyone.	1 2 3 4 5 6 7 8 9 10
☆You have a desire to fix other people's problems.	1 2 3 4 5 6 7 8 9 10
☆You are loyal to a fault.	1 2 3 4 5 6 7 8 9 10
☆You sacrifice your own needs for the needs of others.	1 2 3 4 5 6 7 8 9 10
☆You do EVERYTHING with your partner.	1 2 3 4 5 6 7 8 9 10
☆You struggle to say 'no' to your partner.	1 2 3 4 5 6 7 8 9 10
☆You don't communicate your desires or needs to your partner.	1 2 3 4 5 6 7 8 9 10
☆You feel responsible for your partner's behavior.	1 2 3 4 5 6 7 8 9 10
☆You would do anything to make the relationship work.	1 2 3 4 5 6 7 8 9 10

My SAFETY PLAN

Remember: Help is always available.

1 MY WARNING SIGNS ARE:

*These can be thoughts, feelings or behaviors that indicate you are at risk.

2 MY EFFECTIVE COPING STRATEGIES ARE:

*These are things you can do to help lift your mood, like meditation or exercise.

3 PEOPLE I CAN REACH OUT TO FOR DISTRACTION:

Person 1: Contact No.
Person 2: Contact No.
Person 3: Contact No.

4 PEOPLE I CAN REACH OUT TO FOR HELP:

Person 1: Contact No.
Person 2: Contact No.
Person 3: Contact No.

5 STEPS I CAN TAKE TO MAKE MY ENVIRONMENT SAFER:

-
-
-
-
-

6 IN THE EVENT OF A CRISIS:

Call Emergency Contact #1:
Call Crisis Hotline:
Call Emergency Services:

Personalized Safety Plan

Name:_____ Date:_____

1 STEP 1: SAFETY DURING A VIOLENT INCIDENT.

Women cannot always avoid violent incidents. In order to increase safety, battered women may use a variety of strategies.

I can use some of the following strategies:

- If I decide to leave, I will_____.
  (Practice how to get out safely. What doors, windows, elevators, stairwells, or file escapes would you use?)
- I can keep my purse and car keys ready and put them (location)_____ in order to leave quickly.
- I can tell _____ about the violence and request that she or he call the police if she or he hears suspicious noises coming from my house.
- I can teach my children how to use the telephone to contact the police, the fire department, and 911.
- I will use _____ as my code with my children or my friends so they can call for help.
- If I have to leave my home, I will go to _____. (Decide this even if you don't think there will be a next time.)
- I can also teach some of these strategies to some or all of my children.
- When I expect we're going to have an argument, I'll try to move to a place that is low risk, such as _____. (Try to avoid arguments in the bathroom, garage, kitchen, near weapons, or in rooms without access to an outside door.)
- I will use my judgment and intuition. If the situation is very serious, I can give my partner what he/she wants to calm him/her down. I have to protect myself until I can leave.

2 STEP 2: SAFETY WHEN PREPARING TO LEAVE.

Battered women frequently leave the residence they share with the battering partner. Leaving must be done with a careful plan in order to increase safety. Batterers often strike back when they believe that a battered woman is leaving the relationship.

I can use some or all of the following strategies:

- I will leave money and an extra set of keys with _____ so I can leave quickly.
- I will keep copies of important documents or keys at_____.
- I will open a savings account by _____, to increase my independence.
- Other things I can do to increase my independence include:_____
  _____
- I will check with _____ and _____ to see who would be able to let me stay with them or lend me some money.
- I can leave extra clothes or money with _____.
- I will sit down and review my safety plan every _____ in order to plan the safest way to leave the residence.
- I will rehearse my escape plan and, as appropriate, practice it with my children.

Personalized Safety Plan

Page 2

3 STEP 3: SAFETY IN MY OWN RESIDENCE.

There are many things that a woman can do to increase her safety in her own residence. It may be impossible to do everything at once, but safety measures can be added step by step.

Safety measures I can use:

- I can change the locks on my doors and windows as soon as possible.
- I can replace wooden doors with steel/metal doors.
- I can install security systems including additional locks, window bars, poles to wedge against doors, an electronic system, etc.
- I can purchase rope ladders to be used for escape from second floor windows.
- I can install smoke detectors and fire extinguishers for each floor of my house/apartment.
- I can install an outside lighting system that activates when a person is close to the house.
- I will teach my children how to make a collect call to me and to _____ (name of friend, etc.) in the event that my partner takes the children.
- I will tell the people who take care of my children which people have permission to pick up my children and that my partner is not permitted to do so. The people I will inform about pick-up permission include:
  _____(name of school)
  _____(name of babysitter)
  _____(name of teacher
  _____(name of Sunday-school teacher)
  _____(name[s] of others)
- I can inform _____ (neighbor) and _____ (friend) that my partner no longer resides with me and that they should call the police if he is observed near my residence.

4 STEP 4: SAFETY WITH AN ORDER OF PROTECTION

Many batterers obey protection orders, but one can never be sure which violent partner will obey and which will violate protective orders. I recognize that I may need to ask the police and the courts to enforce my protective order.

The following are some steps I can take to help enforcement of my protection order:

- I will keep my protection order _____ (location). Always keep it on or near your person. If you change purses, that's the first thing that should go in the new purse.
- I will give my protection order to police departments in the community where I work, in those communities where I visit friends or family, and in the community where I live.
- There should be a county and state registries of protection orders that all police departments can call to confirm a protection order. I can check to make sure that my order is on the registry. The telephone numbers for the county and state registries of protection orders are:
  _____ (county) and _____ (state)

Personalized Safety Plan

Page 3

- I will inform my employer; my minister, rabbi, etc; my closest friend; and _____ that I have a protection order in effect.
- If my partner destroys my protection order, I can get another copy from the clerk's office.
- If the police do not help, I can contact an advocate or an attorney and file a complaint with the chief of the police department or sheriff.
- If my partner violates the protection order, I can call the police and report the violation.

5 STEP 5: SAFETY ON THE JOB AND IN PUBLIC.

Each battered woman must decide if and when she will tell others that her partner has battered her and that she may be at continued risk. Friends, family, and co-workers can help to protect women. Each woman should carefully consider which people to invite to help secure her safety.

I might do any or all of the following:

- I can inform my boss, the security supervisor, and _____ at work.
- I can ask_____ to help me screen my telephone calls at work.
- When leaving work, I can _____.
- If I have a problem while driving home, I can_____.
- If I use public transit, I can _____.
- I will go to different grocery stores and shopping malls to conduct my business and ship at hours that are different from those I kept when residing with my battering partner.
- I can use a different bank and go at hours that are different from those kept when residing with my battering partner.

6 STEP 6: SAFETY AND DRUG OR ALCOHOL USE.

Most people in this culture use alcohol. Many use mood-altering drugs. Much of this is legal, although some is not. The legal outcomes of using illegal drugs can be very hard on battered women, may hurt her relationship with her children, and can put her at a disadvantage in other legal actions with her battering partner. Therefore, women should carefully consider all potential cost of the use of illegal drugs. Beyond this, the use of alcohol or other drugs can reduce a woman's awareness and ability to act quickly to protect herself from her battering partner. Furthermore, the use of alcohol or other drugs by the batterer may give him an excuse to use violence. Specific safety plans must be made concerning drugs or alcohol use.

If drug or alcohol use has occurred in my relationship with my battering partner, I can enhance my safety by some or all of the following:

- If I am going to use, I can do so in a safe place and with people who understand the risk of violence and are committed to my safety.
- If my partner is using, I can_____.
- To safeguard my children, I might_____.

Personalized Safety Plan

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7 STEP 7: SAFETY AND MY EMOTIONAL HEALTH.

The experience of being battered and verbally degraded by partners is usually exhausting and emotionally draining. The process of building a new life takes much courage and incredible energy.

To conserve my emotional energy and resources and to avoid hard emotional times, I can do some of the following:

- If I feel down and am returning to a potentially abusive situation, I can _____.
- When I have to communicate with my partner in person or by telephone, I can _____.
- I will try to use "I can..." statements with myself and be assertive with others.
- I can tell myself, "_____" whenever I feel others are trying to control or abuse me.
- I can read _____ to help me feel stronger.
- I can call _____ and _____ for support.
- I can attend workshops and support groups at the domestic violence program or _____ to gain support and strengthen relationships.

8 STEP 8: ITEMS TO TAKE WHEN LEAVING.

When women leave partners, it is important to take certain items. Beyond this, women sometimes give an extra copy of papers and an extra set of clothing to a friend just in case they have to leave quickly.

Money: Even if I never worked, I can take money from jointly held savings and checking accounts. If I do not take this money, he can legally take the money and close the accounts.

Items on the following lists with asterisks by them are the most important to take with you. If there is time, the other items might be taken, or stored outside the home. These items might best be placed in one location, so that if I have to leave in a hurry, I can grab them quickly. When I leave, I should take:

*Identification for myself
*My birth certificate
*School and vaccination records
*Checkbook, ATM card
*Key – house, car, office
*Medications
*Welfare identification, work permits, green cards
*Children's birth certificates
*Social Security cards
*Money
*Credit cards
*Driver's license and registration
*Copy of protective order

Personalized Safety Plan

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Additional items to consider:

Passport(s), divorce papers
Medical records - for all family members
Lease/rental agreement, house deed, mortgage payment book
Bank books, insurance papers
Address book
Pictures, jewelry
Children's favorite toys and/or blankets
Items of special sentimental value

Telephone numbers I need to know:

Police/sheriff's department (local) - 911 or _____
Police/sheriff's department (work)_____
Police/sheriff's department (school)_____
Prosecutor's office_____
Battered women's program (local)_____
National Domestic Violence Hotline: 800-799-SAFE (7233)
800-787-3224 (TTY)
www.ndvh.org
County registry of protection orders_____
State registry of protection orders_____
Work number_____
Supervisor's home number_____

I will keep this document in a safe place and out of the reach of my potential attacker.

