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Treatment of Trauma for Latina and African American Survivors of Intimate Partner Violence

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TREATMENT OF TRAUMA FOR LATINA AND AFRICAN AMERICAN SURVIVORS OF INTIMATE PARTNER VIOLENCE

by

Shanna B. Dulen

A DISSERTATION

Submitted to the Faculty of the University of Miami in partial fulfillment of the requirements for the degree of Doctor of Philosophy

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the requirements for the degree of
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TREATMENT OF TRAUMA FOR LATINA AND AFRICAN AMERICAN
SURVIVORS OF INTIMATE PARTNER VIOLENCE

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The mental health field lacks an array of effective interventions designed to assist women victims of intimate partner violence (IPV). Moreover, treatment modalities responsive to the needs of racially and ethnically diverse populations are under researched. This presents a significant challenge to serving ethnic minority women who are known to experience more crime, violence victimization, and psychological trauma than their dominant-ethnic group counterparts. This study integrated research and theory of trauma with current IPV literature and tested the utility of a brief trauma-based approach in reducing trauma related symptomatology in a predominantly Latina and African American clinical sample. Traumatic Incident Reduction (TIR) is a time limited intervention that seeks to resolve trauma and psychological symptoms through various memory-based methods, guided exposure techniques, and the use repetitious story-telling of traumatic event(s). By taking this approach, this research sought to add to the emerging literature on the effects of TIR in alleviating symptoms associated with trauma exposure. Treatment effects in 106 survivors of IPV were examined (age = 36, SD=9, 80.2% Latina, 19.8% African American, mean hours spent in TIR treatment $M = 6.4$, $SD = 5.28$). Paired $t$-tests
supported the hypotheses that TIR significantly ($p < .001$) reduced symptoms of PTSD, anxiety, and depression and increased self-concept. Multiple regression analyses found that as the hours in TIR increased so did the participants self-concept ($R^2 = .179$, $F(4, 75) = 4.08$, $p = .005$). Multiple regression analysis also supported the hypothesis that as the total number of crimes as a victim increased Depression increased significantly ($R^2 = .125$, $F(4, 76) = 2.72$, $p = .036$). Chi squares and $t$-tests found no differences between those who remained in treatment versus those who terminated prematurely.
Dedications

I dedicate this dissertation to my family for your love and support through this process. I would not have been able to complete my goals if I did not have your support.

I would like to dedicate this dissertation to my parents, Marsha Dulen and Doug Dulen, who have supported my education, in all manners, and for their patience. Thank you for supporting my life and career choices and everything each of you have done in order to help me fulfill my dream of becoming a psychologist.

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Chapter I: Introduction

Statement of Problem

The past decade has been marked in part by a flurry of natural disasters, the economic recession, the spread of war and terrorism, and an increased awareness about the intimate partner violence epidemic affecting women and children across the world. This decade has also been marked by accumulated evidence of pronounced health disparities affecting racial and ethnic minorities groups in this country. Concern about the effects of these and other events on the mental health and well-being of the citizens of this nation have led many psychologists to pay close attention to the recognition and treatment of Post Traumatic Stress Disorder (PTSD) across ethnic and racial groups (Eisenman et al., 2008). Although we know more today than we did 20 years ago about the symptoms and causes of psychological trauma, knowledge about effective interventions to address these symptoms and improve the lives of afflicted ethnic and racial individuals is sadly lagging behind.

The proposed study aims to understand the efficacy of a promising approach to assist racial and ethnic minority survivors of violence and crimes. Traumatic Incident Reduction (TIR) is a time limited intervention that seeks to resolve trauma and psychological symptoms through an array of memory-based methods, guided exposure techniques, and the use repetitious story-telling of traumatic event(s). Moreover, TIR is designed to be a low cost alternative to traditional psychiatric and psychological interventions and is believed to be applicable across ethnic and racial groups.

Recent studies have found TIR to be efficacious in the treatment of trauma related symptomatology among female inmates, unaccompanied refugees, and urban youth
populations. To date, however, little is known about the effectiveness of TIR with adult ethnic minority populations. This presents a significant challenge in our ability to serve ethnic minority women known to experience more crime and violence victimization and more psychological trauma than their dominant ethnic groups counterparts. The proposed study seeks to fill this gap by exploring the reported trauma history of Latina and African American populations receiving services for trauma and intimate partner violence (IPV) related symptoms in Miami-Dade County and within this context evaluate the impact of TIR in the occurrence and intensity of these symptoms. In particular, I want to study the impact of TIR in symptoms of anxiety, depression, and post-traumatic stress disorder (PTSD). In addition, the study evaluates the impact of TIR in the survivors’ self-concept.

Rationale

Psychological trauma affects millions of people residing in the US each day. Stressors with a high likelihood of producing a trauma response include: natural disaster, physical abuse, sexual abuse, intimate partner violence, community violence, and loss of a significant attachment figure (Keane, 1996). As a result of one’s inability to gain mastery over a trauma, instability in one’s mental health can surface. This instability is often manifested in the form of anxiety disorders, PTSD, and depression (Breslau, Davis, Adreski, & Peterson, 1991; van der Kolk, 1994). Within this context it is worth mentioning that anxiety, depression, and PTSD are the most diagnosed mental illnesses in the US (Breslau, Davis, Adreski, & Peterson, 1991; Odio, 2003; Van der Kolk, 1996).

Trauma Resolution Center (TRC) is one of the main providers of trauma-oriented services in South Florida. Strategically located in the downtown area of Miami, TRC
serves a predominantly low socioeconomic Latino and Black clientele. According to US Census Bureau (2008) Latinos, African Americans, and Whites comprise 61.7%, 20%, and 12.7% of the population in Miami-Dade County, respectively. Those seeking treatment at TRC identify IPV, sexual abuse, and violent crime as the most frequent forms of traumatic experiences. Also, the number of immigrants in our communities makes the immigration process an added stressor for this population of interest.

A number of researchers have suggested that IPV-related physical and mental health symptoms are magnified for abused immigrant Latinas who face multiple stressors, higher levels of social isolation and entrapment, and exacerbating cultural factors (Kelly 2010; Perilla, 1999; Perilla, Bakeman, & Norris, 1994; Ramos, Carlson, & McNutt, 2004). Recent population-based studies of IPV have found prevalence rates among both blacks and Latinos of approximately 25% compared to 14% among Whites (Caetano, Field, Ramisetty-Mikler, & McGrath, 2005; Kelly, 2010). Latinos have the highest IPV recurrence rate at 58% and Whites the lowest at 37% (Caetano, Field, Ramisetty-Mikler, & McGrath, 2005; Kelly, 2010). While rates of IPV across race and ethnicity are inconsistent in the available literature, it is widely acknowledged that even the most empirically sound estimates of IPV likely reflect only a fraction of the actual problem (Kelly, 2010; Krug, Dahlberg, Mercy, Zwi, Lozano, 2002).

Each year significant financial resources are allocated to combat the negative effects of trauma, specifically through the use of various treatment modalities. Traditional interventions in this area tend to include a combination of medication treatment and specialized psychological services delivered by highly trained clinicians. Outcome studies show that early diagnoses and timely interventions are the most cost
effective and the most beneficial for the person suffering (Lownstein, 1994; Odio, 2003). Thus, the advent of a treatment approach that could effectively reduce trauma related symptoms for ethnic minority populations at a low cost would be a welcome development in the field. TIR is a brief, one-to-one, person centered, and highly structured treatment method aimed at symptom reduction related to the negative effects of past traumas (Gerbode, 2006). While TIR has not been studied extensively the accumulating evidence suggests that TIR has a positive and at times dramatic impact in alleviating symptoms of PTSD, depression, and anxiety while increasing one’s self-concept (Bisbey & Bisbey, 1998; Descillo, Greenwald, Schmitt, & Reslan, 2010; Valentine, 1995; Valentine & Smith, 2001). The proposed dissertation is designed in part to test these claims.
Chapter II: Review of the Literature

Overview

This chapter reviews research literature on both Latina and African American populations concerning trauma. More specifically, the effects of trauma, the stress concept, and various facets of PTSD are analyzed based on theoretical foundations, prevalence, and research designs. Additionally, intimate partner violence in Latino and African American communities and the associated mental health effects are discussed in regard to their relevance to this study. Next, I will review TIR, both protocol and relevant research. Finally, I will revisit the purpose of the study and present the hypothesis guiding the data analysis.

Population of Interest

Latinos

This study focuses on the trauma experiences, intimate partner violence, and the impact of TIR on both Latino and African American individuals. Latinos now constitute the largest ethnic minority group in the United States with 44.3 million resident individuals. This number represents 14.8% of the 299 million total individuals residing in the U.S. (Pole, Gone, Kulkarni, 2008; U.S. Census Bureau, 2006). Latinos are also the fastest growing ethnic group in the U.S. and are projected to comprise 29% of the U.S. population by 2050 (Kelly, 2010; Pew Hispanic Center, 2008; US Bureau of the Census, 2004). Unlike other minority groups, The Census Bureau identifies Latinos as an “ethnic” group rather than a “racial” group, due to the differing ethnic characteristics, counties of origin, and cultural diversities that exist. With 3,646,499 registered Latinos, the state of Florida has the third largest Latino population after California and Texas.
(U.S. Census Bureau, 2006). While most Latinos in the US were born here, there are an increasing number of new immigrants and immigrant residents who have family members who plan to immigrate (Pole, Gone, Kulkarni, 2008). Thus, Latinos are attentive to immigration legislation that may impact them and their family members; and this is particularly true in matters pertaining to bilingualism and religious matters (American Psychological Association, 2003; Pole, Gone, Kulkarni, 2008).

Many Latinos ascribe to a set of core values that include familismo (i.e., prioritizing needs of the family of the individual), simpatia (i.e., valuing interpersonal harmony), personalismo (i.e., valuing warm and emotionally involved social relationships; Fraga, Atkinson, & Wampold, 2004), and fatalismo (i.e., the belief that outcomes are predetermined and unalterable; Ruef, Litz, Schlenger, 2000) (Pole, Gone, Kulkarni, 2008). While these core values can be a guideline as to how to approach many Latino groups, it is probable that there is significant within-group variability in these values as well as other factors (Pole, Gone, Kulkarni, 2008). These factors can include: geographic origin, citizenship or immigration status, circumstances under which the person may have left his or her country of origin, including potential refugee status, generational level, acculturation level, educational background, political affiliation, and socioeconomic status (Pole, Gone, Kulkarni, 2008; U.S. Census Bureau, 2001).

**African Americans**

While the majority of African Americans can trace their ancestry to the slave trade, this group also consists of more recent immigrants from Africa and Caribbean territories (e.g. Cuba, Dominican Republic, Panama, Haiti, and the Virgin Islands; Pole, Gone, Kulkarni, 2008). After enduring generations of racial inequality and legalized
racial segregation, some African Americans still report being survivors of racial discrimination, even years after the equal civil rights were passed and implemented (Pole, Gone, Kulkarni, 2008). African Americans have historically been overrepresented among the undereducated, the poor, homeless, and incarcerated, but have made recent gains in terms of education and income level (Jencks, 1994; Pole, Gone, Kulkarni, 2008; Thernstrom & Thernstrom, 1997). When discussing African Americans, it is important to remember the great diversity that exist within the community on geographic, socioeconomic, and generational variables (Pole, Gone, Kulkarni, 2008). Despite intragroup differences, African Americans often share a number of cultural characteristics, including religious orientation, strong work ethic, reliance on extended family networks, and maintenance of right kinship bonds, all of which may be contributors to the resilience that has been commonly noted amongst this group (McCollum, 1997; Pole, Gone, Kulkarni, 2008; Sampson, Raudenbush, & Earls, 1997).

Trauma

Trauma stems from the Greek root word that means, “wound, a shock to the system” (Everstine & Everstine, 1993, pg. 3; Valentine, 2000). According to van der Kolk and McFarlane (1996, pg. 3), “experiencing trauma is an essential part of being human.” If one is to assume this stance, the stress response that follows a traumatic incident should be considered an inevitable part of the human experience (Everstine & Everstine, 1993 & Valentine, 2000). When experienced forcefully, trauma impairs the survivor’s sense of equilibrium and defense mechanisms in place, thus disorganizing the present constructs and modes of effective coping (Everstine & Everstine, 1993; Valentine, 2000). In the aftermath of the trauma, the old constructs are shattered and new
constructs are hastily erected during or immediately after the traumatic incident (Janoff-Bulman, 1992; Valentine, 1995). Disorganization is one of trauma’s main effects, leading to a system overload for the person, where he or she is unable adequately to process the traumatic event (Valentine, 1995; Waites, 1993).

The construct of trauma is defined in both the medical and psychological professions and evolved from multiple etiologies and symptom presentations (Odio, 2003). The medical definition refers to a physical trauma related to bodily injury, but it fails to capture the larger impact a trauma can have on a person. The psychological definition views a traumatic stressor as “an overwhelming event resulting in helplessness in the face of intolerable danger, anxiety, and instinctual arousal” (Eth & Pynoos, 1985; Sourander, 1998, pg. 724). The exposure to multiple stressors greatly decreases a person’s ability to cope successfully with his or her environment (Sourander, 1998). Psychological trauma and its ramifications are the foci of this investigation.

Psychological trauma can be prompted by natural disasters, violence in families, physical and sexual abuse, community and national violence, neglect, bullying, catastrophic events, mechanical accidents, medical emergencies, war or mass violence, and long-term exposure to extreme poverty or verbal abuse. Persons exposed to traumatic events have almost twice the rate of psychiatric disorders of individuals without these experiences. Moreover, psychological functioning decreases significantly with the number of traumatic events experienced (Ford, Pat-Horenczyk, & Brom, 2009). Individual responses to trauma cannot be understood solely by focusing on individual resiliency factors: the mediating effects of social, political, and ecological contexts must also be taken into consideration (Goodman, 2004; Punamaki, 1989). Goodman’s findings
The severity and duration of the event distinguishes trauma from stress (Valentine, 2000). The event must be serious enough to challenge basic assumptions, such as a violation of human rights, justice, fairness, safety, and predictability to constitute a trauma (Janoff-Bulman, 1992; Valentine, 2000). Trauma can disrupt the person’s current schemas and can diminish one’s ability to cope (Valentine, 2000). In such events, the fight-or-flight response is activated to manage stress in emergency situations (Valentine, 2000). The autonomic nervous system, particularly the reticular activation system of the brain stem, the hypothalamus, and the pituitary gland all mediate the fight or flight response (Valentine, 2000; van der Kolk, 1987; Zuckerman, 1991). While most evidence states that a trauma can temporarily alter micro-structural neuro-chemistry, it is possible that severe trauma events can permanently alter such structures (Valentine, 2000).

The Effects of Trauma

The effects of trauma have varied consequences that are dependent upon many factors. While some individuals can be affected and suffer significant impairment in their daily lives, others exposed to the same potentially traumatic events can appear to have
little to no impact on their lives and functioning. Thus, what is traumatic for one person may not be for another. Carlson (1997) proposed that trauma entails three specific characteristics: 1) the incident is perceived as highly negative; 2) the experience is sudden 3) the person is unable to control the events and there is subsequent threat to the person’s physical safety and psychological integrity. However, a person does not have to experience all of the aforementioned characteristics to experience an event as traumatic (Carlson, 1997).

The Stress Concept

Over the past 30 years, efforts to understand the social and psychological origins of mental illness have tended to focus on the distribution of stressful events as one mechanism explaining differing rates of psychological and physical problems across gender, racial, ethnic, and social class categories (Adams & Boscarino, 2005; Aneshensel, Rutter, & Lachenbruch, 1991; Breslau, Davis, Andreski, & Peterson, 1991; Breslau et al. 1998; Kessler, Mickelson, & Williams, 1999; Kessler, Sonnega, Bromet, & Hughes, 1995; Turner, Wheaton, & Lloyd, 1995). As a result, a considerable literature has developed linking exposure to negative life and traumatic events to psychological distress (Adams & Boscarino, 2005; Galea et al., 2002; Plant & Sachs-Ericsson, 2004, Turner, Wheaton, & Lloyd, 1995). Since the induction of stress into research literature, there has been a widely accepted vernacular that embodies an elastic definition, allowing stress to be examined from various perspectives (Cooper & Dewe, 2007). Traditional views of the causes of disease have been transformed by the concept of stress, which has evolved into a pop-cultural term that not only defines what ails the masses but also
promulgates a genre of self-help and do-it-yourself books for the general public (Roskies, 1983).

Stress is an evolved concept typically identified as one or more of three general types: systemic or physiological, psychological, and sociocultural (Monat, Lazarus, & Reevy, 2007). Physiological stress is the body’s potentially harmful reaction to events (Cannon, 1953; Monat, Lazarus, & Reevy, 2007; Selye, 1976). Psychological stress is primarily concerned with cognitive and emotional factors that may lead to the appraisal of threat (Lazarus, 1966; Monat, Lazarus, & Reevy, 2007). Lastly, sociocultural stress focuses on disturbance of social systems or social units (Monat, Lazarus, & Reevy, 2007; Smelser, 1963).

The study of stressful life events emerged when psychologists and psychiatrists began looking at the relationship between life events and psychiatric disorders (Cooper & Dewe, 2007). Early work demonstrated that stimuli associated with emotional arousal could cause changes in the basic physiological processes (Cooper & Dewe, 2007; Dohrendwend & Dohrenwend, 1974). The common denominator in psychosomatic illness was noted as the interpretation of the event as threatening (Cooper & Dewe, 2007; Wolf, Wolf, & Hare, 1950). While Wolf et al.’s (1950) conclusions proved to be somewhat controversial, it became central to the subsequent research on stressful life events. More specifically, this spawned research that explored the link between life events and disease onset (Cooper & Dewe, 2007).

Stress and psychiatric illness has had a long history of research which often links stress with depression, anxiety, and PTSD, to name a few. PTSD has gained increased consideration in recent years due to media attention on domestic violence, terrorist
attacks, and war. War, armed conflict, mass violence, and human rights violations of varying intensity have increased in many parts of the world in recent years, and terrorism has been seen as an integral component of these conflicts (Lee, Isaac, & Janca, 2007).

Post Traumatic Stress Disorder (PTSD)

The Diagnostic and Statistical Manual of Mental Disorder (DSM IV-TR) (APA, 2000) defines PTSD as the development of characteristic symptoms following exposure to an extreme traumatic stressor involving direct personal experience of an event that involves actual or threatened death or serious injury, or other threat to one’s physical integrity; or witnessing an event that involves death, injury, or a threat to physical integrity of another person; or learning about the unexpected or violent death, serious harm, or threat of death or injury experienced by a family member or other close associate. The person’s response to the event must involve intense fear, helplessness, or horror. The characteristic symptoms resulting from the exposure to the extreme trauma must include persistent re-experiencing of the traumatic event, persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness, and persistent symptoms of increased arousal (APA, 2000, pg. 463).

PTSD refers to the DSM-IV TR definition where the person experiences symptoms of intrusion, avoidance, and arousal (American Psychiatric Association, 1994; Valentine, 2002) with the following symptoms: recurrent traumatic memories and a general numbing of responses, as well as a persistent sense of increased arousal leading to intense anxiety irritability, outbursts of anger, difficulty concentrating, and insomnia (Horrowitz, 1986; Smajke & Weane, 1995; Suarez-Orozco & Suarez-Orozco, 2002).
Lifetime prevalence rates of PTSD are twice as high for women as for men, 10.4% vs. 5% respectively (Foa, Keane, Friedman, 2000). Women are four times more likely to develop PTSD when exposed to the same trauma; however, gender differences in response to treatment have not been studied systematically, making it difficult to speak to probable gender differences (Foa, Keane, Friedman, 2000). A review of the literature suggests that women are more responsive to PTSD treatment than men; however, most studies note important differences between the treatment groups, making valid comparisons difficult and impossible to conclude that gender is predictive of treatment of response (Foa, Keane, Friedman, 2000).

Treatment for PTSD

Research on treatment efficacy for PTSD began in the early 1980’s following the introduction of the disorder as an official diagnostic category within the DSM-III (Foa, Keane, Friedman, 2000). Many studies have been published regarding treatment of PTSD and as such, variations with respect to methodological rigor and results often differ. Therefore, the strength of the conclusions drawn varies within treatments (Foa, Keane, Friedman, 2000). In general, psychotherapy, cognitive-behavioral therapy, and medications, specifically selective serotonin reuptake inhibitors, have been shown to be efficacious treatments for PTSD (Foa, Keane, Friedman, 2000).

There are many treatment modalities that focus on trauma resolution that are supported by empirical evidence including trauma-focused cognitive-behavioral therapy (TF-CBT; Cohen, Mannarino, & Deblinger, 2006; Foa, Keane, Friedman, 2000), eye movement desensitization and reprocessing (EMDR; Rodenburg, Benjamin, de Roos, Meijer, & Stams, 2009), and group CBT (Chemtob, Nakashima, Hamada, & Carlson,
All of these interventions combine some form of exposure therapy, that is, having the survivor concentrate on the memory, with various distinguishing treatment elements. Overall, exposure therapy in conjunction with various CBT techniques has demonstrated the most consistent positive findings (Foa, Keane, & Friedman, 2000).

**Prevalence and Prediction of PTSD**

This section presents the prevalence rates of PTSD using non-Latino White Americans as the reference group. Most large-scale epidemiological studies report that Latinos have lower rates of mood, anxiety, and other mental disorders than their non-Latino White counterparts (Kessler, Berglund, Demler, Jin, Merikangas, & Walters, 2005; Pole, Gone, Kulkarni, 2008; Robins & Reiger, 1991; Zhang & Snowden, 1999). However, other studies report a higher rates of mood disorder (Kessler, McGonagle, Zhao, Nelson, Hughes, Eshleman, et al., 1994) and alcohol use disorders (Zhang & Snowden, 1999) among Latinos (Pole, Gone, Kulkarni, 2008).

Several studies report that, compared to non-Latino White Americans, Latinos have higher rates of PTSD or report more severe PTSD symptoms (Pole, Gone, Kulkarni, 2008). This has been found to be the case in studies of police officers (Pole, Best, Metzler, & Marmar, 2005; Pole, Best, Weiss, Metzler, Liberman, Fagan, et al., 2001), war veterans in treatment (Rosenheck & Fontana, 1996), survivors of Hurricane Andrew in Florida (Perilla, Norris, Lavizzo, 2002), survivors of Hurricane Paulina in Mexico (Norris, Perrial, & Murphy, 2001) Vietnam combat veterans, and survivors of the September 11 terrorist attacks in New York City (Galea, et al., 2002) (Pole, Gone, Kulkarni 2008). Furthermore, a September 11 survivors study found that Latinos were
more likely to develop delayed PTSD onset (Adams & Boscarino, 2006). While not every study conclusively reports elevated rates of PTSD for Latino populations (Penk et al., 1989), a body of research suggests higher rates of PTSD with this group (Pole, Gone, Kulkarni, 2008).

Geographic origin and acculturation status appear to carry the most significant moderating relationship for within-group variation of the prevalence of PTSD (Pole, Gone, Kulkarni, 2008). According to Pole et al., (2008) Caribbean Latinos may be impacted more by PTSD than other Latino groups. Ortega and Rosenheck (2000) found that Puerto Rican, but not Mexican American, Vietnam veterans report more severe PTSD symptomatology than their non-Latino European American counterparts (Pole, Gone, Kulkarni, 2008). Among survivors of the September 11 terrorist attacks, Dominican and Puerto Rican Latinos reported more severe PTSD symptom presentation (Galea et al., 2004) and Puerto Ricans overall higher rates of PTSD (Adams & Boscarino, 2005). While explanations for these differences remain unclear, poor social support (Galea et al., 2004) and culture-bound syndromes (combination of psychiatric and somatic symptoms that are considered to be a recognizable disease only within a specific society or culture) have been associated with stressful life events and higher rates of traditional anxiety disorders, such as PTSD (Guarnaccia, Canino, Rubio-Stipec, & Bravo, 1993; Pole, Gone, Kulkarni, 2008).

Although many Latinos now living in the United States have endured severe trauma in the context of war, civil unrest, migration, and extreme poverty in their countries of origin, research is not conclusive when it comes to differences in exposure to traumatic stress and subsequent rates of PTSD among Latino subgroups (Pole, Gone,
Kulkarni, 2008). Since there is good reason to believe that exposure to traumatic events shares the same relationship with PTSD in Latino and non-Latino groups (Norris et al., 2001), it seems reasonable to argue that Latinos may not be more sensitive to trauma exposure than other ethnic groups (Pole, Gone, Kulkarni, 2008).

Concerning the occurrence of traumatic stress and PTSD in African American communities, African Americans are said to have lower rates of mood and substance use disorders than White individuals (Kessler et al., 1994; Zhang & Snowden, 1999). However, some studies report higher rates of a few anxiety disorders (e.g. simple phobia and agoraphobia) (Robins & Reiger, 1991; Zhang & Snowden, 1999) in African American communities. However, several studies have found higher rates of PTSD or PTSD symptoms among African Americans. For example, Kulka et al. (1990) found that African American Vietnam combat veterans had current PTSD rates of 20.6% versus 13.7% for White combat veterans. Another study following a random sample of the Buffalo Creek dam collapse found that two decades after the event African Americans were more likely than Whites to show delayed PTSD onset and less likely to show symptom remission (Green, Lindy, et al., 1990).

Inconsistencies found within studies examining symptomatology within ethnic populations could stem from weak study designs, inappropriate sample selection strategies (e.g., use of convenience samples), reliance on measures that are not culturally sensitive, and treatment of Latinos as an undifferentiated group (Adams & Boccarino, 2005). Additionally, race and ethnic differences in mental illness are rarely assessed within the context of large-scale trauma studies, where the focus is typically placed on
non-normative events, large-scale crises, and natural disasters (Adams & Boscarino, 2005; Norris, 1992).

**Intimate Partner Violence in Latino and African American Communities**

Intimate Partner Violence (IPV) has a wide-reaching impact on individual, family, and community health, highlighted by significant emotional and economic burdens for the victims. This section will draw attention to research trends and results relevant to this proposal and the population of interest. More specifically, IPV research findings will be utilized in order to inform research design and hypotheses for this current dissertation. IPV is defined as “physical and/or sexual assault or threats of assault against a married, cohabiting, or dating current or estranged intimate partner by the other partner, inclusive of emotional abuse and controlling behaviors in a relationship with history of physical and/or sexual assault” (Campbell, et al., 2011, p. 243; Saltzman, Fanslow, McMahon & Shelley, 1999).