Review date:_____

This document was modified from the packet produced and distributed by:

NATIONAL CENTER
on Domestic and Sexual Violence
training * consulting * advocacy
7800 Shoal Creek, Ste 120-N
Austin, Tx 78757
tel: 512.407.9020 * fax: 512.407.9022
www.ncdsv.org

Family Systems Theory

Describe the impact/relevance of the 8 components of Bowen Family Systems Theory.

1. Triangles -
2. Differentiation of Self -
3. Nuclear Family Systems -
4. Family Projective Process -
5. Multigenerational Transmission Process -
6. Emotional Cut-Off -
7. Sibling Position -
8. Societal Emotional Process -

Goals of Family Systems Theory Thinking:

- Understand the Family Emotional System
- Observe and recognize family patterns
- Reduce anxiety and relieve symptoms
- Restore trust and fairness
- Increase differentiation
- Demonstrate intergenerational patterns

The WHOLE is equal to more

Than the sum of its PARTS.

FAMILY GENOGRAM

Draw your family genogram. Look for triangles among family members.

Session 6

Systems & Feedback Loops

Think of some events/situations when you used your Feeling Guidance System or your Intellectual Guidance System. You may even put people who you respond to in specific ways in each box.

Feeling Guidance System

INTELLECTUAL GUIDANCE SYSTEM

Now write down any instance where you used both situations to make a Functional Decision.

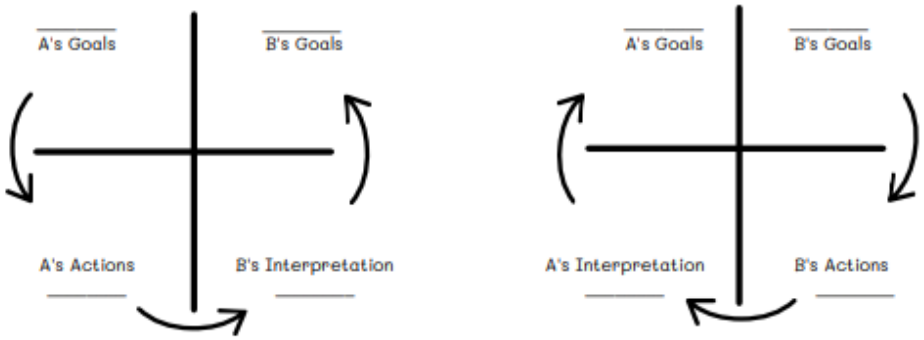
FUNCTIONAL DECISIONS

Positive & Negative

FEEDBACK LOOPS

Think of your goals and your partners perceived goals. Fill in your names below and on the graphic. Think about each partners actions and the other partner's interpretation of those actions.

Partner A:_____ **Partner B:**_____



Environmental Effects:

Session 7

Levels of Differentiation

Are you able to express your differences from others while still feeling caring and connected to them? Most people can do this easily when their stress level is low. To gain a better sense of how far you have come in expressing your individuality and differentiating from others, examine the way you operate during crisis and conflict.

Directions: Circle a number 1 though 5 to show how similar you are to statements that describe either an undifferentiated or differentiated person. Rate strictly because differentiation is difficult and few people master this task completely.

Undifferentiated Person		**Differentiated Person**
Indifference & Intolerance		Concern & Toleration
• I have few preferences and like others to make decisions.	1 2 3 4 5	• I am aware of my preference, even if I choose to go along with others.
• My opinions, beliefs, and principles, are almost identical to my family's, friends', or church's.	1 2 3 4 5	• I have questioned the beliefs of my family, friends, and religion before reaching my own conclusions.
• I am easily swayed by others' viewpoints.	1 2 3 4 5	• I consider others' ideas and choose whether or not to change my own.
• I try to get others to see things my way or try to defend myself.	1 2 3 4 5	• I can state my position without attacking others or defending myself.
• When my preferences differ from others, I either win or lose.	1 2 3 4 5	• I can make compromises without fear of giving up parts of myself.
• I express my beliefs with words like "We think...., I agree with..."	1 2 3 4 5	• I express my beliefs with the words "I think...."
• I prefer to be with people whose views are similar to my own.	1 2 3 4 5	• I enjoy points of view that differ from my own.
Emotions Rule Intellect		Intellect Rules Emotions
• My reactions are usually caused by others.	1 2 3 4 5	• I can reason, reflect, and evaluate my reactions to people and events.
• I am rarely emotional, OR I have 'knee-jerk" reactions.	1 2 3 4 5	• I am able to experience passionate emotions without losing myself.
• When I am emotional, I seem to lose my powers of reason.	1 2 3 4 5	• My intellect and logic rule my emotions.
• My decisions are based on instinct and what "feels" right.	1 2 3 4 5	• I am able to think through my decisions.
• I often don't know the reasons for my decisions.	1 2 3 4 5	• I am aware of the reasons for my decisions.
• When others are in conflict, I am drawn to take sides.	1 2 3 4 5	• During conflict, I see both sides of the issue.
Other-Oriented Goals		Self-Serving Goals
• My long-term goals are more for my relationship than for me.	1 2 3 4 5	• I have long-term goals that affect only me.
• It is hard for me to act without others' love and approval.	1 2 3 4 5	• I can risk losing others' approval when something is important to me.
• I feel angry, hurt, or resentful when others don't approve of me.	1 2 3 4 5	• I am temporarily sad or feel calm when others withhold approval.

Taken from *Family Therapy in Clinical Practice* (Jason Aronson, 1978)

SETTING BOUNDARIES

DATE: / /

MOST IMPORTANT PRIORITIES

MATERIAL BOUNDARIES

PHYSICAL BOUNDARIES

SPIRITUAL BOUNDARIES

EMOTIONAL BOUNDARIES

MENTAL BOUNDARIES

MY SELF-CARE FOR THIS WEEK IS:

COMMUNICATION PRACTICE

Using 'I' statements makes it possible for others to receive your message in a clear, constructive manner.

I feel...

Use feeling words to express emotions.
Be aware of your nonverbal communication (tone & body language).

I need...

Telling others what you need helps them help you. For instance, 'I need time' or 'I need to talk'.

I can...

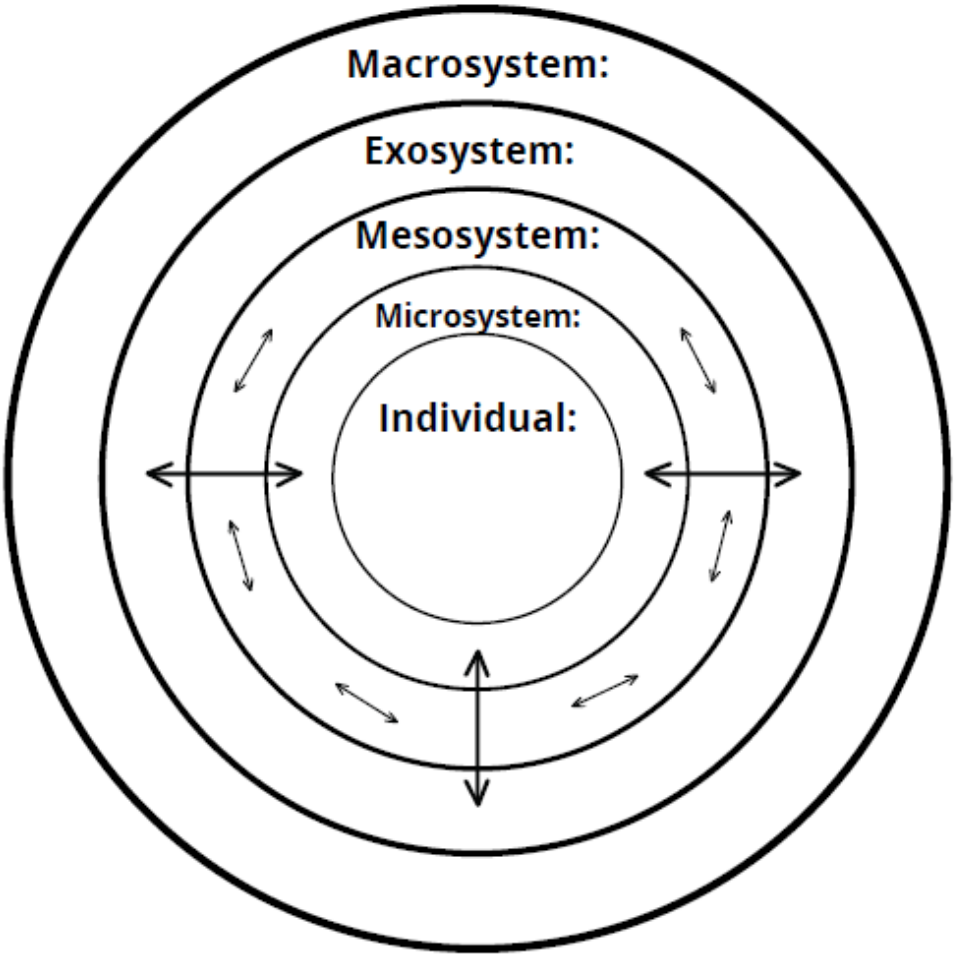
Focus on the positives: Consider your strengths, possible solutions, and past times you were successful.

I will...

Think of actions you can take to generate the results you want to achieve.

Ecological Levels

Think about the various components of your life and the interactions with people and agencies throughout your life. Place each interaction within the correct ecological level. Try to think about the levels that need more support.



Individual: Sex, Age, Health, Characteristics
Microsystem: Family, School, Health Services, Church, Peers
Mesosystem: The interconnectedness of the microsystem and exosystem
Exosystem: Industry, Mass Media, Neighbors, Social Services, Local Politics, Extended Family
Macrosystem: Attitudes and Idealogies of the culture

Additional
RESOURCES

WORK SHEETS &
HANDOUTS

Self-Exploration Sentence Completion

In order to be happy with yourself, you must first get to know yourself. Getting to know who you are can be touch soemtimes, but once you develop a relationship with you, you will be able to see the goo in you and what you have to offer other people.