While most female survivors of sexual violence experience negative psychological symptoms immediately after the event, many demonstrate significant recovery within a year after the assault (Dancu, Riggs, Hearst-Ikeda, Shoyer, & Foa, 1996; Kimerling & Calhoun, 1994; Martin, Macy, & Young, 2011; Rothbaum, Foa, Riggs, Murdock, & Walsh, 1992). However, there is variation among women in the severity of psychological symptoms experienced soon after sexual violence, as well as in the duration of these symptoms (Martin, Macy, & Young, 2011). Some studies suggest that the severity of women’s reaction to the trauma and their associated immediate psychological responses to sexual violence predicts the speed of their psychological
recovery, with those having the most severe responses post-assault being slower to recover (Martin, Macy, & Young, 2011; Rothbaum, et al., 1992).

Women who have previously experienced violence often evidence deficient psychological health outcomes in response to a current incident of sexual violence (Martin, Macy, & Young, 2011). A study of 117 rape survivors found those who had been sexually abused as children were more likely to be physically and sexually victimized as adults, which in turn, was associated with greater PTSD severity one month after being raped (Martin, Macy, & Young, 2011; Nishith, Mechanic, & Resick, 2000). A survey of 600 adult female sexual assault survivors found that those with a prior history of trauma, including child sexual abuse, reported higher levels of PTSD symptoms (Ullman, Filipas, Townsend, & Starzynski, 2007). There is some evidence to suggest that continuous victimization affects women’s physiological stress reactions (e.g., cortisol responses), which in turn may affect women’s psychological responses to trauma (Martin, Macy, & Young, 2011; Resnick, Yehuda, Pitman, & Foy, 1995; Resnick, Yehuda, & Acierno, 1997).

Research has often found that women who have experienced more severe sexual violence during adulthood have higher levels of psychological symptoms (Martin, Macy, & Young, 2011). For example, a survey of 323 adult females sexually assaulted at age 14 or older (including community residents, college students, and mental health agency patients) found that those who believed that their life was in danger at the time of assault were more likely than others to evidence high levels of PTSD symptoms (Ullman & Filipas, 2001). Similar results were found with other samples (Ullman, et al., 2006). Research findings are equivocal as to whether or not women with closer social ties to the
perpetrator (such as those who are married, dating, etc.) experience more negative psychological sequelae in response to sexual violence (Martin, Macy, & Young, 2011). For instance, an investigation of 96 female undergraduates sexually assaulted at age 12 or older found that, after controlling for the severity of violence experienced, there were greater levels of PTSD-related hyperarousal and intrusion symptoms among those assaulted by marital partners, followed by acquaintances, sexual intimates and dating partners (Culbertson & Dehle, 2001). However, this effect was not seen for PTSD-related avoidance symptoms (Culbertson & Dehle, 2001). A survey of more than 700 women sexually assaulted at age 14 or older found that those assaulted by relatives other than partners or husbands reported the highest level of PTSD symptoms, followed by those assaulted by strangers, partners or husbands, and lastly acquaintances; however, no differences were found between the four groups in terms of their depression symptoms (Ullman, et al., 2006). Note that these PTSD findings may be at least partially explained by the fact that assaults by strangers were more severe in nature compared to assaults by other persons (Martin, Macy, & Young, 2011).

Researchers have also examined whether women’s demographic characteristics are related to their psychological responses to sexual violence. This work suggests that women who are sexually assaulted at younger ages are more likely than those assaulted at older ages to evidence suicide ideation (Ullman & Brecklin, 2002), higher levels of PTSD symptoms (Ullman, et al., 2007), and externalizing PTSD symptoms (Martin, Macy, & Young, 2011; Miller & Resnick, 2007). Research findings are equivocal concerning whether women’s psychological responses to sexual violence are related to their race and ethnicity (McFarlane, et al., 2005a; Miller and Resnick, 2007; Ullman &
Brecklin, 2002; Ullman, Filipas, Townsend, & Starzynski, 2007) or their education levels (Miller & Resnick, 2007; Ullman & Filipas, 2001; Ullman, et al., 2007). Several studies have not found women’s income levels, employment status, or marital and relationship status to be related to the psychological health of adult female sexual assault survivors (Miller & Resnick, 2007; Ullman & Brecklin, 2002 Ullman, et al., 2007).

The cost for adequate psychological and medical treatment of IPV survivors is high. In light of the pronounced prevalence of sexual violence against women (Tjaden & Thoennes, 2000), the many ways in which sexual violence can affect women’s health (Coker, et al., 2002), and female sexual assault survivors’ elevated utilization of health care services (Conoscenti & McNally, 2006; Kimerling & Calhoun, 1994; Lesserman, et al., 1996), national and statewide investigations have attempted to estimate the financial costs associated with such violence (Martin, Macy, & Young, 2011). Although estimates from these studies vary, in part due to the types of costs and types of sexual violence considered, they all demonstrate that sexual violence imposes a considerable financial burden (Martin, Macy, & Young, 2011) on society.

An estimated 322,230 intimate partner rapes of US females in 1995 cost $992 per assault, which includes costs due to medical care, ambulance transport, mental health care, and lost productivity of the survivor, as reported by the National Violence Against Women Survey, the Medical Expenditure Panel Survey, and other sources, (Max, Rice, Finkelstein, Bardwell, & Leadbetter, 2004). This translates to a total annual cost of $319.7 million (Martin, Macy, & Young, 2011). Other studies have estimated the financial cost of sexual violence taking into consideration both tangible costs and intangible costs, such as those associated with how the violence affects the survivors’
quality of life (Martin, Macy, & Young, 2011). Using data from the National Women’s Health Study, the National Crime Victimization Survey, and other sources, a National Institute of Justice study estimated that each of the 1,467,000 rapes and sexual assaults of men and women in 1993 cost $87,000, with approximately $5,000 being due to tangible costs (medical care, ambulance transport, mental health care, police/fire services, social/victim services, property loss/damage, and lost productivity of the survivors) and approximately $82,000 being due to intangible costs (the effect on the survivors’ quality of life) (Miller, Cohen, & Wiersema, 1996). This translates to a total US cost of $127 billion for the rape and sexual assault of adult women and men, the highest annual victim cost of all the crimes studied, surpassing assault, murder, drunk driving, and child abuse (Martin, Macy, & Young, 2011).

Although women’s self-reports often provide the best information researchers can gather concerning these offenses, exclusive reliance on self-reported data generally results in under-detection of sexual violence because some women do not disclose such information due to embarrassment, shame, or concern about what will happen to themselves or their families (Martin, Macy, & Young, 2011). While some studies use a single question to ask about sexual violence, most studies employ more sophisticated assessment techniques, such as psychometrically sound, standardized instruments comprised of multiple questions (Martin, Macy, & Young, 2011). Moreover, most assessments do not pose questions using potentially emotionally loaded terms such as “rape” that may be defined very differently by different persons, but instead ask about specific types of behaviors. Some assessments ask women to recall information concerning sexual violence that they experienced throughout their lifetimes (Martin,
Since recall of past events is imperfect, the findings of such studies are affected by recall bias.

The Stith and colleagues (2004) meta analysis of 94 studies conducted from 1980 to 2000 found small (<.10) effect sizes for several demographic factors predictive of IPV victimization among females including age (r=−.07), low income (r=−.04), and number and presence of children (r=.06). More recent studies have presented larger effect sizes for factors such as use of female violence toward male partners (r=.41), female depression (r=.28), and fear of partner violence (r=.27) (Campbell, et al., 2011).

In another multivariate analysis from the data of the Behavioral Risk Surveillance System (BRFSS), Vest, Catlin, Chen, & Brownson (2002) found specific factors that differentiated physically abused women from their non-abused counterparts. These factors include educational achievement discordance, specifically, when the woman had a higher education than her partner; cohabitating; being unmarried, being African American and a young age, low income, no access to insurance or Medicaid, cigarette use, prior history of physical abuse, poor self-perceptions of physical and mental health, and children residing in the home (Vest, et al. 2002). The multivariate analysis of survey data collected from women in 12 geographically diverse US cities yielded two characteristics of the women that were independently associated with abuse victimization being less than 26 years of age and reporting fair or poor mental health significantly increased the risk of IPV (Walton-Moss, Manganello, Frye, & Campbell 2005). Caution should be used when interpreting findings of cross sectional studies like this one. Poor mental health, poor physical health, and cigarette use, in longitudinal studies are generally interpreted to be consequences of IPV as opposed to risk factors (Campbell,
It is evident from these reviews, that there are relatively few victim-based factors consistently acknowledged as precursors to IPV (Campbell, et al., 2011).

An increased risk of IPV has been associated with separation or divorce more consistently than single marital status (Campbell, et al., 2011). However, most of these research studies have been cross sectional, and elevated IPV risks associated with separation or divorce are likely due to the large proportions of women leaving abusive relationships when responding to surveys (Vest et al., 2002; Walton-Moss et al., 2005).

Intimate partner violence rates tend to differ by race or ethnicity but not in consistent directions, where reasonable conclusions could be surmised. The preponderance of empirical research suggests little relationship between race or ethnicity and lifetime IPV victimization when other factors such as income are factored into the equation (Campbell, et al., 2011). African American women are more likely to be survivors of IPV when compared to White women (Vest et al., 2002; Walton-Moss et al., 2005), but statistical differences vanish when adjusting for other socio-demographic factors, predominantly income, or geographic location in terms of urban and underserved areas (Vest et al., 2002; Field & Caetano, 2004). In a review of population based and longitudinal research on IPV, Field and Caetano (2004) concluded that there is a small increased risk for current IPV for African American women when compared to White and Latina women when controlling for income and other risk factors. As argued by Campbell and her colleagues (2011) the additional risk for current rather than lifetime IPV suggests that although being African American probably does not increase the risk for ever being victimized by IPV, the cultural context as well as lack of resources and
structural oppression common for African American women may contribute to
difficulties escaping or changing the violent relationship.

Numerous studies have concluded that experiencing violence in childhood has a
considerable vulnerability factor for IPV victimization later in life (Campbell, et al.,
2011). Some of most compelling evidence for this assertion comes from a large
retrospective study of 9,367 female HMO patients in San Diego, known as the ACE study
(Whitfield, Anda, Dube, & Felitti, 2003), and from an analysis of the New Zealand
prospective birth cohort study (Fergusson, Boden, & Horwood, 2008). In the ACE study,
women who reported one violent childhood experience more than doubled their risk of
IPV victimization later in life (adjusted OR=2.3; 95% CI=1.6, 3.1) (Whitfield, et al.,
2003). Women who experienced physical abuse, sexual abuse, and witnessed IPV as
youth were 3.5 times more likely to report IPV later in life (Whitfield, et al., 2003). In
the analysis of the New Zealand birth cohort, an overall measure of exposure to abuse in
childhood, specifically the severity of child physical and sexual abuse and parental
violence, was significantly correlated with IPV in multivariate analyses. For females,
childhood sexual and physical abuse, but not witnessing parental IPV, was associated
with IPV victimization in bivariate analyses (Fergusson, et al., 2008).

Women who are physically and sexually abused as children have an elevated risk
of victimization by an intimate partner (Arias, 2004). A study by Coid, Petruckevitch,
Feder, Chung, Richardson, & Moorey, (2001), looked at over 1200 women and
concluded that unwanted sexual intercourse in childhood (<16 years) and severe physical
abuse by parents or caregivers were correlated with IPV in later life (odds ratio 3.54, 95%
CI=1.52, 8.25 and 3.58; 2.06, 6.20 respectively). In most analyses, all types of child
abuse increased the risk of re-victimization; however, Maker, Kemmelmeier, and Peterson (2001) found that victims of childhood sexual abuse were at the highest risk, with a 3-5 times greater risk of re-victimization than their non-abused counterparts. In another study, childhood physical abuse increased the risk of IPV by more than two (2.21) and witnessing parental IPV increased risk by 3.0 (Ehrensaft, Cohen, Brown, Smailes, Chen, & Johnson, 2003).

The considerable number of studies conducted on large, diverse populations finding the association between childhood maltreatment and IPV in adulthood bolsters the cycle of violence theory (Campbell, et al., 2011). Re-victimization is often endured within the family unit and is highly related with low self-esteem as well as dissociation during the re-victimization, both of which are resultant trauma responses from the childhood maltreatment (Whitfield, et al., 2003). The lasting mental health ramifications from childhood trauma, including PTSD and depression, may make it more laborious for women to liberate themselves from abusive relationships (Campbell, et al., 2011).

Mental Health Effects of IPV

Survivors of intimate partner violence (IPV) endure significant mental health sequelae, which manifest as symptoms of psychological and physical distress (Kelly, 2010). Major depressive disorder (MDD), PTSD, and anxiety have become the most frequently diagnosed mental health problems related to IPV (Kelly, 2010; Roberts, Lawrence, Williams, & Raphael, 1998; Torres & Han, 2000; Woods, 2000). Meta-analysis of IPV as a risk factor for mental health disorders found that weighted mean prevalence of PTSD was 63.8% (range from 31%-84.4%), major depression 47.6%
(range from 15%-83%), and suicidality 17.7% (range 4.6%-77%; Golding, 1999; Kelly, 2010).

Research shows that women who experience sexual violence during adulthood are more likely than non-victimized women to exhibit various psychological health problems, including PTSD, anxiety, depression, and suicide ideation and attempts (Martin, Macy, & Young, 2011). For example, research with a random sample of 2,876 women with health insurance, aged 18-64, found that those who had experienced intimate partner sexual violence were more than twice as likely as non-victimized women to have high levels of depressive symptoms (Bonomi, Anderson, Rivara, & Thompson, 2007). A cross-sectional survey of 1,152 women, aged 18-65, recruited from family practice clinics found that those who had experienced intimate partner sexual violence were twice as likely as non-victimized women to report symptoms of PTSD, anxiety, and depression; moreover, they were four times more likely to have attempted suicide (Coker, et al., 2002). Numerous other investigations have found high levels of psychological symptoms among survivors of sexual violence (Breitenbecher, 2006; Ullman, Filipas, Townsend, & Starzynski, 2006).

McFarlane, Groff, O’Brien, & Watson, 2006) and health risk behaviors (Kelly, 2010; Tomasulo & McNamara, 2007). As Campbell et al. (2011) noted, the cycle of violence can be perpetuated in Latino and African American communities, related to the cultural context, lack of resources, and structural oppression. This study delves into the treatment efficacy for Latina and African American survivors of IPV, each of whom have been the recipients of TIR. Discussed next, is TIR and its treatment outcomes.

**Traumatic Incident Reduction**

Traumatic Incident Reduction (TIR) was first proposed by Frank Gerbode in 1989 as procedure to reduce symptoms experienced by survivors of traumatic events (Gerbode, 1989; Gerbode, 2006; Valentine, 1995). TIR is a structured, person-centered, one-on-one, brief, memory based procedure used to reduce or eliminate the negative psychological effects of past traumas to promote insight and personal growth (Gerbode, 2006; Valentine, 1997; Valentine, 2002). TIR is based on the principle that the very act of trying to repress painful memories is what holds them in place and gives them control over the individual. In practice TIR trained facilitators follow a manualized treatment protocol in guiding clients to review past traumas their own pace, until an “endpoint” or resolution is reached (Gerbode, pg. 152, 2006). The endpoint is indicative that the heightened psychological and physiological responses associated with the trauma do not continue to disrupt normative functioning (Gerbode, 2006). At this point, the therapeutic activity should be ended. While indicators may vary between both activities and clients, the endpoint of any activity always includes an improvement in emotional state and an emancipation of attention from the trauma (Gerbode, 2006). The TIR methodology, it consists of extroversion of the viewer's attention, positive or very positive indicators, and
often a realization of some kind (Gerbode, 2006). While a client will usually reach an endpoint in a single session, further work may be necessary in subsequent sessions on that incident or other associated traumas (Gerbode, 2006, pg. 152).

While TIR can be viewed as a form of exposure therapy or deconditioning, the core importance of the client insight to the resolution process distinguishes TIR from procedures based mainly on a conditioning model. According to Gerbode (2006) TIR differs from other therapies such as EMDR, Thought Field Therapy, and Tapas Acupressure Technique, in that it is not explained on the basis of hypothesized, non-experienced physical or paraphysical principles or processes. Instead, TIR is based on experiences, memories, feelings, and thoughts that are common to and recognizable by everyone.

TIR is a unique therapeutic intervention in comparison to more traditional behavioral and cognitive therapies because it is a departure from therapist centered directive and didactic approaches (Gerbode, 2006). Instead, the clients own words are utilized to direct and guide the process (Odio, 2003). This facilitates processing of client-identified issues not the agenda of the facilitator who does not interpret the material that has been brought forth within the session. This approach is meant to foster autonomy with the traumatized client.

Theoretical Basis of TIR

TIR stems from an experiential discipline named “metapsychology” (Gerbode, 2006, p. 152). “Freud’s term has been updated to mean the careful definition, study, classification, and analysis of those common and universal elements of human experience that anyone, including clients and therapists, can easily recognize” (Gerbode, 2006, p.
Metapsychology was conceived by Gerbode (2006) as a way of being person-centered and, at the same time, directive and structured. Moreover, Gerbode sought a treatment modality that addressed the limitations of person-centered treatment approaches thus involving a way to provide clients with structure, but not imposing a belief system (Gerbode, 2006). “Metapsychology meets this challenge, in that the therapist can structure the session referring only to metapsychology-based elements that the client already knows to be a part of his experience” (Gerbode, 2006, p. 153).

Speaking about trauma Freud (1910/1984) spoke of trauma, which later became the basis for TIR:

> What left the symptom behind was not always a single experience. On the contrary, the result was usually brought about by the convergence of several traumas, and often by the repetition of a great number of similar ones. Thus it was necessary to reproduce the whole chain of pathogenic memories in chronological order, or rather in reversed order, the latest ones first and the earliest ones last; and it was quite impossible to jump over the later traumas in order to get back more quickly to the first, which was often the most potent one (p. 37).

According to Gerbode, (2006) TIR is an accurate operationalization of Freud’s insights. Research by others, such as Perls (1969), Hubbard (1950), Foa and Rothbaum (1997), Boudewyns and Shipley (1983), Stampfl and Lewis (1967), and Beck (1970), have all confirmed that repeatedly addressing a past trauma can resolve it (Gerbode, 2006).
TIR differs from other approaches to trauma by making an unusual combination of two very different elements:

a) complete, person-centered respect for the authority of the client concerning his own experience; and

b) a highly structured, predictable approach that allow both practitioner and client to have a clear understanding of exactly what each is to do and why (Gerbode, 2006, p. 154).

Respecting the authority of the client and the therapist who embodies a stance as a “facilitator” who helps a “viewer”, endorses the metapsychology stance (Gerbode, 2006, p. 154).

Gerbode (2006) postulates that TIR brings relief for trauma survivors through defining time as a series of subjective activities. These activities are set into motion by an individual forming a decision to do something (Odio, 2003). If the individual completes the activity, it is thus finished and no longer impedes the present and therefore not leading to the development of a trauma response (Gerbode, 2006 & Odio, 2003). However, if an activity is not completed, it becomes a psychological burden in the present, which can possess a greater or lesser degree of the survivor’s attention depending on the coping skills the survivor has at his or her disposal. Additionally, successful coping with a traumatic event is also dependent on the cognitive capacities and level of processing the survivor is privy to (Bisbey & Bisbey, 1998; Descilo, 2002; Odio, 2003).

Moore (1992) proposes that for an event to provoke a significant stress reaction (Ellis, 1962), the event must trigger and threaten an aspect of a pre-existing belief system (Valentine, 1995; Veronen & Kilpatrick, 1983). Since the first line of defense when
faced with trauma is reflexive (Waites, 1993), “insight is a luxury that the mind cannot afford when locked in a struggle for survival (Everstine & Everstine, 1993, pg. 18; Valentine, 1995). Thus, cognitive distortions emerge with various thematic components of sympathy for the perpetrator, magical thinking, and beliefs that one deserves punishment for their wrongs (Valentine, 1995).

Proponents of TIR assert that clients are given an opportunity to correct cognitive distortions by retelling their story (Valentine, 1995). TIR has traumatized individuals suffering from symptoms of PTSD relive the event in a safe, controlled environment, reexamine the conclusions that were drawn from the experience(s), and arrive at a alternate comprehension of the event (Valentine, 1995).

For some, the experience of a traumatic event can lead to a repression of a part of the event or the event in its entirety (Gerbode, 2006; Odio, 2003). Such repression can result in the traumatic event never fully having the opportunity to resolve itself. This can lead the survivor to form an inaccurate decision and/or perception at the time of the traumatic incident, resulting in feelings of shame, guilt, and fear (Gerbode, 1989; Bisbey & Bisbey, 1998; Descilo, 2002; Odio, 2003). Theoretically, this concept is similar to what is referred to as an “irrational belief” in CBT (Gerbode, 1989 & Odio, 2003). The processing decision made under the duress of a traumatic event creates a hole in the time construct, where resolution becomes an incomplete activity (Gerbode, 1989). The trauma survivor may not be aware of how this incomplete activity can compound the effects of the event leading to a trauma response (Gerbode, 1989; Odio, 2003).

Valentine (1995) presented bolsters the TIR perspective, defining trauma as:
A wound, shock to the system that takes place in the wake of an unexpected event. It is experienced “forcefully” and impairs the defense mechanisms. Old constructs are shattered and one begins operating from hastily made constructs that were formed during or immediately after the traumatic incident (p. 73).

Cognitive disorders that follow in the wake of the trauma can consume and impede the survivor’s life (Valentine, 1995). TIR asserts that clients with an opportunity to correct the hastily constructed cognitive distortions are capable of continuing on a path of healthy recovery (Odio, 2003). In order to gain mastery over traumas, clients then retell their story, relive the event in a safe, controlled environment (Odio, 2003). Such procedures allow survivors to reexamine the constructs that were drawn from the traumatic event, and cultivate more accurate and adaptive conclusions (Valentine, 1995).

Descilo (2000) describes TIR as akin to watching a movie. The clinician directs the client repeatedly to review the traumatic or stress inducing event, often endorsing a behind the scenes role in order to promote autonomy within the survivor (Descilo, 2002). The client is asked to view the event in his/her mind, silently observing (Gerbode, 2006). The client is then instructed to report discuss the event, view it silently again, and so on until s/he reaches an end point (Gerbode, 2006). Similar to watching a movie multiple times, the act of repetition assists in the emergence of different aspects of the traumatic event to emerge (Odio, 2003).

Clinical Traumatology Rules

The methodological components and techniques of TIR requires adherence to basic assumptions and guidelines. Following Gerbode (1989) TIR proponents refer to the
counselor or therapist as a facilitator in the process of assisting a client to resolve his or her traumas. TIR is longer in length than a typical therapy session, meaning that the session can last upwards of two to four hours, until a therapeutic “end point” is reached (Gerbode, 2006, p. 157). Thus, the facilitator must ensure that the client is comfortable in the physical setting and is afforded all appropriate amenities (Gerbode, 1989). The facilitator is not to, “under any circumstances, make any assertions, suggestions, or evaluations of any kind to the viewer about oneself, the viewer, or anything the viewer has said or done” (Gerbode, 2006, p. 164). This is to ensure the client is fully able to immerse oneself and concentrate on the traumatic material surfacing (Gerbode, 1989 & Odio 2003). The facilitator is trained to act in a predictable manner, in order to not surprise or distract the client, using refined communication skills (Gerbode, 1989; Gerbode, 2006; Odio, 2003). Treatment is only efficacious when the participant is committed to resolving the trauma and has resolved to complete the work on one’s own accord.

**TIR Assumptions**

TIR operates under the assumption that everyone has the innate ability to heal themselves against traumas and negative life events given the proper supports and coping capacities (Gerbode, 1989; Odio, 2003). In order to process a traumatic event and begin the healing process, the environment where the session is taking place must promote a sense of safety (Descilo, 2002; Odio, 2003). Traumatic events can be triggers and embody generalizability to other situations when all or some portion of the traumatic event is reactivated (Odio, 2003). Such reactivation typically occurs through sensory cues, and one may not be aware of what is triggering the symptoms, which can lead to a
heightened state of arousal. Further, one may not be aware the trauma is being re-experienced nor the lasting effects of this trauma response (Descilo, 2002). The survivor would most likely endorse justifications of behaviors and rationalizations tend to take place in the present that prohibit healing and promote cognitive distortions (Descilo, 2002).

Another assumption of TIR is the effectiveness of repetition, utilized to achieve a deeper level of trauma resolution (Bisbey & Bisbey, 1989; Descilo, 2002; Odio, 2003). Repetition of an emotionally uncomfortable event serves as a trigger to the event itself or material connected to the trauma, which is stored in state dependent learning (Descilo, 2002). State dependent learning is when a person has to be in a similar state to the time one has learned or experienced something in order to remember it (Odio, 2003).

Emotions play a vital role in the process and outcome of trauma resolution (Bisbey & Bisbey, 1998, Descilo, 2002; Gerbode, 1989; Odio, 2003). To cultivate trauma resolution utilizing TIR, the facilitator must have a firm and accurate read on how the participants’ emotions manifest (Gerbode, 1989). More specifically, a skilled facilitator should identify where each emotion stands in conjunction to others and accurately assess the emotional state of the participant during the sessions (Gerbode, 1989). The assumption is that a participant will explore his or her feelings by describing what they felt during their traumatic event by reliving it in the present (Gerbode, 1989 & Odio, 2003). The facilitator must be adept in aiding the participant to manage his or her painful and distressing emotions, all the while grounding the participant to retain a sense of safety while immersing oneself into past traumas (Descilo, 2002; Gerbode, 1989, & Odio, 2003). At this juncture, the participant can begin simultaneously to experience
feelings in all their intensity, while maintaining a sense of safety to all the connections that were damaged at the time of the traumatic event (Odio, 2003).

Lastly, TIR assumes the traumatic events need to be addressed from different “causal directions” (Descilo, 2002). A causal direction or “causal flow” is “defined as the direction of an activity as observed by an individual” (Descilo, 2002). There are four basic types of causal directions.

1. Something that was caused by an outside source, which one experiences personally.
2. Events that a person causes towards another to experience.
3. Observation of another or others to cause to other person.
4. Events that one directly causes the self to experience (Descilo, 2002, p. 163).

Gerbode (1989) describes causal directors or flows simply: the causation of the incidents or flow occurs from the perspective of the survivor, perpetrator, witness, the “reflexive” viewer.

Benefits of TIR

The advantages stated by Valentine (1995) of TIR are related to its efficacy in distressing symptom reduction. It is purported that the successes are from image flooding in a humane and respectful manner (Valentine, 1995). It is postulated that since the flooding occurs in one session, not over the course of many, that the client is in control of the interpretation of the trauma (Valentine, 1995). Additionally, post-TIR evaluation sessions indicate that the clients preferred the non-interpretation approach of the facilitator, because it gave room for one’s own narrative and resolution of the trauma (Valentine, 1995). Another strength of the intervention that is related to the creation of
one’s narrative is that TIR may add to self-efficacy (Bandura, 1982; Bandura, 1986) since the clients are cognizant that their symptom reduction is due to their own efforts. Lastly, TIR is relatively straightforward and easy to learn for both the therapist and the client (Valentine, 1995).