My name is: _____

I love to: _____

I don't like to: _____

I am responsible for: _____

I get excited about: _____

My biggest strength is: _____

My biggest weakness is: _____

What I want from my life is: _____

I am afraid that: _____

Someone that I admire is: _____

Someone who admires me is: _____

I am confident that I can: _____

I am not confident when: _____

What I value in a relationship is: _____

What I value in a career is: _____

One change I want to make is: _____

The three things I care about most are: _____

My Protective Factors

Protective factors help you be resilient when faced with challenges. Fill in the below areas to help identify strengths in your life.

Social Support

List two people in your life that you can talk to about your problems.

Skills

Describe at least one thing you are good at, or have knowledge on.

Coping Strategies

Describe a time when you've overcome a challenge.

Personal Identity

Describe something you are proud of, relating to your personal identity.

Community

List any interest activities you are engaged in.

WHAT WORKS?

Think about the people in your life that can provide support.

Family

Talking to family members who support your healthy relationship choices.

What works?	What doesn't?
	

Friends

Making new friends who support your healthy relationship choices.

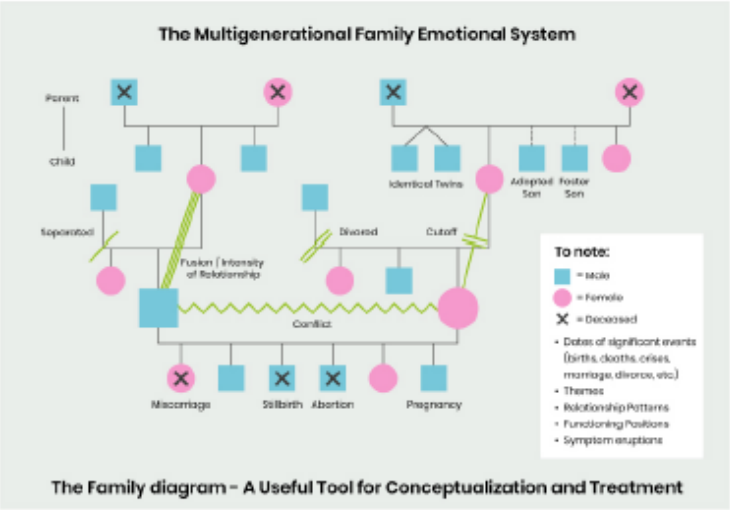
What works?	What doesn't?
	

The Power & Control Wheel

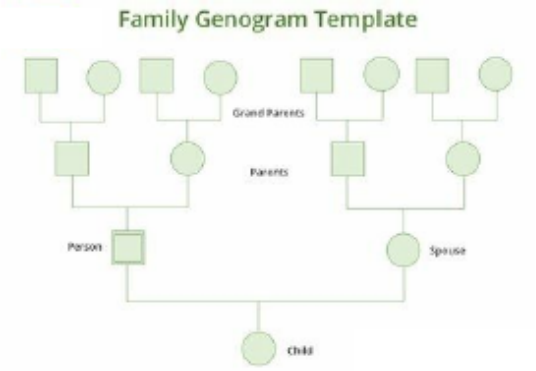
The Equality Wheel

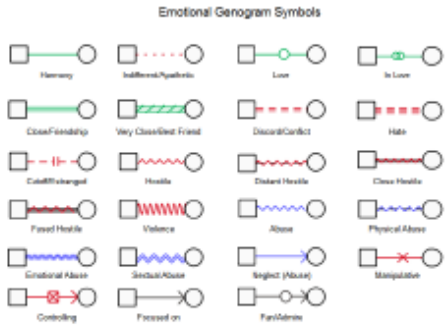
Domestic Abuse Intervention Programs
202 East Superior Street
Duluth, Minnesota 55802
218-722-2781
www.TheDuluthModel.org

Sample Genogram

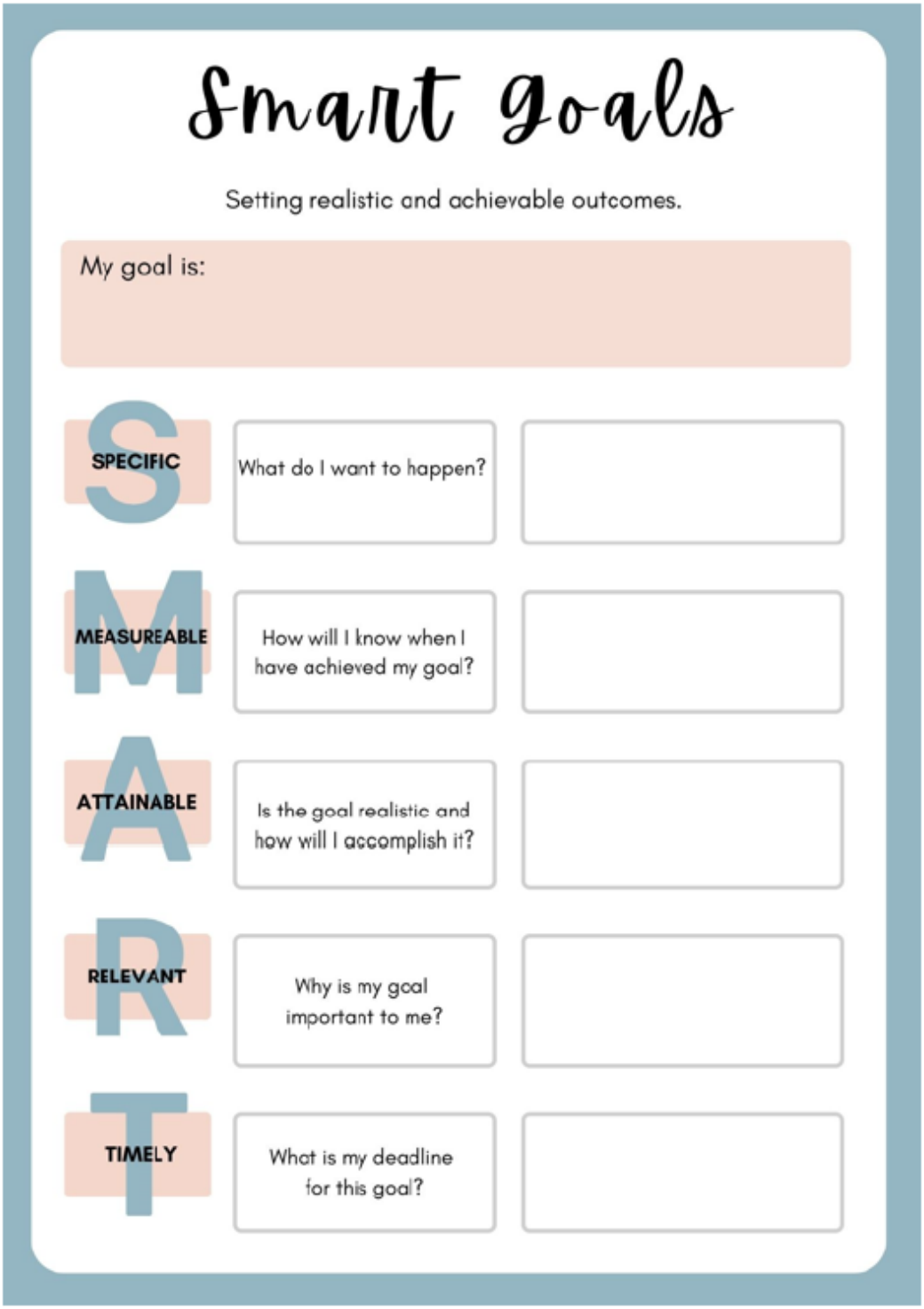


Helpful Tools






SELF LOVE
THE CHOICE TO ACCEPT, APPRECIATE, PROTECT AND BE GENTLE WITH YOURSELF.
BE PROUD OF YOUR ACHIEVEMENTS
THINK, SPEAK AND TALK TO YOURSELF WITH KINDNESS
FORGIVE YOURSELF
LISTEN TO YOUR BODY
KNOW AND ACCEPT YOUR FEELINGS
ACCEPT HELP
SAY NO TO COMPARISONS AND SELF JUDGEMENT
SET HEALTHY BOUNDARIES


Smart Goals
Setting realistic and achievable outcomes.
My goal is:
S
SPECIFIC
What do I want to happen?
M
MEASUREABLE
How will I know when I have achieved my goal?
A
ATTAINABLE
Is the goal realistic and how will I accomplish it?
R
RELEVANT
Why is my goal important to me?
T
TIMELY
What is my deadline for this goal?

Reflection Writing Prompt

Name:

Date:

WRITE A REFLECTION:

What is the most significant event that is affecting you currently?
Write a reflection on what the event is and how you currently feel about it.

ASSESSMENT *forms*

The outcome evaluations will be completed at the beginning of the program and serve as a baseline measure of the participants' depression and social supports. The same measures (SF-36, the BDI, and the MOS-SSI) will be administered once the participants have completed half of the psycho-educational classes and at least one therapeutic session. The last administration of the SF-36, BDI, and the MOS-SSSI will be completed once the participant has completed all ten psycho-educational classes and at minimum two total therapeutic sessions. Assessment administration can be done in an online format in order to streamline and document results. Participants can complete the online forms in the office with available computers.

The program will also use the Vulnerability and Mental Health Scale (VMHS). This scale is modified from the Abusive Behavior Inventory (ABI), the Depression, Anxiety, and Stress Scale (DASS), and incorporates questions relating to the 'Cycle of Violence' (Walker, 1979). This measure would also be imperative to give at the beginning and end of the program.