*Clients for TIR*

TIR has been stated to be most effective for individuals who are motivated to resolve their disconcerting emotions and memories stemming from traumatic events (Valentine, 1995). A good candidate for TIR treatment is one who is suffering from PTSD symptoms including anxiety, flashbacks, phobias, nightmares, intrusive thoughts, depression, and avoidant behaviors (Valentine, 1995). TIR is primarily designed for individuals, not families or couples (Valentine, 1995). Moreover, proponents of, indicate that this approach is most effective after trauma survivors have gone through the crisis period and have achieved certain level of emotional security in their lives. PTSD symptoms are typically the most intense during the first three months following the traumatic event (Rothbaum, Foa, Riggs, Murdock, & Walsh, 1992; Valentine, 1995). Since TIR is designed to elicit strong emotions, it is important that people be in a secure emotional state and be less symptomatic of initial PTSD symptoms (Valentine, 1995). Thus, TIR is not recommended for individuals who are currently experiencing highly stressful events (Valentine, 1995). Persons who are potential candidates should be screened for sleeping, eating, and substance abuse issues prior to treatment and excluded if determined to not meet the minimum participation requirements (Valentine, 1995).
**TIR vs. Emotional Flooding**

Of all clinical interventions TIR is most similar to emotional flooding (Whitaker, 1977), in that the client is asked to remember an event numerous times. According to Valentine (1995) TIR is distinguished from flooding in the following ways:

1) The client picks the memory with no assistance from the therapist other than having been instructed to choose a time-limited, emotionally charged event.

2) TIR should be completed in one session, lasting two to four hours, rather than one hour or eight weeks in a row.

3) Sessions should not be terminated until the therapist sees signals that the event has lost its emotional charges and the client is experiencing a lighter, calmer sensation.

4) The therapist offers no interpretation regarding the event (p. 74).

“TIR is also distinctive in that it is both client-centered and therapist-directed, balancing Whitaker’s (1977) battle for initiative and battle for structure” (Valentine, 1995, p. 75). TIR clearly delineates client and therapist roles: the client takes responsibility for the work related to psychological change and the therapist’s role is centered on providing the structure and format of the session (Valentine, 1995). Again, this approach seeks to foster autonomy of the client’s efforts and psychological gains.

**The Intervention**

Valentine (1995) highlights the various steps needed to implement TIR. Preparation for the client is important, as there is no presumed uniform trauma experience
or internalization processes. Initial exploration begins within the TIR framework, where
the therapist explains the theorized purpose of viewing the trauma in a repetitive fashion
as well as informing the client that a heightened emotional state is likely to occur as a
requisite for successful treatment. “Additionally, clients might be told that they will be
‘viewing’ the incident much as they were in an afternoon matinee watching a movie of
themselves” (Valentine, 1995, p. 75). The therapist explains that his or her word choices
will be rather scripted and repetitive in nature, which is a departure from traditional
psychotherapy, where affirmation, interpretation, and reflection are central techniques.
Prior to delving into the trauma, the client practices the TIR technique with a pleasant or
non-emotionally charged incident, with aims at familiarizing the client with the TIR
structure (Valentine, 1995).

Once the client is prepared for the session, the therapist begins by asking the
client, “When was it (referring to the traumatic event)?” There are many acceptable
answers, all of which include, but are not limited to: year, date, season, time of day, the
client's age. The therapist then asks “How long did it last?” After an answer is provided,
the therapist asks the client to “freeze” the event in their mind. This is followed up by the
question “What are you aware of?” Next, the clients are asked to describe the sensation
or a setting of which they were aware of at the beginning of the incident. Further details
of the event are withheld at this point and the client is asked to “move silently through the
incident.” Once the client indicates they have finished moving silently through the
trauma, the therapist asks, “What happened?” After the client is finished retelling the
event, the therapist then instructs the client to move once more through the story, from
the beginning.
The process is repeated and the therapist is able to check with the client to see how the incident is going for them at that moment. The therapist must be cognizant of the client’s answers, affect, and body language to determine when the viewing can be terminated. The session ends without discussing the event further, probing, or reframing the event. This is essential in TIR, because it allows clients to decide on the reality or perception of the event with which they can best be comforted. Additionally, the client may be advised that further discussion with bystanders may be contraindicated and by no means are they allowed to let an outside party alter their therapeutic work or gains.

*End Points in TIR*

Gerbode (1989) defines the end point in TIR as when the activity of trauma resolution has been successfully completed (Odio, 2003). End points are manifested by a set of phenomena that indicate the successful termination of the activity and the resolution of PTSD symptomology (Gerbode, 1989; Odio, 2003).

*Prior Research on TIR*

Research on treatment efficacy on TIR is on its early stages of development but it is expanding. “Since TIR’s inception, research and knowledge have moved from an anecdotal base to experimental outcome studies regarding efficacy” (Valentine, 2002, p. 258). The first published article on the method used a case study and presented an overview of the treatment (Bisbey 1995). Bisbey (1995) designed a true experimental study based on survivors of crime in England. Additionally, Valentine & Smith (2001) engaged in a multiyear ethnographic study that examined the experience of TIR as perceived through the eyes and minds of treatment seekers. Lastly, a dissertation using a
quasi-experimental design to examine the efficacy of TIR was published (Coughlin, 1995).

TIR has been shown to be effective in two controlled outcome studies (Bisbey, 1995; Valentine, 1997). Valentine (1997) found TIR to be significantly more effective than no treatment when measuring treatment seekers’ scores on the Posttraumatic Symptom Scale (PSS), The Beck Depression Inventory (BDI), the Clinical Anxiety Scale (CAS), and the Generalized Expectancy Success Scale (GESS) (Gerbode, 2006). In the second study, (Bisbey, 1995), TIR was found significantly better than both controls and also Direct Exposure for the same period of treatment time (averaging at 16.5 hours), as measured by the Penn Inventory, Impact of Event Scale, Crime-Related PTSD Scale, and the Individual Trauma Checklist. Qualitative studies on TIR propose that TIR is effective (Carbonell & Figley, 1996; Coughlin, 1995; Valentine, 2000; Valentine & Smith, 2001). The aforementioned studies examined treatment efficacy of TIR and each have demonstrated positive treatment outcomes.

Two empirical studies have found TIR to be quite effective in the resolution of trauma in adult populations. Bisbey (1995) discovered when comparing randomly assigned survivors of a crime to either direct therapeutic exposure (DTE), TIR, or a waiting list control group, both treatment groups improved markedly more on all PTSD-related measure as compared to the control group. Additionally, the TIR group improved significantly more than the DTE group on all PTSD-related measures (Bisbey, 1995). Both DTE and TIR treatment groups significantly improved on the depression, obsessive-compulsive and psychoticism subscales while the control group did not (Bisbey, 1995). The TIR group improved significantly more on the obsessive-compulsive subscale than
the DTE group (Bisbey, 1995). The TIR group improved measurably on the paranoid ideation subscale while the DTE and control groups did not (Bisbey, 1995). The outcome of this study supports the notion that treatment involving repeated exposure to the traumatic event in a supportive, non-challenging environment will reduce the symptomology of PTSD (Bisbey, 1995).

Valentine (2000) found that TIR was effective in reducing symptoms of depression, anxiety, and PTSD in an experimental outcome study of a randomly assigned sample of 123 female inmates. TIR also demonstrated therapeutic effectiveness of increasing levels of self-efficacy, through measurement of expectancy of success, or how successful one believes s/he will be in treatment for (Valentine, 2000; Valentine & Smith, 2001). Repeated-measures MANOVA showed significant differences between the treatment and the comparison control conditions on all measures at post test and follow-up time intervals except for the PTSD Intrusion subscale at the posttest interval (Valentine, 2000; Valentine & Smith, 2001). Thus the efficacy of TIR in alleviating PTSD, depression, anxiety, and low expectancy of success received statistical support from this study at both posttest and follow-up measurement periods, with the exception of the PTSD Intrusion subscale at the posttest interval, though differences were found at the follow-up testing interval (Valentine, 2000; Valentine & Smith, 2001). Additionally, reports indicated that the control group’s scores remained stable across all three testing periods, while the treatment condition’s scores decreased steadily indicating symptom alleviation (Valentine, 2000; Valentine & Smith, 2001). The results on all measures at the follow-up time interval added persuasive evidence of the stability of the TIR intervention (Valentine, 2000; Valentine & Smith, 2001).
More recently, the use of TIR with children and adolescents has been the subject of research. Two open clinical trials of TIR, one with urban at-risk youth and one with unaccompanied refugee minors (URM) were recently conducted. In the urban at-risk youth study, 33 completed the TIR course of treatment (Descillo, Greenwald, Schmitt, Reslan, 2010). For PTSD and Depression there was a reduction from pretreatment scores to post-treatment scores, indicating treatment efficacy (Descillo, Greenwald, Schmitt, Reslan, 2010). Moreover, there was a significant increase in the pretreatment self-concept scores to post-treatment scores (Descillo, Greenwald, Schmitt, Reslan, 2010). Unaccompanied minors also experienced efficacious treatment results for TIR. More specifically, there were noteworthy score reductions in PTSD and depression, from pretest scores to post-test scores (Descillo, Greenwald, Schmitt, Reslan, 2010). No differences were found in the analyses for PTSD based on gender, age, or total number of sessions in either pre or posttest scores (Descillo, Greenwald, Schmitt, Reslan, 2010). In the depression measure, females had a greater reduction in scores than their male counterparts, however, the difference subsided and were no longer significantly different at posttest measures (Descillo, Greenwald, Schmitt, Reslan, 2010). Additionally, there were no interaction effects for age and total number of sessions in the depression measure. For the happiness measure, female scores were higher when comparing pre and posttest scores, in contrast to no significant differences for males (Descillo, Greenwald, Schmitt, Reslan, 2010). Female pretest scores were higher than male pretest scores; however, at post-treatment measures, the differences were not significantly different (Descillo, Greenwald, Schmitt, Reslan, 2010). The low dropout rates in the URM study indicated that the participants tolerated TIR well (Descilo, Greenwald, Schmitt, Reslan,
The progression in both studies from pretreatment pathological to post-treatment normative levels of PTSD symptoms were remarkable given the fairly small number of sessions undergone to address histories of multiple traumas and loss events (Descilo, Greenwald, Schmitt, Reslan, 2010).

*Rationale for Examining TIR with Participants in Miami*

This literature review has delved into the conceptual and empirical foundations of TIR. To summarize, TIR is a structured, brief, person-centered therapy with underpinnings from metapsychology. TIR has shown treatment efficacy with various populations, including female inmates, unaccompanied refugee minors, urban youth, and survivors of crime in England.

This proposal seeks to expand the scope of research to a new population: Latina and African American survivors of intimate partner violence residing in Miami-Dade County. Proposed participants in this study have been exposed to a vast array of stressors, but the most prominent of them is IPV followed by sexual abuse. Extensive research has shown that exposure to trauma makes individuals highly susceptible and vulnerable to further stressors and psychological distress. Treatment for IPV survivors can reach exorbitant amounts, TIR offers a less costly alternative that claims to alleviate psychological distress.

*Research Questions*

This study is guided by the following questions:

1a) Do Latina and African American intimate partner violence survivors report significant symptom reductions for PTSD, Depression, Anxiety, and significant increases in Self-Concept following TIR treatment?
1b) Are the PTSD, Depression, and Anxiety post test scores positively related to each other and does Self-Concept have a negative relationship with the variables?

1c) Out of PTSD, Depression, Anxiety and Self-Concept, which variable experiences the greatest amount of change from pre to post test evaluation, indicating symptom reduction?

2a) What variables are related to the changes in the PTSD, Self-Concept, Depression and Anxiety?

2b) Is race related to change in the outcome variables?

2c) Is the number of traumatic events related to change in the outcome variables?

2d) Is the number of hours in TIR treatment related to change in the outcome variables?

2e) Is TIR only treatment versus TIR and auxiliary services related to change in the outcome variables?

3a) Are there significant differences between those participants who remained in TIR treatment versus those who terminated services prematurely?

3b) Is age of the participant a factor in whether the participant remained in treatment or terminated early?

3c) Is geographic location of the participant a factor in whether the participant remained in treatment or terminated early?

3d) Is ethnic identity of the participant a factor in whether the participant remained in treatment or terminated early?
3e) Are the pretest results on the measures used to determine PTSD, Self-Concept, Anxiety, and Depression a factor in whether the participant remained in treatment or terminated early?

**Hypotheses**

Hypothesis #1a: It is hypothesized that those who participated in TIR experienced a symptom reduction as well as an increase in self-concept. More specifically, a positive change in self-concept is predicted (indicating an increase in self-concept) and negative change (indicating a decrease in symptoms) is predicted for symptoms of PTSD, Depression, and Anxiety.

Hypothesis #1b: It is also hypothesized that the PTSD, Depression, and Anxiety post test scores will all be positively related to each other and Self-Concept will have a negative relationship with the variables.

Hypothesis #1c: PTSD is hypothesized to have the largest pre to post test change, since the intervention is aimed at trauma reduction.

Hypothesis #2b: It is hypothesized that race, either Latina or African American will have a positive relationship in treatment success and that no differences will exist between the women.

Hypothesis #2c: It is hypothesized that the more traumatic events experienced (number of crimes committed against the participant), the more symptomatic person will be and less self-concept she will have.

Hypothesis #2d: A positive relationship between number of hours in treatment and treatment success is hypothesized.
Hypothesis #2e: It is hypothesized that those individuals who received additional services will exhibit more change on the outcome variables than those who have only received TIR.

Hypothesis #3a: It is hypothesized that a significant difference exists between those who remained in TIR treatment versus those who terminated services prematurely.

Hypothesis #3b) Age not is hypothesized to a significant difference that exists between the participants.

Hypothesis #3c) Those participants whose geographic location (zip code) are farthest from the treatment center are hypothesized to have terminated services at a higher rate than those located closer to TRC.

Hypothesis #3d) Ethnic identity is hypothesized to be a factor in whether a person terminated treatment prematurely.

Hypothesis #3e) Lastly, pretreatment scores for PTSD, Self-Concept, Anxiety, and Depression are hypothesized to have negative impact on those who terminated prematurely.
Chapter III: Research Design

Design

This study sought to gain knowledge about the efficacy of TIR with clients who participated in treatment at the Trauma Resolution Center in Miami, FL. These clients who have experienced traumatic events were asked to complete various measures of PTSD, anxiety, depression and self-concept before and after participating in treatment. Demographic data, pretreatment and post treatment scores, and other relevant variables were used to test the following hypotheses regarding whether TIR could be attributed to symptom reduction for PTSD, anxiety, and depression and an increase in self-concept. PTSD is hypothesized to have the largest pre to post test change, since the intervention is aimed at trauma reduction. It is hypothesized that race, either Latina or African American will have a positive relationship in treatment success and that no differences will exist. It is hypothesized that the more traumatic events experienced (personal experience with trauma, the number, and the number of events witnessed), the more symptomatic the person will be and less self-concept she will have. Additionally, a positive relationship between number of hours in treatment and treatment success is hypothesized. Some individuals received other treatments in addition to TIR. Those persons who participated in group and auxiliary services will be compared to those who just received primarily TIR. It is hypothesized that those individuals who received additional services will exhibit better psychological wellness as opposed to those who have only received TIR.

Lastly, it is hypothesized that a significant difference exists between those who remained in TIR treatment versus those who terminated services prematurely. Age is not
hypothesized to be a significant difference that exists between the participants. Those participants whose geographic location (zip code) are farthest from the treatment center are hypothesized to have terminated services at a higher rate than those located closer to TRC. Ethnic identity is hypothesized to be a factor in whether a person terminated treatment prematurely. Pretreatment scores for PTSD, self-concept, anxiety, and depression are hypothesized to have negative impact on those who terminated prematurely.

Variables

In this study, the primary proposed variables of interest are: PTSD Symptoms, anxiety symptoms, depression symptoms, and self-concept. The intake questionnaire (Appendix A) was used by TRC staff to gather the following information regarding the client. Other variables of interest were derived from the intake questionnaire.

PTSD Symptoms will be measured by the Posttraumatic Stress Disorder Checklist – Civilian (PCL-C) (Weathers, Litz, Herman, Huska, & Keane, 1993). The PCL-C is an easily administered self-report 5-point rating scale that assesses how much the person has been bothered by each of the seventeen items on the checklist, which are related to the DSM-IV-TR symptoms for PTSD (Weathers, Litz, Herman, Huska, & Keane, 1993).

Anxiety Symptoms were measured by the Clinical Anxiety Scale (CAS). The CAS is a 25-item category partition scale that was designed to measure the amount of anxiety reported by a respondent (Westhuis & Thyer, 1989).

Depression Symptoms will be measured by the Center for Epidemiological Studies Depression Scale (CES-D). The CES-D is a 20 item, self-report depression scale
that covers the major components of depression, measuring the frequency of symptoms during the past week (Radolff, 1977).

*Self-concept* will be measured by the Generalized Expectancy for Success Scale (GESS). GESS is a 30-items that measure individual’s perceptions of whether they can attain their personal goals (Fibel & Hale, 1979; Valentine & Smith, 2001).

The following variables were derived from the intake questionnaire. Race was a dichotomous variable with either Latina or African American women. *Total Number of Crimes as a Victim* will be determined by the reported number of crimes the participant noted. *Total Hours in TIR* was reported by the primary therapist who conducted TIR with the patient. *Auxiliary Services* are comprised of the following: chiropractic, massage, holistic, and breath work as noted by the respective service providers. *Age* of the participant. *Country of Origin* the participant listed. *Geographic Location from Treatment Center* was determined by the participants’ zip codes and a mileage analysis using an on-line mapping service.

*Research Setting*

Data collection and service provision took place at the Trauma Resolution Center (TRC). Since 1995, The Trauma Resolution Center (formerly known as Victim Services) has helped people of all nationalities and ages suffering from diverse trauma recover from their experiences and lead lives without traumatic stress, depression, and anxiety. Additionally, TRC has helped at-risk youth recover from trauma and find inner strengths. The Department of Children and Families gave TRC licensure as Substance Abuse Prevention, acknowledging the work completed in conjunction with Drug Dependency
Court and local substance abuse programs. TRC is also licensed as a Community Mental Health Center.

Participants

This study includes data from 106 women who received services at the Trauma Resolution Center in the 2008-2009 fiscal year. There were 85 Latinas, 21 African Americans, and the remaining 12 that were excluded from this study were Anglo, Asian, or Native American women. There were 58 English and 48 Spanish speaking adults who received services during the 2008-2009 fiscal year. TRC primarily serves individuals who are seeking resolution from traumatic experiences. The population in this study is demographically similar to that of Miami-Dade county, primarily Latino at approximately 61%, 20% African American, and 12% White.

Instruments

*Intake Assessment Questionnaire* was comprised of measures included in this study, and was known as the TRC Intake Assessment Questionnaire (Appendix A). This was an extensive questionnaire designed to determine the most appropriate set of services for the client. The questionnaire included the PCL-C, GESS, CAS, CES-D, and the Short Depression-Happiness Scale (Joseph, Linley, Harwood, Lewis, & McCollam, 2004) measures. This study relied on data from four of the five measures, including the PCL-C, GESS, CAS, CES-D. In addition, the following variables were also used: status of treatment, hours in TIR, hours in auxiliary services (massage, chiropractic, EMDR, breath-work meditation, holistic, were all grouped together due to the few number of clients who used such services), age, gender, race, country of origin, preferred language, zip code, and number of crimes committed against client.
Posttraumatic Stress Disorder Checklist – Civilian (PCL-C) (Appendix B English Version; Appendix C Spanish Version) was developed by Weathers et al. (1993) and was used to determine the severity of PTSD symptoms experienced by the participant. The reported test-retest reliability was excellent over a 2-3 day period (Weathers et al., 1993). Internal consistency was very high for each of the three subgroups of items corresponding to the DSM-IV-TR symptom clusters as well as for the full 17-item scale (Weathers et al., 1993). The PCL correlated with other measures of PTSD, such as the Mississippi Scale (MS-C), the PK scale of the MMPI-2, the Center for Epidemiological Studies – Depressed Mood Scale (CES-D), and the Impact of Event Scale (IES) (Weathers et al., 1993). Used as a continuous measure, the PCL had good diagnostic utility (Weathers et al., 1993). More specifically, subscales were found to be highly interrelated, with correlation coefficients of .73 between scores on the hyper arousal and avoidance subscales, .76 between scores on the re-experiencing and avoidance subscales, and .75 between scores on the hyper arousal and re-experiencing subscales (Ruggiero, Ben, Scotti, & Rabalais, 2003). Cronbach’s alpha coefficients (.94, .85, .85, and .87 for the PCL-C total, re-experiencing, avoidance, and hyper arousal scores, respectively) were indicative of high internal consistency (Ruggiero, et al., 2003). Convergent validity was found in the high correlations (i.e., $r > .75$) between PCL total scores and scores obtained on two well-established PTSD measures: the IES and MS-C (Ruggiero, et al., 2003). The test-retest correlation coefficients for total scores on the PCL-C were .92 ($p > .001$) for participants with 2-week retest intervals. The PCL-C was administered in both English and Spanish. The Spanish version of the PCL-C was found to not have any significant differential item functioning (DIF) and the measure was determined to not be subject to
biases within the questions (Miles, Marshall, & Schell, 2008). Additionally, the PCL-C Spanish and English versions were found to have functional equivalence, indicating successful translation and when using the scale to measure symptom severity, there would appear to be little to no need to correct for the DIR (Miles, Marshall, & Schell, 2008). Example questions on the assessment tool included: repeated, disturbing memories thoughts or images of a stressful experience from the past; feeling very upset when something reminded you of a stressful experience from the past; having physical reactions; avoiding activities or situations because they remind person of past stressful experience; and feeling irritable or having angry outbursts (Weathers et al., 1993).

The Clinical Anxiety Scale (CAS) (Appendix D English Version; Appendix E Spanish Version) is a 25-item assessment that was psychometrically derived from a larger pool of questions largely based upon the diagnostic criteria for the anxiety disorders found in the DSM-IV-TR (Westhuis & Thyer, 1989). A high score indicates that the respondent is experiencing high levels of anxiety, and a low score indicates lower levels of respondent-experienced anxiety (Westhuis & Thyer, 1989). Eight of the scale’s items are positively worded and seventeen are negatively worded statements (Westhuis & Thyer, 1989). The varied wording pattern reduces the effects of response-set biases (Westhuis & Thyer, 1989). Scores for the CAS can range from 0 to 100 (Westhuis & Thyer, 1989). When scoring the scale, one must first reverse-score all the positively worded items changing item scores of 1 to 5, 4 to 2, 5 to 1, and a score of 3 is not changed (Westhuis & Thyer, 1989). The reverse score numbers are 1, 6, 7, 9, 13, 15, and 16 and will need to be summed with the remaining scores, subtracting the number of
completed items from, multiplying by 100 and dividing the number by four (Hudson, 1992).

The coefficient alpha for the CAS, as computed from three sample groups (personnel and civilian employees of the U.S. Army, sample group of university students, and a clinical sample drawn from an anxiety disorder support group) was .94 indicating reliability (Westhuis & Thyer, 1989). The Standard Error of Measurement (SEM) was 4.2, which was relatively low, suggesting a minimal amount of measurement error (Westhuis & Thyer, 1989). The discriminant validity coefficient is .77 and was more effective at discriminating between criterion groups than any of the other measures examined, including: Index of Family Relations (IFR), Generalized Contentment Scale (GCS), Psycho-Social Screening Package (PSSP), Rational Behavior Inventory (RBI), Mobility Inventory for Agoraphobia (MIA), and Michigan Alcoholism Screening Test (MAST) (Westhuis & Thyer, 1989). The CAS also endorsed good stability, with two-week test-retest correlations that ranged from .64 - .74 (Hudson, 1992). Additionally, the CAS has good known-group validity, where it can discriminate significantly between groups known to be suffering from anxiety and lower anxiety control groups (Westhuis & Thyer, 1989). Using the clinical cut off score of 30, the CAS has a very low error rate of 6.9% in distinguishing between anxiety and control groups (Westhuis & Thyer, 1989). The Spanish Version of the CAS was shown to have appropriate convergent ($r \geq 0.70$) and discriminant validity ($p < 0.001$), internal consistency (Chronbach's $\alpha > 0.75$), test-retest reliability (intraclass correlation coefficient $> 1.5$; Bulbena, Bobes, Luque, Dal-Ré, Ballesteros, & Ibarra, 2003). The Spanish Version of the CAS shows appropriate validity
and reliability and can be utilized to assess the severity of anxiety symptoms (Westhuis & Thyer, 1989).

The Center for Epidemiologic Studies Depression (CES-D) Scale (Appendix F English Version; Appendix G Spanish Version) was developed by Raldoff (1977) as a short scale designed to measure depressive symptomology in a general population. The items that make up the scale are symptoms associated with depression, which were in previously validated longer scales (pg. 385). The CES-D continues to remain amongst the most commonly used measures to assess symptoms of depression (O’Rourke, 2004). The CES-D (Raldoff, 1977) is a 20 item measure to which the respondents rate the frequency of the various depressive symptoms over the previous week (O’Rourke, 2004). Responses are recorded along a 4-point, Likert-type scale ranging from rarely or none of the time (0) to most or all of the time (3) (O’Rourke, 2004, Raldoff, 1977). Scale scores greater than 15 out of 60 on the CES-D Scale are suggestive of clinically significant depressive symptomology (O’Rourke, 2004; Raldoff & Teri, 1986). It was concluded that the CES-D Scale is not negated by age, physical disease, or cognitive or physical impairment (Lewinsohn, Seeley, Roberts, & Allen, 1997; O’Rourke, 2004). Nor do responses appear to vary as a function of the respondents’ gender, meaning gender is invariant (O’Rourke, 2004).