Pre-Test and Post-Test measures on curriculum content will be given within the 5 five minutes and last 5 minutes of the psycho-educational classes.

Program evaluations in the form of an Exit Survey will be given to participants who have completed the core components of the program. A modified exit survey would be given to any participant who was unable to complete the program.

Program staff and therapist will complete quarterly meetings to discuss how the program is running, the assessment results of program participants, and any changes that need to be made.

Program Tracker

NAME: _____

Dates/Notes		Present	Pre-Test	Activity	Post-Test			
Session 1								
Session 2								
Session 3								
Session 4								
Session 5								
Session 6								
Session 7								
Session 8								
Session 9								
Session 10								

Dates		Beginning	Middle	End
VMHS				
BDI				
SF-36				
MOS-SSSI				

Exit Survey	
Exit Survey Sent	
Exit Survey Completed	

Dates		1	2	3	4	5	6	7	8	9	10
Resource Meetings											
Support Groups											
Individual Therapy											
Family Therapy											

VULNERABILITY AND MENTAL HEALTH SCALE

1 = NEVER
2 = RARELY
3 = OCCASIONALLY
4 = FREQUENTLY
5 = VERY FREQUENTLY

1.Called you names and/or criticized you.....1 2 3 4 5
2.Has nitpicked or yelled at you..... 1 2 3 4 5
3.Has withheld affection from you. 1 2 3 4 5
4.Has put you down. 1 2 3 4 5
5.Threatens you.....1 2 3 4 5
6.Accuses you of being unfaithful.....1 2 3 4 5
7.Tried to keep you from doing something you wanted to do. 1 2 3 4 5
(Examples: going out with friends, going to meetings)
8.Gave you angry stares or looks. 1 2 3 4 5
9.Prevented you from having money for your own use..... 1 2 3 4 5
10.Ended a discussion with you and made the decision himself..... 1 2 3 4 5
11.Engages you to argue.....1 2 3 4 5
12.Attempt to calm him.....1 2 3 4 5
13.Trying to reason or justify his actions.....1 2 3 4 5
14.Agree with him to avoid argument, overly-compliant.....1 2 3 4 5
15.Try to reason with him when he is angry.....1 2 3 4 5
16.Stay and take him back after an incident.....1 2 3 4 5
17.Forgive him and feel hopeful after an incident.....1 2 3 4 5
18.Threatened to hit or throw something at you.....1 2 3 4 5
19.Pushed, grabbed or shoved you.....1 2 3 4 5
20.Put down your family and friends.....1 2 3 4 5
21. Accused you of paying too much attention to someone or something else.....1 2 3 4 5
22.Put you on an allowance.....1 2 3 4 5
23.Used the children to threaten you. (Examples: told you that you would lose custody, said he would leave town with the children).....1 2 3 4 5
24.Became very upset with you because dinner, housework or laundry was not ready when he wanted it, or done the way he thought it should be..... 1 2 3 4 5
25.Said things to scare you. (Example: told you something bad would happen, threatened to commit suicide) 1 2 3 4 5
26.Slapped, hit or punched you..... 1 2 3 4 5
Made you do something humiliating or degrading. (Example: begging for forgiveness, having to ask his permission to use the car or do something). 1 2 3 4 5
27.Checked up on you. (Examples: listened to you phone calls, checked the mileage on your car, called you repeatedly at work).....1 2 3 4 5
28.Drove recklessly when you were in the car.....1 2 3 4 5
29.Pressured you to have sex in a way that you didn't like or want.....1 2 3 4 5
30.Refused to do housework or childcare.....1 2 3 4 5
31.Threatened you with a knife, gun or other weapon.....1 2 3 4 5
32.Told you that you were a bad parent.....1 2 3 4 5
33.Stopped you or tried to stop you from going to work or school.....1 2 3 4 5
34.Threw, hit, kicked or smashed something.....1 2 3 4 5
35.Kicked you.....1 2 3 4 5

VULNERABILITY AND MENTAL HEALTH SCALE (PAGE 2)

36.Physically forced you to have sex.....1 2 3 4 5
37. Threw you around.....1 2 3 4 5
38. Physically attacked the sexual parts of your body.....1 2 3 4 5
39.Choked or strangled you.....1 2 3 4 5
40.Used a knife, gun, or other weapon against you.....1 2 3 4 5
41. I find it hard to wind down.....1 2 3 4 5
42.I couldn't seem to experience any positive feeling at all.....1 2 3 4 5
43.I found it difficult to work up the initiative to do things.....1 2 3 4 5
44.I tend to over-react to situations.....1 2 3 4 5
45.I felt that I was using a lot of nervous energy.....1 2 3 4 5
46.I was worried about situations in which I might panic and make a fool of myself.....1 2 3 4 5
47.I felt I had nothing to look forward to.....1 2 3 4 5
48.I found myself getting agitated.....1 2 3 4 5
49.I found it difficult to relax 1 2 3 4 5
50.I was intolerant of anything that kept me from getting on with what I was doing.....1 2 3 4 5
51.I felt I was close to panic.....1 2 3 4 5
52. I felt that I was rather touchy.....1 2 3 4 5
53.I felt scared without any good reason.....1 2 3 4 5

_____
_____

54.Do you have children with your abuser? Yes/No
55. Are the children part of the reason for staying? Yes/No

Please explain:

_____
_____

56.Do you feel like a better parent when your abuser is not present? Yes/No
Please explain:

_____
_____

57.How many times have you returned to your abuser after wanting to separate? 1 2 3 4 5+
Why did you return:

_____
_____

58.Have you been in a domestic violence situation prior to the most recent situation? Yes /No
59.Did you know the relationships were domestic violence?

_____

60.Do you have friends that you can count on for help if needed? Yes/No

61.Do you participate in any activities outside of the house? Yes/No
Please explain:

_____
_____

62. What is the one thing you are most concerned about at this moment?

_____
_____

Beck's Depression Inventory

This depression inventory can be self-scored. The scoring scale is at the end of the questionnaire.

1.
- 0 I do not feel sad.
- 1 I feel sad
- 2 I am sad all the time and I can't snap out of it.
- 3 I am so sad and unhappy that I can't stand it.

2.
- 0 I am not particularly discouraged about the future.
- 1 I feel discouraged about the future.
- 2 I feel I have nothing to look forward to.
- 3 I feel the future is hopeless and that things cannot improve.

3.
- 0 I do not feel like a failure.
- 1 I feel I have failed more than the average person.
- 2 As I look back on my life, all I can see is a lot of failures.
- 3 I feel I am a complete failure as a person.

4.
- 0 I get as much satisfaction out of things as I used to.
- 1 I don't enjoy things the way I used to.
- 2 I don't get real satisfaction out of anything anymore.
- 3 I am dissatisfied or bored with everything.

5.
- 0 I don't feel particularly guilty
- 1 I feel guilty a good part of the time.
- 2 I feel quite guilty most of the time.
- 3 I feel guilty all of the time.

6.
- 0 I don't feel I am being punished.
- 1 I feel I may be punished.
- 2 I expect to be punished.
- 3 I feel I am being punished.

7.
- 0 I don't feel disappointed in myself.
- 1 I am disappointed in myself.
- 2 I am disgusted with myself.
- 3 I hate myself.

8.
- 0 I don't feel I am any worse than anybody else.
- 1 I am critical of myself for my weaknesses or mistakes.
- 2 I blame myself all the time for my faults.
- 3 I blame myself for everything bad that happens.

9.
- 0 I don't have any thoughts of killing myself.
- 1 I have thoughts of killing myself, but I would not carry them out.
- 2 I would like to kill myself.
- 3 I would kill myself if I had the chance.

10.
- 0 I don't cry any more than usual.
- 1 I cry more now than I used to.
- 2 I cry all the time now.
- 3 I used to be able to cry, but now I can't cry even though I want to.

11.
- 0 I am no more irritated by things than I ever was.
- 1 I am slightly more irritated now than usual.
- 2 I am quite annoyed or irritated a good deal of the time.
- 3 I feel irritated all the time.

12.
- 0 I have not lost interest in other people.
- 1 I am less interested in other people than I used to be.
- 2 I have lost most of my interest in other people.
- 3 I have lost all of my interest in other people.

13.
- 0 I make decisions about as well as I ever could.
- 1 I put off making decisions more than I used to.
- 2 I have greater difficulty in making decisions more than I used to.
- 3 I can't make decisions at all anymore.

14.
- 0 I don't feel that I look any worse than I used to.
- 1 I am worried that I am looking old or unattractive.
- 2 I feel there are permanent changes in my appearance that make me look unattractive
- 3 I believe that I look ugly.

15.
- 0 I can work about as well as before.
- 1 It takes an extra effort to get started at doing something.
- 2 I have to push myself very hard to do anything.
- 3 I can't do any work at all.

16.
- 0 I can sleep as well as usual.
- 1 I don't sleep as well as I used to.
- 2 I wake up 1-2 hours earlier than usual and find it hard to get back to sleep.
- 3 I wake up several hours earlier than I used to and cannot get back to sleep.

17.
- 0 I don't get more tired than usual.
- 1 I get tired more easily than I used to.
- 2 I get tired from doing almost anything.
- 3 I am too tired to do anything.

18.
- 0 My appetite is no worse than usual.
- 1 My appetite is not as good as it used to be.
- 2 My appetite is much worse now.
- 3 I have no appetite at all anymore.

19.
- 0 I haven't lost much weight, if any, lately.
- 1 I have lost more than five pounds.
- 2 I have lost more than ten pounds.
- 3 I have lost more than fifteen pounds.

20.

0	I am no more worried about my health than usual.
1	I am worried about physical problems like aches, pains, upset stomach, or constipation.
2	I am very worried about physical problems and it's hard to think of much else.
3	I am so worried about my physical problems that I cannot think of anything else.

21.