The test-retest reliability of the CES-D was only reported in 11 of 155 studies (O’Rourke, 2004). The mean correlation coefficient was $r = .70$ ($SD = .17$) over an average interval of 24 months ($SD = 24.31$ months; O’Rourke, 2004). Considerable variability was observed, however, ($r = .43$ to .92); what was largely as a function of the time over which the CES-D was administered, which was 1 to 59 months (O’Rourke,
2004). This extensive range of coefficients should not necessarily be considered a measurement limitation because depressive symptomology is generally not an enduring phenomenon (Meeks, Murrell, & Mehl, 2000) because most episodes of clinical depression are believed to remit in six months (American Psychiatric Association, 1994; O’Rourke, 2004). The average estimates of internal consistency as measured by Chronbach’s 𝛼 was .88 (SD = .05, median = .89; O’Rourke, 2004). This average suggests strong internal consistency across studies (i.e., .90 ≥ 𝛼 ≥ .80; Clark and Watson, 1995; DeVillis, 1991; O’Rourke, 2004). Since the majority of the participants in this study are Spanish speaking, the utility of the Spanish Version of the CES-D is essential. Reuland et al. (2009) found that the Spanish Version of the CES-D had sensitivities ranging from 76% to 92% and specificities ranging from 70% to 74%, indicating fair evidence supporting the diagnostic accuracy of the CES-D in general primary care. The English and Spanish Versions of the CES-D were found to have functional equivalence, including accurate translation.

*Generalized Expectancy for Success Scale (GESS)* (Appendix H English Version; Appendix I Spanish Version) is a 30-question measure in Likert format where the subject responds from 1 (highly improbable) to 5 (highly probable) that “In the future I will …” (Fibel & Hale, 1978; Mearns, 1989). Seventeen items are phrased in the positive or success direction and thirteen in the negative or failure direction (Fibel & Hale, 1978). Items are randomly ordered and the scale is scored additively, in the direction of success, such that a high total scale score indicates a high expectancy for success (Fibel & Hale, 1978). Each item is a different completion of the proposition and represents the belief in some future success or failure (Mearns, 1989). Factor analysis suggests that the
instrument measures three aspects of generalized expectancy: General efficacy (GE), long-range career orientation expectancy (LRCOE), personal problem solving (PLPS), and a fourth factor that does not have a consistent theme (Fibel & Hale, 1978).

Test-retest reliability for the GESS during a six week period was .83 for both genders (Fibel & Hale, 1978). Internal consistency for using coefficient alpha was .90 for females and .91 for males. The GESS has been used in approximately 34 studies since inception with excellent reliability and consistency. A valid version of the GESS could not be located via on-line searches.

Procedures

Participation in the proposed study was on a voluntary basis. All eligible participants were those who completed at least one session of TIR. The TRC therapist explained the purpose and procedures of TIR and allowed ample time to gain comfort with the treatment and practice using a pleasant memory.

Persons are excluded from participating in TIR if they were currently abusing drugs or alcohol; taking certain psychotropic medications which prevent access to memories; psychotic; lack ego strength; are a mandated client, whether the mandate is from the court or a parent (unless a client agrees to the treatment, it is not likely to be effective); or are too young to understand the process or to focus long enough for a resolution to occur. Clients are referred from all over the county by many different sources. Former clients referred about one-third of the current treatment seekers for trauma work. Facilitators of TIR have a scripted method of approach for engaging participants in treatment, which is part of the TIR training and was also covered in the TRC mandatory groups. All clients attended the Psychobiology of Trauma, which
included learning what to expect from treatment. If a client requires more than 20 hours of individual treatment, it must be approved by Ms. Descilo. For those clients who have disengaged in treatment, their clinicians contact them.

Clients were asked to fill out pre, mid, and post treatment evaluations that consisted of the PCL-C, CES-D, CAS, and GESS as part of their treatment. The participant filled out the assessment, if she was able to read and respond accordingly. However, if there were questions or literacy barriers, the therapist would then read the questionnaires to the participant and record the answers. The questionnaires consisted of six content areas: an intake questionnaire sheet, research consent, a severity of PTSD symptoms, a depression measure, an anxiety measure, a general expectancy of success measure. Confidentiality and anonymity was maintained throughout several measures that included: no names to be recorded; instead, identification numbers will be assigned and recorded on all instruments and demographic data. Informed consent was already obtained from TRC, who was the originator of this research project.

Additionally, the General Informed Consent and Agreement (Appendix A) drafted and utilized by TRC was obtained from each of the research participants. The contract detailed research potentialities, the associated benefits and risks, confidentiality, agreement to treatment, and financial responsibilities. Therapists fully explained the informed consent, both orally and with a written copy. Participants had full knowledge of the potential risks and benefits associated with participation in the treatment and any subsequent research. All data and materials collected were stored in a locked file cabinet and all associated data stored electronically will be password protected.
Data Analytic Strategy

The data analysis in this study was conducted in five steps, using SPSS v17 (SPSS, 2008). The first analysis conducted obtained the descriptive analyses of the mean, standard deviation, range, and variance were obtained for each of the variables of interest.

The second step utilized paired $t$-tests. Paired $t$-tests were chosen because the pretreatment participant can be linked with the same post treatment participant. As the scores were dependent, leading to the requirement of the paired observation for the $t$-test. Since $n_1 = n_2 = n$ for the $t$-test for paired observations, the test was robust with respect to the assumptions of homogeneity of variance (Glass & Hopkins, 1996). Therefore, the paired $t$-test is usually more powerful than independent groups’ $t$-tests (Glass & Hopkins, 1996). Additionally, the degree of correlation between the paired observations needed to be taken into account in the analysis (Glass & Hopkins, 1996). This type of research design was generally more powerful than a simple random assignment of persons to method without equating pairs of pre/post treatment, or stratifying (Glass & Hopkins, 1996). Meaning one is more likely to find a treatment effect if it exists and more importantly, no more likely to make a type I error (Glass & Hopkins, 1996). Normality and equal variance assumptions will be assessed through skew and kurtosis in histograms and Levene’s test, respectively.

The third analysis strategy used was multiple regression to determine if the following variables were related to the change in pretreatment versus post treatment scores: race, number of traumatic events, number of hours in TIR treatment, TIR only treatment vs. TIR and auxiliary services, and lastly pretest results on the measures used to
determine PTSD, Self-Concept, Anxiety, and Depression. In order to compute the multiple regression analyses, the dependent variables were recoded to obtain the difference score computed by (postscore – prescore) for each of the variables. Then, each of the predictors were regressed on the outcomes in four different multiple regressions. Each standard multiple regression addressed the relationship between the predictor variables (Race, Number of Hours in TIR Treatment, Number of Crimes as a Victim, and Auxiliary Services) and the outcome variables (PTSD, Self-Concept, Anxiety, and Depression). Significance was obtained from the Coefficients Table, where change from before treatment to after treatment, controlling for the predicting variables would be indicated. For example, a significant relationship of outcome variables and race would indicate that the change from pre to post was different for Latinos as compared to African Americans.

The fourth analysis conducted was to determine the treatment effect size for the outcome variables. Cohen’s $d$ was computed for each of the variables using the mean pretreatment minus the mean post treatment scores, and then divided by the average of the pre and post treatment standard deviations.

Finally, the fifth analysis conducted was to answer whether there were significant differences between those participants remained in treatment versus those who terminated services prematurely. A dichotomous variable was created to test for those who either completed treatment or terminated prematurely, by analyzing what the outcome of the treatment was, as determined by the therapist. Specifically, I looked at the status of the client’s treatment (completed, improved, withdrawn/dropped out, referred out, or completed and improved) and then created a dichotomous variable where the participant
either finished treatment (variables for completed treatment: completed, improved, or completed and improved) or terminated early (variables for terminated treatment: withdrawn/dropped out and referred out).

Independent samples $t$-tests and chi-square tests were used. To answer if the age of a participant and pretreatment scores for PTSD, Self-Concept, Anxiety, and Depression were factors, an independent sample’s $t$-tests were used to determine if the continuous variable means differ significantly. Next, $t$-tests were conducted to determine if age and PTSD, self-concept, anxiety, and depression pretreatment scores were factors in termination of treatment prematurely. For $t$-tests, the following assumptions will be examined: homogeneity of variance, independent observations, normally distributed observations (Keith, 2006). In order to determine if participants who completed treatment were different from those who did not based on geographic location determined by zip code or ethnic identity, chi-square tests were used for each categorical variable of interest. For chi-square tests, independence of cells and adequate cell size (i.e., at least five people in every cell) was monitored and met (Keith, 2006). Additionally, to ensure independence, each person was only in one of the determined categories (Keith, 2006).
Chapter IV: Results

Summary Statistics and Results

In all, 140 participants began TIR treatment at TRC. Of those 140, 34 (24.3%) were eliminated who did not meet the inclusionary criteria of: female (males, 15 excluded), Latina or African American (White, Asian, Native American, 12 excluded), survivor of IPV (other trauma, 7 excluded). The exclusions had repeats in categories, thus, once a participant was eliminated he/she was not considered in any other category. This was the process for each exclusionary criterion. Of the original 140 participants in TIR, we retained 106 (75.7%) for analysis.

Descriptive Analysis of Sample

The age of the respondents ranged from 19 to 60 years of age, $M = \text{age of 36}$ and $SD = \text{9 years}$. The racial and ethnic compositions of the participants were as follows: Latina (80.2% of the sample) and African Americans (19.8%). There were 58 (54.7%) English speakers versus 48 (45.3%) Spanish speakers. A total of 20 countries of origin were identified, including the US. The majority of respondents originated from the US (15.1%) and Columbia (15.1%), followed by Honduras (11.3%), and Venezuela (10.4%), who both represented a large portion as well. Figure 1 below is a pie chart depicting the countries of origin for the participants of this investigation.
Each of the participants were survivors of IPV. Of the participants, 96 (99.0%) identified as heterosexual and 1 (1.0%) identified as homosexual. Thirty-nine (36.8%) were legally married, 31 (29.2%) were single, 18 (17.0%) were divorced, 6 (5.7%) were separated, 2 (1.9%) stated they were widows, and 10 (9.3%) did not answer the question. Of the 106 female participants, 63 (59.4%) were involved in legal matters related to intimate partner violence, while 33 (31.1%) were not, and 10 (9.4%) did not answer the question. Forty-four (41.5%) were not legally married to the perpetrator, and 38 (35.8%) were legally married to the perpetrator, and 24 (22.6%) chose to not answer the question. The majority of the women were not living with the perpetrator, 72 (67.9%), 11 (10.4%) were living with the perpetrator, and responses for 23 (21.7%) women were missing. Forty-two (39.6%) women had children with the perpetrator, 34.9 (46.8%) did not, and
missing data was noted at 27 (25.5%). Additionally, 44 (41.5%) of the women had children from a previous relationship in comparison to the 33 (31.1%) that did not, and 29 (27.4%) did not report an answer for this question. Overall, the range of children was from zero to six for the participants, see Table 1.

Table 1:

*Number of Children*

<table>
<thead>
<tr>
<th>Number of Children</th>
<th>Frequency</th>
<th>Percent (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>22</td>
<td>20.8%</td>
</tr>
<tr>
<td>1</td>
<td>35</td>
<td>33.0%</td>
</tr>
<tr>
<td>2</td>
<td>19</td>
<td>17.9%</td>
</tr>
<tr>
<td>3</td>
<td>14</td>
<td>13.2%</td>
</tr>
<tr>
<td>4</td>
<td>7</td>
<td>6.6%</td>
</tr>
<tr>
<td>5</td>
<td>6</td>
<td>5.7%</td>
</tr>
<tr>
<td>6</td>
<td>2</td>
<td>1.9%</td>
</tr>
<tr>
<td>Missing</td>
<td>1</td>
<td>.9%</td>
</tr>
<tr>
<td>Total</td>
<td>106</td>
<td>100%</td>
</tr>
</tbody>
</table>

Seventy-two (67.9%) of the women were employed at the time of treatment and 28 (26.4%) were unemployed, missing data was 6 (5.7%). There was a variety of educational attainments for the participants, see Table 2.

Table 2:

*Highest Level of Education*

<table>
<thead>
<tr>
<th>Highest Level of Education</th>
<th>Frequency</th>
<th>Percent (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than High School</td>
<td>11</td>
<td>10.4%</td>
</tr>
<tr>
<td>Some High School</td>
<td>4</td>
<td>3.8%</td>
</tr>
<tr>
<td>GED</td>
<td>4</td>
<td>3.8%</td>
</tr>
<tr>
<td>High School Diploma</td>
<td>30</td>
<td>28.3%</td>
</tr>
<tr>
<td>Tech or Specialty School</td>
<td>2</td>
<td>1.9%</td>
</tr>
<tr>
<td>Associates Degree</td>
<td>9</td>
<td>8.5%</td>
</tr>
<tr>
<td>Some College</td>
<td>17</td>
<td>16.0%</td>
</tr>
<tr>
<td>Bachelor’s</td>
<td>18</td>
<td>17%</td>
</tr>
<tr>
<td>Master’s</td>
<td>3</td>
<td>2.8%</td>
</tr>
<tr>
<td>Ph.D., M.D., or J.D.</td>
<td>1</td>
<td>.9%</td>
</tr>
</tbody>
</table>
Thirty-three (31.0%) women reported a psychiatric history. Fourteen (13.2%) were on psychotropic medications during their treatment. Forty-six (43.4%) women had sought previous treatment prior to their current treatment at TRC. Ten (9.4%) of the women reported a previous psychiatric hospitalization and 38 (40.9%) of the women reported considering or attempting suicide. The number of women whom reported zero suicide attempt or considerations were 42 (39.6%), one suicide attempts were 24 (22.6%), two suicide attempts were 6 (5.7%), three suicide attempts were 4 (3.8%), six suicide attempts were 1 (.9%), missing 13 (12.3).