0	I have not noticed any recent change in my interest in sex.
1	I am less interested in sex than I used to be.
2	I have almost no interest in sex.
3	I have lost interest in sex completely.

INTERPRETING THE BECK DEPRESSION INVENTORY

Now that you have completed the questionnaire, add up the score for each of the twenty-one questions by counting the number to the right of each question you marked. The highest possible total for the whole test would be sixty-three. This would mean you circled number three on all twenty-one questions. Since the lowest possible score for each question is zero, the lowest possible score for the test would be zero. This would mean you circles zero on each question. You can evaluate your depression according to the Table below.

Total Score	Levels of Depression
1-10	These ups and downs are considered normal
11-16	Mild mood disturbance
17-20	Borderline clinical depression
21-30	Moderate depression
31-40	Severe depression
over 40	Extreme depression

36-Item Short Form Survey Instrument (SF-36)

RAND 36-Item Health Survey 1.0 Questionnaire Items

Choose one option for each questionnaire item.

1. In general, would you say your health is:

- ○ 1 - Excellent
- ○ 2 - Very good
- ○ 3 - Good
- ○ 4 - Fair
- ○ 5 - Poor

2. **Compared to one year ago**, how would you rate your health in general **now**?

- ○ 1 - Much better now than one year ago
- ○ 2 - Somewhat better now than one year ago
- ○ 3 - About the same
- ○ 4 - Somewhat worse now than one year ago
- ○ 5 - Much worse now than one year ago

The following items are about activities you might do during a typical day. Does **your health now limit you** in these activities? If so, how much?

	Yes, limited a lot	Yes, limited a little	No, not limited at all
3. **Vigorous activities**, such as running, lifting heavy objects, participating in strenuous sports	○ 1	○ 2	○ 3
4. **Moderate activities**, such as moving a table, pushing a vacuum cleaner, bowling, or playing golf	○ 1	○ 2	○ 3
5. Lifting or carrying groceries	○ 1	○ 2	○ 3
6. Climbing **several** flights of stairs	○ 1	○ 2	○ 3
7. Climbing **one** flight of stairs	○ 1	○ 2	○ 3
8. Bending, kneeling, or stooping	○ 1	○ 2	○ 3
9. Walking **more than a mile**	○ 1	○ 2	○ 3
10. Walking **several blocks**	○ 1	○ 2	○ 3
11. Walking **one block**	○ 1	○ 2	○ 3
12. Bathing or dressing yourself	○ 1	○ 2	○ 3

SHORT FORM – 36 HEALTH SURVEY QUESTIONNAIRE (PAGE 2)

During the **past 4 weeks**, have you had any of the following problems with your work or other regular daily activities **as a result of your physical health**?

	Yes	No
13. Cut down the **amount of time** you spent on work or other activities	○ 1	○ 2
14. **Accomplished less** than you would like	○ 1	○ 2
15. Were limited in the **kind** of work or other activities	○ 1	○ 2
16. Had **difficulty** performing the work or other activities (for example, it took extra effort)	○ 1	○ 2

During the **past 4 weeks**, have you had any of the following problems with your work or other regular daily activities **as a result of any emotional problems** (such as feeling depressed or anxious)?

	Yes	No
17. Cut down the **amount of time** you spent on work or other activities	○ 1	○ 2
18. **Accomplished less** than you would like	○ 1	○ 2
19. Didn't do work or other activities as **carefully** as usual	○ 1	○ 2

20. During the **past 4 weeks**, to what extent has your physical health or emotional problems interfered with your normal social activities with family, friends, neighbors, or groups?

- ○ 1 - Not at all
- ○ 2 - Slightly
- ○ 3 - Moderately
- ○ 4 - Quite a bit
- ○ 5 - Extremely

21. How much **bodily** pain have you had during the **past 4 weeks**?

- 1 - None
- 2 - Very mild
- 3 - Mild
- 4 - Moderate
- 5 - Severe
- 6 - Very severe

22. During the **past 4 weeks**, how much did **pain** interfere with your normal work (including both work outside the home and housework)?

- 1 - Not at all
- 2 - A little bit
- 3 - Moderately
- 4 - Quite a bit
- 5 - Extremely

These questions are about how you feel and how things have been with you **during the past 4 weeks**. For each question, please give the one answer that comes closest to the way you have been feeling.

How much of the time during the **past 4 weeks**...

	All of the time	Most of the time	A good bit of the time	Some of the time	A little of the time	None of the time
23. Did you feel full of pep?	1	2	3	4	5	6
24. Have you been a very nervous person?	1	2	3	4	5	6
25. Have you felt so down in the dumps that nothing could cheer you up?	1	2	3	4	5	6
26. Have you felt calm and peaceful?	1	2	3	4	5	6
27. Did you have a lot of energy?	1	2	3	4	5	6
28. Have you felt downhearted and blue?	1	2	3	4	5	6
29. Did you feel worn out?	1	2	3	4	5	6
30. Have you been a happy person?	1	2	3	4	5	6
31. Did you feel tired?	1	2	3	4	5	6

32. During the **past 4 weeks**, how much of the time has **your physical health or emotional problems** interfered with your social activities (like visiting with friends, relatives, etc.)?

- ○ 1 - All of the time
- ○ 2 - Most of the time
- ○ 3 - Some of the time
- ○ 4 - A little of the time
- ○ 5 - None of the time

How TRUE or FALSE is **each** of the following statements for you.

	Definitely true	Mostly true	Don't know	Mostly false	Definitely false
33. I seem to get sick a little easier than other people	○ 1	○ 2	○ 3	○ 4	○ 5
34. I am as healthy as anybody I know	○ 1	○ 2	○ 3	○ 4	○ 5
35. I expect my health to get worse	○ 1	○ 2	○ 3	○ 4	○ 5
36. My health is excellent	○ 1	○ 2	○ 3	○ 4	○ 5

MOS SOCIAL SUPPORT SURVEY

People sometimes look to others for companionship, assistance, or other types of support. How often is each of the following kinds of support available to you if you need it? Choose one number from each line.

	None of the time	A little of the time	Some of the time	Most of the time	All of the time
1. Someone to help you if you were confined to bed	1	2	3	4	5
2. Someone you can count on to listen to you when you need to talk	1	2	3	4	5
3. Someone to give you good advice about a crisis	1	2	3	4	5
4. Someone to take you to the doctor if you needed it	1	2	3	4	5
5. Someone who shows you love and affection	1	2	3	4	5
6. Someone to have a good time with	1	2	3	4	5
7. Someone to give you information to help you understand a situation	1	2	3	4	5
8. Someone to confide in or talk to about yourself or your problems	1	2	3	4	5
9. Someone who hugs you	1	2	3	4	5
10. Someone to get together with for relaxation	1	2	3	4	5
11. Someone to prepare your meals if you were unable to do it yourself	1	2	3	4	5
12. Someone whose advice you really want	1	2	3	4	5
13. Someone to do things with to help you get your mind off things	1	2	3	4	5
14. Someone to help with daily chores if you were sick	1	2	3	4	5
15. Someone to share your most private worries and fears with	1	2	3	4	5
16. Someone to turn to for suggestions about how to deal with a personal problem	1	2	3	4	5
17. Someone to do something enjoyable with	1	2	3	4	5
18. Someone who understands your problems	1	2	3	4	5
19. Someone to love and make you feel wanted	1	2	3	4	5

R.E.S.T. Resources, Education, Support & Therapy

Exit Survey

We value your feedback. Please let us know how your experience has been by answering the following questions.

Please circle a number at the end of each question.

Question	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
I learned how to access, connect, and utilize community resources.	5	4	3	2	1
I gained useful knowledge from being in the program.	5	4	3	2	1
I feel like I have ways to access support groups.	5	4	3	2	1
I have increased my system levels of supports.	5	4	3	2	1
I have benefited from the therapy I have attended.	5	4	3	2	1

Most impactful aspects of the program:

Suggestions for improvements:

R.E.S.T. Resources, Education, Support & Therapy

Program Non-Completion Exit Survey

We value your feedback. Please let us know how your experience has been by answering the following questions.

Please circle a number at the end of each question.

Question	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
I learned how to access, connect, and utilize community resources.	5	4	3	2	1
I gained useful knowledge from the part of the program I attended.	5	4	3	2	1
I feel like I have ways to access support groups.	5	4	3	2	1
I have increased my system levels of supports.	5	4	3	2	1
I have benefited from the therapy I have attended.	5	4	3	2	1
I would have liked to continue in the program.	5	4	3	2	1

Please briefly describe the reason you had to leave the program.

Ways the program could have supported you better:

FEEDBACK AND *suggestions*

This project will continue to have small modifications and adjustments to better meet the needs of our participants and our coordinating program facilitators. We appreciate your input as a valued facilitator of the program being implemented. If you have any feedback or suggestions about any part of the program, please email them to the address below.

WE WELCOME YOUR FEEDBACK:

Hillary May, DMFT
drhillarymay@gmail.com

As part of program improvement, multiple evaluation measures in the areas of process and outcome goals are determined within the structure of the program. As our partners continue to provide data on their program implementation, the coordinators will have more valuable information to analyze for program effectiveness. Your willingness to submit aggregate data will enhance the programs ability to ensure accountability of program components as well as program effectiveness for participants. We appreciate your willingness to be part of an innovative combined treatment model program for IPV.

We welcome ideas and suggestions on operational, technical, and economic aspects that have helped the program run smoothly in your facility. Thank you for sharing your tips and tricks so others may benefit.

RESOURCES

RESOURCES FOR VICTIMS AND SURVIVORS OF DOMESTIC VIOLENCE
NATIONAL CRISIS ORGANIZATIONS AND ASSISTANCE:

The National Domestic Violence Hotline
1-800-799-7233 (SAFE)
www.ndvh.org

National Dating Abuse Helpline
1-866-331-9474
www.loveisrespect.org

National Child Abuse Hotline/Childhelp
1-800-4-A-CHILD (1-800-422-4453)
www.childhelp.org

National Sexual Assault Hotline
1-800-656-4673 (HOPE)
www.rainn.org

National Suicide Prevention Lifeline
1-800-273-8255 (TALK)
www.suicidepreventionlifeline.org

National Center for Victims of Crime
1-202-467-8700
www.victimsofcrime.org

National Human Trafficking Resource Center/Polaris Project
Call: 1-888-373-7888 | Text: HELP to BeFree (233733)
www.polarisproject.org

National Network for Immigrant and Refugee Rights
1-510-465-1984
www.nnirr.org

National Coalition for the Homeless
1-202-737-6444
www.nationalhomeless.org

National Resource Center on Domestic Violence
1-800-537-2238
www.nrcdv.org and www.vawnet.org

Futures Without Violence:
The National Health Resource Center on Domestic Violence
1-888-792-2873
www.futureswithoutviolence.org

National Center on Domestic Violence, Trauma & Mental Health
1-312-726-7020 ext. 2011
www.nationalcenterdvtraumamh.org

National Runaway Safeline
1-800-RUNAWAY or 1-800-786-2929
www.1800runaway.org

A NOTE TO THE participant

Dear Friend,

You have come so far. Breathe deeply and know it is all worth it. I hope you once again find the things that make your heart smile. I hope you are able to see the joy in seeing the sun sparkle and the water glisten. While I hope you are able to find a peace and joy with the one you love one day, I also hope that every little moment of joy along the way is enough. I have often used the metaphor of a broken glass heart that has been pieced together and glued one by one. Your heart may be delicate but through those cracks there is room to let in both light and love.

I hope you are able to take a moment and reflect on some of the places you have been, the adventures you have experienced, as well as the trials you have endured. Find gratitude and joy in all of your moments. There are too many moments to count, sometimes they are steps forward and sometimes they may feel like steps backwards. I encourage you to appreciate each of them for what they are. While it may be difficult to actually see or feel your progress, you are indeed progressing. Look for the ways you can feel whole. Celebrate the times where you have made choices that define you as a person.

You have given your all to both things great and small. You may have a direction set on your path or you may feel like you have no direction at all. Either way, may glorious light and happiness continue to find you along your journey. May you always remember that even on the days your feet are not taking you in the direction of your desires, you are still on your journey. You are still practicing both small and great acts of courage each day.

Remember, even the strongest souls get exhausted. We all need people to be there for us and I hope you can find those people who are truly there for you. Give yourself the permission to let go. If you continue to hold on to what is consuming you, you are allowing your past to take up all the space in your heart that is meant for your future. In order to find the human being that is meant to bring you deep joy and experience love like you deserve, you have to be free to accept it. You have to heal. You have to let go. You deserve the future that you once dreamed of. It is waiting for you. Choose it.

Best Wishes,
Hillary May

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R.E.S.T.
R.E.S.T. PROGRAM MANUAL

CHAPTER SIX

SUMMARY AND APPLICATIONS

Project Summary and Applications

The R.E.S.T. is a combined treatment model program that is comprised of four distinctive service components each of which will be described within this section and articulated within the Program Manual. As previously explained, the R.E.S.T. Program incorporates components to not only improve women's mental health but also provide imperative psychoeducation, connection to community resources, and integration of peer support groups. This program sets the foundation for women to be met at the individual level to build supports into the survivors' lives at each ecological level. Women learn to understand family system concepts while learning to build supports at the microsystem and mesosystem level. Women are also able to look at themselves as an individual and determine their own characteristics that either hinder or facilitate change in their lives.

In the first program component, the R.E.S.T. Program delivers resources to the participants in a structured and formatted process. Instead of just telling the participant about the resources that are available to the community, the facilitator helps determine the priority area of need while considering the interests of the participant. The facilitator is also able to link other program participants to community resources together, so individuals can attend events with someone familiar. These community resources are different per geographic region of program implementation; however, all areas have access to governmental and county run programs. It is the job of the facilitator and coordinating organization to research and develop a list of programs that are offered in

the region. This can include community resources in housing, healthcare, food, church programs, exercise groups, reduced fee art classes, cooking, college and career, and information on city transportation. While some individuals may need many basic needs supports others may have basic needs met and be interested in extracurricular options. Women in intimate partner violence tend to seclude themselves and focus all their attention on the relationship and/or children. Helping women connect to outside activities with others not only helps to build their systems of supports but is also imperative to their healing process.

The second component of the program involves education in intimate partner violence, family system theory, and healthy relationships. Women typically become so used to the interactions that they are living in that they fail to recognize they are experiencing abuse. Women experiencing intimate partner violence tend to justify and reason for the situation they are in. Teaching women not only about intimate partner violence but also about family systems theory and healthy relationships offers the knowledge base for women to make different choices in what they are experiencing.

The third program component is support groups. Many women who are survivors of intimate partner violence reach out and receive support through a shelter or a program; however, much of the support is limited to the place the services are provided. It is the goal of the R.E.S.T. Program to incorporate both in-person support groups for women as well as online and social media accessed support groups for women. By allowing women to make connections outside of the program, relationships can be built with others who have a sense and understanding of what it may feel like to live in some of these situations. Outsiders, who have never experienced abuse from a loved one, typically have

a difficult time understanding the complicated and arduous feelings that are involved for survivors. Being able to make connections that extend beyond the walls of the facility contributes to building a healthy and stable support system across ecological levels.

Finally, the fourth component of the program is therapy for the participants in the program. Therapy can be conducted at any time throughout the program, and it is expected for participants to attend ten therapy sessions to process the emotions of living through intimate partner violence. Participants may be at different places along their emotional journey. Therapist and participants will determine the course of their treatment and their desired goals. While some women may choose to leave the relationship, some women may have partners that are willing to work on their relationship. Each therapist will be cognizant of the participants desired goals keeping in mind safety as the number one priority. The program also offers family therapy which provides opportunities for families to develop new interactional skills that systemically address the needs of the entire family. Families can receive support while challenging maladaptive homeostasis. Creating a secure family foundation is necessary whether moving forward with or without an abusive partner.

All R.E.S.T. program components draw from research-based methods and approaches and are designed to be measured for quality and effectiveness. Each program component can be implemented at any time while the participant is in the program. Components may be sequential or simultaneous depending on the priority of needs of the participant. It is expected that participants in the program access all program components before program completion.

Program Outcomes

Increase in Community Resource Connections

Intimate partner violence survivors are often unaware of community resources that are available and which they have access to. This program aims to increase awareness of community resources to survivors of intimate partner violence by making community connections. By creating community connections and promoting integration of individuals who have experienced abuse, the program is helping the participant while simultaneously creating community awareness of the struggles and difficulties of intimate partner violence. By having women who are survivors in the community and participating in womens' groups, church groups, athletic events, art sessions, etc., the door of communication is opened to other women who may need additional supports.

Increase in Knowledge and Skill Acquisition

Another key outcome of this program is the skill acquisition and knowledge attainment from the psycho-educational groups. Increased relationship skills of communication can help couples navigate the situations and events that have the potential to get out of control. Being able to understand feedback loops and family systems theory allows participants to be cognizant of behavioral patterns of their partners. Knowing the concept of circular causality can help participants understand the relationship interactional effects. Learning what creates a healthy relationship and focusing on goals and aspirations of their own is imperative in the process of healing. While implementing these skills and specific tools during times of conflict may not always have a positive

outcome, participants will know they have done everything they could. Participants' goal is to make themselves better with the understanding they cannot make their partner choose to act differently. These skills are based on the Family Systems Theory and measured through the pre and post-tests that are completed at each psycho-educational session.

Increase in Social Supports and Connection

Social supports are essential for women who have experienced intimate partner violence. Survivors often feel alone, as well as shame and guilt associated with the abuse. By creating and developing social supports, women will feel less isolated and more supported throughout their difficult journey. Increased social support and connection are measured through the MOS-SSSI (Medical Outcome Survey – Social Support Survey Instrument) and through the SF-36 (Short Form – Health Survey Questionnaire). Specifically, the MOS-SSSI was chosen to measure social support because it measures within four main areas being: Emotional/Informational Support, Tangible Support, Affectionate Support, and Positive Social Interactions. The SF-36 also looks at social functioning along with 7 other domain areas. These measures will be completed at the beginning, middle, and end of the programs to determine effectiveness and make needed adjustments to service delivery to the participant.

Improved Mental Health

Another goal of this program is improving the mental health status of the participants. While all program components help facilitate improved mental health,

participants specifically engage in individual and family therapy to address individual needs. Some women may need more intensive supports in this area and choose to participate in EMDR to create more adaptive memory connections while processing negative cognitions. Other survivors may need to focus more on family therapy and the interactions and engagement with their children or other significant family members. The needs of each participant are considered. This goal is measured through the BDI (Beck Depression Inventory) and the SF-36 (Short Form – Health Survey Questionnaire). The BDI is a common assessment used to indicate levels and severity of depression. The SF-36 looks at the domains of emotional role functioning as well as mental health. These measures will be completed at the beginning, middle, and end of the programs in order to determine effectiveness and make needed adjustments to service delivery to the participant.

Application

Through the development of a combined treatment model program to meet the needs of women survivors of intimate partner violence, this program has integrated prominent themes in research related to IPV while incorporating the relevant theories of Bronfenbrenner's Ecological Model Theory, as well as Family Systems Theory. Through the application of providing psycho-educational classes and individual/family therapy and the integration of connections to community resources and support groups, this program aims to fill a void in current literature and needs of women survivors of IPV. "Victims of intimate partner violence (IPV) are known to be at high risk for revictimization" (Kuijpers, et al.,2012). It is the aim of this program to do more than

merely provide support and safety for survivors of intimate partner violence. This program aims to help women improve connections to community resources, receive psycho-educational lessons, increase social supports, and engage in individual and family therapy to decrease the chances of revictimization among this population. "More than two-thirds of female victims of non-sexual domestic violence were revictimized within a year" (Walby & Allen, 2004). With over 66% of women being revictimized within a year (Walby & Allen, 2004) the current programs are addressing the current needs of the victims but not creating sustainable changes that impact future interactions. This program aims to provide a structural framework for a program that addresses multiple needs and lasting changes for the survivors of IPV.

The future direction for this project includes implementation of this program in established shelters and organizations that work with survivors of IPV and domestic abuse. It would be an objective of this project through implementation and evaluation to determine the effectiveness of this program in meeting the needs of the IPV survivor population. As the program is implemented and coordinating organizations provide data and evaluative information, changes can be made as necessary to continue improvements within the program. This program has the potential to fill a void in the current available approaches for services for survivors of IPV before revictimization occurs. The aim of this theory grounded program is to provide knowledge and format to organizations that work with this population in order to have a lasting impact on the choices, social support, mental health, and relationships of survivors. It is the desire for this program to ultimately reach women across the nation, both those that have access to community organizations and those who don't.

Recruitment and Marketing Strategies

To transition this project to the implementation stage, a marketing and recruitment strategy will need to be developed. This program is intended to be implemented in organizations that are already developed such as shelters and domestic violence centers. The developer may reach out to shelters and mental health clinics within the community to aid in partnership of program implementation. Through community outreach events and social media, fliers may be distributed and information about the program can be attained. Both individuals who have experienced IPV and those who have not may see the flier (Appendix 1) and have awareness of the program to spread information about the program by word of mouth.

Specifically, the developer intends to meet with program directors of domestic violence agencies to provide information and awareness of the theories which have founded this model program. Through this, the program can be explained more comprehensively and implemented in established shelters. Many shelters may have one or more similar pieces of the program in place. Meetings to discuss the adjustments and modifications to take place to implement the R.E.S.T. program completely would be necessary. Program directors, clinicians, and other staff can work collaboratively to guide referrals to the program. As the program becomes more established within domestic violence organizations, more referrals may occur. By creating opportunities to share the desired goals of this program in the community and with coordinating organization directors, the program can be more clearly defined within the population of IPV survivors, as well as the clinics and shelters in which it will be implemented. With collaboration among community resource partners, the outcomes of the R.E.S.T. Program

include individual outcomes, relational outcomes, and systems/societal outcomes.

Conclusion and Future Directions

As designed, the R.E.S.T. program can be integrated into organizations as a collective and comprehensive program. The R.E.S.T program can be implemented alongside an existing domestic violence program or perhaps at Community Mental Health centers that receive a wide geographic demographic. It is likely that the R.E.S.T. program would be able to be implemented into domestic violence shelter organization programs quite seamlessly due to already staffed therapists within the organization. Among the advantages to implementation alongside an existing program are the effects of shared staffing, shared resources, and coordination of care of program participants. A limitation of a coordinated approach could be the lack of program visibility and decreased chances to use the program as a preventative measure.

In terms of feasibility, the program can be implemented in an already established organization for a lesser amount than a typical stand-alone program. Considering a therapist on staff working 40 hours a week would be approximately 2080 hours per year. The program therapist components take 306/2080 of the therapist's hours accounting for approximately 15% of their case load for one group. The program is expected to run a minimum of 3 cohorts within the first year, which would make an approximation of 45% of one of the staffed therapist’s roles/responsibilities would be dedicated to running the program. The overall estimated cost for the program to be implemented within an already established organization would be approximately 47k to run the program for one year under a parent organization, which includes all direct

and indirect costs associated to run the program.

This program has the possibility of aligning with a court approved program for women in domestic violence situations. The local court system in coordination with Child Protective Services would be another avenue to explore for marketing and program implementation. Women with children in domestic violence situations are often investigated on the possibility of neglect for their children when keeping them in an unhealthy environment. Child Protective Services could offer information and marketing flyers for the REST program in order to offer additional supports to women in which they come in contact with. The court system is another place that could be utilized for marketing or in coordination with a court approved program. Some women in domestic violence situations are able to access court resources and attain a domestic violence restraining order (DV-RO). Making information available at the court would be advantageous to this population of women while they are going through the court proceedings.

In the field of mental health, marriage and family therapy is specifically focused on relationship and mental health improvement – a value and perspective that is foundational to the R.E.S.T. Program. More specifically, for survivors of IPV, the importance of personal development to the point of reducing revictimization is imperative. The R.E.S.T Program is distinctive from currently available programs that focus primarily on survivor safety by delivering a program that works to provide resources, psycho-education, groups support, and improve mental health through individual and family therapy, building a foundation to dismantle the systems that

typically oppress women survivors of intimate partner violence at multiple ecological levels.

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APPENDIX A

EXAMPLE MARKETING FLYER

APPENDIX B

VULNERABILITY AND MENTAL HEALTH SCALE

Vulnerability and Mental Health Scale

1 = NEVER
2 = RARELY
3 = OCCASIONALLY
4 = FREQUENTLY
5 = VERY FREQUENTLY

1.Called you names and/or criticized you. 1 2 3 4 5

2.Has nitpicked or yelled at you. 1 2 3 4 5

3.Has withheld affection from you. 1 2 3 4 5

4.Has put you down. 1 2 3 4 5

5.Threatens you 1 2 3 4 5

6.Accuses you of being unfaithful. 1 2 3 4 5

7.Tried to keep you from doing something you wanted to do. 1 2 3 4 5

(Examples: going out with friends, going to meetings)

8.Gave you angry stares or looks. 1 2 3 4 5

9.Prevented you from having money for your own use. 1 2 3 4 5

10.Ended a discussion with you and made the decision himself. 1 2 3 4 5

11.Engages you to argue. 1 2 3 4 5

12.Attempt to calm him. 1 2 3 4 5

13.Trying to reason or justify his actions. 1 2 3 4 5

14.Agree with him to avoid argument, overly-compliant. 1 2 3 4 5

15.Try to reason with him when he is angry. 1 2 3 4 5

16.Stay and take him back after an incident. 1 2 3 4 5

17.Forgive him and feel hopeful after an incident. 1 2 3 4 5

18.Threatened to hit or throw something at you. 1 2 3 4 5

19.Pushed, grabbed or shoved you. 1 2 3 4 5

20.Put down your family and friends. 1 2 3 4 5

21. Accused you of paying too much attention to someone or something else. 1 2 3 4 5

22.Put you on an allowance. 1 2 3 4 5

23.Used the children to threaten you. (Examples: told you that you would lose custody, said he would leave town with the children). 1 2 3 4 5

24.Became very upset with you because dinner, housework or laundry was not ready when he wanted it, or done the way he thought it should be. 1 2 3 4 5

25.Said things to scare you. (Example: told you something bad would happen, threatened to commit suicide) 1 2 3 4 5

26.Slapped, hit or punched you. 1 2 3 4 5

Made you do something humiliating or degrading. (Example: begging for forgiveness, having to ask his permission to use the car or do something). 1 2 3 4 5

27.Checked up on you. (Examples: listened to you phone calls, checked the mileage on your car, called you repeatedly at work). 1 2 3 4 5

28.Drove recklessly when you were in the car. 1 2 3 4 5

29.Pressured you to have sex in a way that you didn't like or want. 1 2 3 4 5

30.Refused to do housework or childcare. 1 2 3 4 5

31.Threatened you with a knife, gun or other weapon. 1 2 3 4 5

32.Told you that you were a bad parent. 1 2 3 4 5

33.Stopped you or tried to stop you from going to work or school. 1 2 3 4 5

34.Threw, hit, kicked or smashed something. 1 2 3 4 5

35.Kicked you. 1 2 3 4 5

APPENDIX C

36-ITEM SHORT FORM SURVEY INSTRUMENT

36-Item Short Form Survey Instrument (SF-36)

RAND 36-Item Health Survey 1.0 Questionnaire Items

Choose one option for each questionnaire item.

1. In general, would you say your health is:

- ○ 1 - Excellent
- ○ 2 - Very good
- ○ 3 - Good
- ○ 4 - Fair
- ○ 5 - Poor

---

2. **Compared to one year ago**, how would you rate your health in general **now**?

- ○ 1 - Much better now than one year ago
- ○ 2 - Somewhat better now than one year ago
- ○ 3 - About the same
- ○ 4 - Somewhat worse now than one year ago
- ○ 5 - Much worse now than one year ago

The following items are about activities you might do during a typical day. Does **your health now limit you** in these activities? If so, how much?

	Yes, limited a lot	Yes, limited a little	No, not limited at all
3. **Vigorous activities**, such as running, lifting heavy objects, participating in strenuous sports	○ 1	○ 2	○ 3
4. **Moderate activities**, such as moving a table, pushing a vacuum cleaner, bowling, or playing golf	○ 1	○ 2	○ 3
5. Lifting or carrying groceries	○ 1	○ 2	○ 3
6. Climbing **several** flights of stairs	○ 1	○ 2	○ 3
7. Climbing **one** flight of stairs	○ 1	○ 2	○ 3
8. Bending, kneeling, or stooping	○ 1	○ 2	○ 3
9. Walking **more than a mile**	○ 1	○ 2	○ 3
10. Walking **several blocks**	○ 1	○ 2	○ 3
11. Walking **one block**	○ 1	○ 2	○ 3
12. Bathing or dressing yourself	○ 1	○ 2	○ 3

During the **past 4 weeks**, have you had any of the following problems with your work or other regular daily activities **as a result of your physical health**?

	Yes	No
13. Cut down the **amount of time** you spent on work or other activities	○ 1	○ 2
14. **Accomplished less** than you would like	○ 1	○ 2
15. Were limited in the **kind** of work or other activities	○ 1	○ 2
16. Had **difficulty** performing the work or other activities (for example, it took extra effort)	○ 1	○ 2

During the **past 4 weeks**, have you had any of the following problems with your work or other regular daily activities **as a result of any emotional problems** (such as feeling depressed or anxious)?

	Yes	No
17. Cut down the **amount of time** you spent on work or other activities	○ 1	○ 2
18. **Accomplished less** than you would like	○ 1	○ 2
19. Didn't do work or other activities as **carefully** as usual	○ 1	○ 2

20. During the **past 4 weeks**, to what extent has your physical health or emotional problems interfered with your normal social activities with family, friends, neighbors, or groups?

- ○ 1 - Not at all
- ○ 2 - Slightly
- ○ 3 - Moderately
- ○ 4 - Quite a bit
- ○ 5 - Extremely

21. How much **bodily** pain have you had during the **past 4 weeks**?

- 1 - None
- 2 - Very mild
- 3 - Mild
- 4 - Moderate
- 5 - Severe
- 6 - Very severe

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22. During the **past 4 weeks**, how much did **pain** interfere with your normal work (including both work outside the home and housework)?

- 1 - Not at all
- 2 - A little bit
- 3 - Moderately
- 4 - Quite a bit
- 5 - Extremely

These questions are about how you feel and how things have been with you **during the past 4 weeks**. For each question, please give the one answer that comes closest to the way you have been feeling.

How much of the time during the **past 4 weeks**...

	All of the time	Most of the time	A good bit of the time	Some of the time	A little of the time	None of the time
23. Did you feel full of pep?	◯ 1	◯ 2	◯ 3	◯ 4	◯ 5	◯ 6
24. Have you been a very nervous person?	◯ 1	◯ 2	◯ 3	◯ 4	◯ 5	◯ 6
25. Have you felt so down in the dumps that nothing could cheer you up?	◯ 1	◯ 2	◯ 3	◯ 4	◯ 5	◯ 6
26. Have you felt calm and peaceful?	◯ 1	◯ 2	◯ 3	◯ 4	◯ 5	◯ 6
27. Did you have a lot of energy?	◯ 1	◯ 2	◯ 3	◯ 4	◯ 5	◯ 6
28. Have you felt downhearted and blue?	◯ 1	◯ 2	◯ 3	◯ 4	◯ 5	◯ 6
29. Did you feel worn out?	◯ 1	◯ 2	◯ 3	◯ 4	◯ 5	◯ 6
30. Have you been a happy person?	◯ 1	◯ 2	◯ 3	◯ 4	◯ 5	◯ 6
31. Did you feel tired?	◯ 1	◯ 2	◯ 3	◯ 4	◯ 5	◯ 6

32. During the **past 4 weeks**, how much of the time has **your physical health or emotional problems** interfered with your social activities (like visiting with friends, relatives, etc.)?

◯ 1 - All of the time

◯ 2 - Most of the time

◯ 3 - Some of the time

◯ 4 - A little of the time

◯ 5 - None of the time

How TRUE or FALSE is **each** of the following statements for you.

	Definitely true	Mostly true	Don't know	Mostly false	Definitely false
33. I seem to get sick a little easier than other people	○ 1	○ 2	○ 3	○ 4	○ 5
34. I am as healthy as anybody I know	○ 1	○ 2	○ 3	○ 4	○ 5
35. I expect my health to get worse	○ 1	○ 2	○ 3	○ 4	○ 5
36. My health is excellent	○ 1	○ 2	○ 3	○ 4	○ 5

APPENDIX D

MEDICAL OUTCOME SURVEY – SOCIAL SUPPORT SURVEY INSTRUMENT

RAND HEALTH CARE

RAND > RAND Health Care > Surveys > RAND Medical Outcomes Study > Social Support Survey >

Social Support Survey Instrument

People sometimes look to others for companionship, assistance, or other types of support. How often is each of the following kinds of support available to you if you need it? Choose one number from each line.

Emotional/Informational support	None of the time	A little of the time	Some of the time	Most of the time	All of the time
Someone you can count on to listen to you when you need to talk	1	2	3	4	5
Someone to give you information to help you understand a situation	1	2	3	4	5
Someone to give you good advice about a crisis	1	2	3	4	5
Someone to confide in or talk to about yourself or your problems	1	2	3	4	5
Someone whose advice you really want	1	2	3	4	5
Someone to share your most private worries and fears with	1	2	3	4	5
Someone to turn to for suggestions about how to deal with a personal problem	1	2	3	4	5
Someone who understands your problems	1	2	3	4	5

Tangible support	None of the time	A little of the time	Some of the time	Most of the time	All of the time
Someone to help you if you were confined to bed	1	2	3	4	5
Someone to take you to the doctor if you needed it	1	2	3	4	5
Someone to prepare your meals if you were unable to do it yourself	1	2	3	4	5
Someone to help with daily chores if you were sick	1	2	3	4	5

Affectionate support	None of the time	A little of the time	Some of the time	Most of the time	All of the time
Someone who shows you love and affection	1	2	3	4	5
Someone to love and make you feel wanted	1	2	3	4	5
Someone who hugs you	1	2	3	4	5

Positive social interaction	None of the time	A little of the time	Some of the time	Most of the time	All of the time
Someone to have a good time with	1	2	3	4	5
Someone to get together with for relaxation	1	2	3	4	5
Someone to do something enjoyable with	1	2	3	4	5

Additional item	None of the time	A little of the time	Some of the time	Most of the time	All of the time
Someone to do things with to help you get your mind off things	1	2	3	4	5

APPENDIX E

BECK'S DEPRESSION INVENTORY

Beck's Depression Inventory

This depression inventory can be self-scored. The scoring scale is at the end of the questionnaire.

1.

0	I do not feel sad.
1	I feel sad
2	I am sad all the time and I can't snap out of it.
3	I am so sad and unhappy that I can't stand it.

2.

0	I am not particularly discouraged about the future.
1	I feel discouraged about the future.
2	I feel I have nothing to look forward to.
3	I feel the future is hopeless and that things cannot improve.

3.

0	I do not feel like a failure.
1	I feel I have failed more than the average person.
2	As I look back on my life, all I can see is a lot of failures.
3	I feel I am a complete failure as a person.

4.

0	I get as much satisfaction out of things as I used to.
1	I don't enjoy things the way I used to.
2	I don't get real satisfaction out of anything anymore.
3	I am dissatisfied or bored with everything.

5.

0	I don't feel particularly guilty
1	I feel guilty a good part of the time.
2	I feel quite guilty most of the time.
3	I feel guilty all of the time.

6.

0	I don't feel I am being punished.
1	I feel I may be punished.
2	I expect to be punished.
3	I feel I am being punished.

7.

0	I don't feel disappointed in myself.
1	I am disappointed in myself.
2	I am disgusted with myself.
3	I hate myself.

8.

0	I don't feel I am any worse than anybody else.
1	I am critical of myself for my weaknesses or mistakes.
2	I blame myself all the time for my faults.
3	I blame myself for everything bad that happens.

9.

0	I don't have any thoughts of killing myself.
1	I have thoughts of killing myself, but I would not carry them out.
2	I would like to kill myself.
3	I would kill myself if I had the chance.

10.

0	I don't cry any more than usual.
1	I cry more now than I used to.
2	I cry all the time now.
3	I used to be able to cry, but now I can't cry even though I want to.

11.

0 I am no more irritated by things than I ever was.
1 I am slightly more irritated now than usual.
2 I am quite annoyed or irritated a good deal of the time.
3 I feel irritated all the time.

12.

0 I have not lost interest in other people.
1 I am less interested in other people than I used to be.
2 I have lost most of my interest in other people.
3 I have lost all of my interest in other people.

13.

0 I make decisions about as well as I ever could.
1 I put off making decisions more than I used to.
2 I have greater difficulty in making decisions more than I used to.
3 I can't make decisions at all anymore.

14.

0 I don't feel that I look any worse than I used to.
1 I am worried that I am looking old or unattractive.
2 I feel there are permanent changes in my appearance that make me look unattractive
3 I believe that I look ugly.

15.

0 I can work about as well as before.
1 It takes an extra effort to get started at doing something.
2 I have to push myself very hard to do anything.
3 I can't do any work at all.

16.

0 I can sleep as well as usual.
1 I don't sleep as well as I used to.
2 I wake up 1-2 hours earlier than usual and find it hard to get back to sleep.
3 I wake up several hours earlier than I used to and cannot get back to sleep.

17.

0 I don't get more tired than usual.
1 I get tired more easily than I used to.
2 I get tired from doing almost anything.
3 I am too tired to do anything.

18.

0 My appetite is no worse than usual.
1 My appetite is not as good as it used to be.
2 My appetite is much worse now.
3 I have no appetite at all anymore.

19.

0 I haven't lost much weight, if any, lately.
1 I have lost more than five pounds.
2 I have lost more than ten pounds.
3 I have lost more than fifteen pounds.

20.

0 I am no more worried about my health than usual.
1 I am worried about physical problems like aches, pains, upset stomach, or constipation.
2 I am very worried about physical problems and it's hard to think of much else.
3 I am so worried about my physical problems that I cannot think of anything else.

21.

0 I have not noticed any recent change in my interest in sex.
1 I am less interested in sex than I used to be.
2 I have almost no interest in sex.
3 I have lost interest in sex completely.

INTERPRETING THE BECK DEPRESSION INVENTORY

Now that you have completed the questionnaire, add up the score for each of the twenty-one questions by counting the number to the right of each question you marked. The highest possible total for the whole test would be sixty-three. This would mean you circled number three on all twenty-one questions. Since the lowest possible score for each question is zero, the lowest possible score for the test would be zero. This would mean you circles zero on each question. You can evaluate your depression according to the Table below.

Total Score	Levels of Depression
1-10	These ups and downs are considered normal
11-16	Mild mood disturbance
17-20	Borderline clinical depression
21-30	Moderate depression
31-40	Severe depression
over 40	Extreme depression