Every participant had reported IPV as her presenting problem for seeking treatment. In addition to IPV, the following were also listed as presenting problems: emotional abuse, rape, marital rape, attempted murder, child abuse and molestation, sexual assault, physical assault, and verbal abuse. TRC had characterized the status of the client’s treatment in five categories, based on the primary therapist’s professional opinion of how the client’s treatment progressed. With regards to this population, 55 (51.9%) had completed treatment and improved, 25 (23.6%) had completed treatment, 17 (15.1%) had either withdrawn or dropped out of treatment, 8 (7.5%) had improved, and 2 (1.9%) had been referred out of TRC for treatment elsewhere. In addition, the therapist rated whether resolution was reached for the women. Seventy-nine (74.5%) were classified under the category that resolution was reached, 20 (18.9%) did not reach resolution, while 3 (2.8%) were categorized as a “maybe,” and 4 (3.8%) were missing. Earlier traumas in addition to the presenting problem of IPV were addressed for 70 (66.0%) of the women and not addressed for 35 (33.0%), 1 (.9%) was missing. The
number of crimes as a survivor the client reported ranged from zero to ten, see Table 3. Forty-one (47.1%) women reported witnessing severe traumatic incidents and 46 (52.9%) did not. The number of severe traumatic events the participants have witnessed ranged from zero to three.

Table 3:

*Total Number of Crimes as a Survivor*

<table>
<thead>
<tr>
<th>Frequency</th>
<th>Valid Percent (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 Crimes</td>
<td>2 1.9%</td>
</tr>
<tr>
<td>1 Crime</td>
<td>35 33.0%</td>
</tr>
<tr>
<td>2 Crimes</td>
<td>26 24.5%</td>
</tr>
<tr>
<td>3 Crimes</td>
<td>19 17.9%</td>
</tr>
<tr>
<td>4 Crimes</td>
<td>8 7.5%</td>
</tr>
<tr>
<td>5 Crimes</td>
<td>3 2.8%</td>
</tr>
<tr>
<td>6 Crimes</td>
<td>1 .9%</td>
</tr>
<tr>
<td>10 Crimes</td>
<td>1 .9%</td>
</tr>
<tr>
<td>Missing</td>
<td>11 10.4%</td>
</tr>
<tr>
<td>Total</td>
<td>106 100.0</td>
</tr>
</tbody>
</table>

**Preliminary Analysis**

To assess the normality of distribution among the variables in the study, the levels of skew and kurtosis and histograms of each variable were reviewed. Each of the variables of interest in this study met the aforementioned criteria.

**Main Analyses**

The main analysis is divided into two parts major parts 1) whether TIR was effective in symptom reductions for PTSD, depression, and anxiety and an increase in
self-concept and 2) do significant differences between those participants who completed TIR treatment versus those who terminated prematurely. In order to develop a parsimonious predictive model of symptom reduction for TIR, I followed the guidelines for paired $t$-tests and multiple regression analyses provided by Glass and Hopkins (1996).

**Research question 1) Do Latina and African American intimate partner violence survivors report significant symptom reductions for PTSD, Depression, Anxiety, and significant increases in Self-Concept following TIR treatment?**

To test hypothesis 1, four paired T-tests were conducted to determine whether TIR treatment was effective in reducing symptoms of PTSD, anxiety, and depression in conjunction with increasing self-concept. Specifically, pretreatment mean scores were compared to post treatment mean scores for each of the measures, to determine if the mean difference (Pre – Post Treatment) scores was significant, see Table 4.

Table 4:

*Paired t-Tests Mean Differences*

<table>
<thead>
<tr>
<th>Paired Samples Test</th>
<th>Mean Pre</th>
<th>Mean Post</th>
<th>Mean Difference (Pre – Post)</th>
<th>Std. Deviation</th>
<th>Std. Error Mean</th>
<th>t</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pair 1 Pretreatment Score PTSD – Post Treatment Score PTSD</td>
<td>57.67</td>
<td>27.32</td>
<td>30.35</td>
<td>16.65</td>
<td>1.77</td>
<td>17.10**</td>
</tr>
<tr>
<td>Pair 2 Pretreatment Score Self-Concept – Post Treatment Score Self-Concept</td>
<td>109.10</td>
<td>130.22</td>
<td>-21.11</td>
<td>22.25</td>
<td>2.39</td>
<td>-8.85***</td>
</tr>
<tr>
<td>Pair 3 Pretreatment Score Anxiety – Post Treatment Score Anxiety</td>
<td>41.82</td>
<td>12.20</td>
<td>29.61</td>
<td>20.21</td>
<td>2.15</td>
<td>13.74**</td>
</tr>
<tr>
<td>Pair 4 Pretreatment Score Depression – Post Treatment Score</td>
<td>34.77</td>
<td>9.40</td>
<td>25.38</td>
<td>13.67</td>
<td>1.46</td>
<td>17.42**</td>
</tr>
</tbody>
</table>
The results show a significant reduction from pretreatment PTSD mean score to post treatment PTSD mean score, \( (M = 30.35, SD = 16.65, SEM = 1.77) \); \( t(87) = 17.10, p < .001 \), see Figure 2.

Figure 2:  
*Mean Pre and Post TIR Treatment PTSD Scores*

Results also showed a significant increase from pretreatment self-concept mean score to post treatment self-concept mean score, \( (M = -21.11, SD = 22.25, SEM = 2.39) \); \( t(86) = -8.852, p < .001 \), see Figure 3.
Concerning reported levels of anxiety, there was a significant reduction from pretreatment anxiety mean score to post treatment anxiety mean score, \((M = 29.63, SD = 22.25, SEM = 2.15)\); \(t(87) = 13.74, p < .001\), see Figure 4.
Significant reductions were also found from pretreatment depression mean score to post treatment depression mean score, \((M = 25.38, \text{SD} = 13.67, \text{SEM} = 1.46); t(87) = 17.42, p < .001\), see Figure 5.
In order to determine the relationship between variables, a correlation matrix was used. PTSD, anxiety, and depression were all positively related to each other and self-concept was negatively related to the aforementioned variables (see Table 5).

Table 5:

*Pretreatment Correlations*

<table>
<thead>
<tr>
<th></th>
<th>Pre PTSD</th>
<th>Pre Self-Concept</th>
<th>Pre Anxiety</th>
<th>Pre Depression</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre PTSD</td>
<td>1 (N=105)</td>
<td>-.39***</td>
<td>.66***</td>
<td>.74***</td>
</tr>
<tr>
<td>Pre Self-Concept</td>
<td>-</td>
<td>1 (N=105)</td>
<td>-.36***</td>
<td>-.44***</td>
</tr>
<tr>
<td>Pre Anxiety</td>
<td></td>
<td></td>
<td>1 (N=105)</td>
<td>.62***</td>
</tr>
<tr>
<td>Pre Depression</td>
<td></td>
<td></td>
<td></td>
<td>1</td>
</tr>
</tbody>
</table>

Note: *p < .05  **p < .01  ***p < .001

The post treatment relationships are as follows: post self-concept and post PTSD ($r = -.50***$), post PTSD and post anxiety ($r = .86***$), and post PTSD and post depression ($r = .85***$), post self-concept and post anxiety ($r = -.53$), and lastly post self-concept and post depression ($r = -.51***$), post anxiety and post depression, ($r = .77***$), see figure 6.
Table 6:

*Post Treatment Correlations*

<table>
<thead>
<tr>
<th></th>
<th>Post PTSD</th>
<th>Post Self-Concept</th>
<th>Post Anxiety</th>
<th>Post Depression</th>
</tr>
</thead>
<tbody>
<tr>
<td>Post PTSD</td>
<td>1</td>
<td>-.50***</td>
<td>.86***</td>
<td>.85***</td>
</tr>
<tr>
<td></td>
<td>N=87</td>
<td>N=88</td>
<td>N=88</td>
<td></td>
</tr>
<tr>
<td>Post Self-Concept</td>
<td>1</td>
<td>-.53***</td>
<td>-.51***</td>
<td></td>
</tr>
<tr>
<td></td>
<td>N=87</td>
<td>N=87</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Post Anxiety</td>
<td></td>
<td>1</td>
<td>.77***</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>N=88</td>
<td></td>
</tr>
<tr>
<td>Post Depression</td>
<td></td>
<td></td>
<td></td>
<td>1</td>
</tr>
</tbody>
</table>

Note: *p < .05  **p < .01  ***p < .001

Hypothesis 1 was supported by the data, where TIR treatment demonstrated statistically significant symptom reduction for PTSD, anxiety, and depression, as well as a statistically significant increase in self-concept. Additionally, it was hypothesized that PTSD, anxiety, and depression would be positively related to each other and self-concept would be negatively related. This hypothesis was supported by correlations statistical data as the signs were all directionally what was expected, see Tables 5 and 6.

*Out of PTSD, Self-Concept, Anxiety, and Depression, which variable has the greatest change from pre to post test evaluation, indicating symptom reduction?*

Depression had the largest effect size, $d=2.3681$, followed closely behind by PTSD with an effect size of $d=2.3196$. Anxiety had an effect size of $d=1.7799$ and Self-
Concept $d = -1.2786$, see Table 7. According to Cohen (1988), each of the aforementioned effect sizes are categorized as large. Thus, the hypothesis that PTSD would have the largest effect size was not supported in this sample, as depression had the largest pre to post treatment change.

Table 7:

*Cohen’s d statistic*

<table>
<thead>
<tr>
<th></th>
<th>PTSD</th>
<th>Self-Concept</th>
<th>Anxiety</th>
<th>Depression</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cohen’s d</td>
<td>2.32</td>
<td>1.28</td>
<td>1.78</td>
<td>2.37</td>
</tr>
</tbody>
</table>

*Note: absolute values represented*

Are the following variables related to the change in pretreatment to post treatment in PTSD, Self-Concept, Anxiety, and Depression: race, number of traumatic events, number of hours in TIR treatment, and lastly TIR only treatment versus TIR and auxiliary services?

Multicollinearity was assed using the variation inflation factor (VIF) statistics. For all variables, the $VIF < 2.00$, and therefore, no problem exists with using multiple regression analysis. Additionally, the normality assumption for residuals was also met with each the variables of interest. To test this hypothesis, four standard multiple regression analysis were performed by regressing the independent variables (race, number of traumatic events, number of hours in TIR treatment, and TIR only treatment versus TIR and auxiliary services) on the dependent variables of treatment outcome for PTSD, self-concept, anxiety, and depression. The dependent variables were recoded to obtain the difference score (post score – pre score) for each of the variables. For this analysis, two of the four regression analyses were significant. The first regression
analysis revealed that the omnibus test was significant, where the hours in TIR treatment increased self-concept, $R^2 = .179$, $F(4, 75) = 4.08$, $p = .005$. There was a significant relationship between the hours in TIR treatment and self-concept treatment outcome, $\beta = .360$, $t(75) = 3.41$, $p = .001$, after controlling for race, number of crimes as a victim, and auxiliary services, see Table 8. The second regression analysis revealed that the omnibus test was significant, where the total number of crimes as a victim increased depression, $R^2 = .125$, $F(4, 76) = 2.72$, $p = .036$. There was a significant relationship between the total number of crimes as a victim and the depression treatment outcome, $\beta = -.25$, $t(76) = -2.27$, $p = .026$, after controlling for race, hours in TIR, and auxiliary services, see Table 9. To further investigate the results of the significance the total number of crimes as a victim was regressed just on the pretreatment depression scores, $\beta = .21$, $t(92) = 2.03$, $p = .045$, see Table 10. The data support that as the total number of crimes goes up 1 unit the pretreatment depression score goes up 1.8 units.

When PTSD was the outcome variable, none of the predictors were significant: race and PTSD, $\beta = .10$, $t(76) = .90$, $p = .370$; crimes as victim and PTSD, $\beta = -.12$, $t(76) = -1.05$, $p = .299$; Hours in TIR and PTSD, $\beta = -.18$, $t(76) = -1.60$, $p = .113$; and auxiliary services and PTSD, $\beta = -.05$, $t(76) = -.43$, $p = .668$

There was a significant relationship between the hours in TIR treatment and self-concept treatment outcome, $\beta = .360$, $t(75) = 3.41$, $p = .001$, after controlling for race, number of crimes as a victim, and auxiliary services, see Figure 14. For outcome variable self-concept, three of the predictors were not significant: Race and self-concept, $\beta = -.10$, $t(75) = -.95$, $p = .346$; crimes as victim and self-concept, $\beta = .54$, $t(75) = 1.46$, $p = .150$; and auxiliary services and self-concept, $\beta = -.07$, $t(75) = -.67$, $p = .502$, see Table 8.
Table 8:

*Outcome of Self-Concept Difference Scores*

<table>
<thead>
<tr>
<th>Coefficients</th>
<th>Unstandardized Coefficients</th>
<th>Standardized Coefficients</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>B</td>
<td>Std. Error</td>
</tr>
<tr>
<td>Race</td>
<td>-6.48</td>
<td>6.82</td>
</tr>
<tr>
<td>Crimes as Victim</td>
<td>2.44</td>
<td>1.67</td>
</tr>
<tr>
<td>Hours in TIR</td>
<td>1.62</td>
<td>.48</td>
</tr>
<tr>
<td>Auxiliary Services</td>
<td>-3.48</td>
<td>5.17</td>
</tr>
</tbody>
</table>

*Note: *p < .05   **p < .01  ***p = .001*

Dependent Variable = Difference in Self-Concept (Self_Concept_post – Self_Concept_pre)

For outcome variable anxiety, none of the predictors were significant: Race and anxiety, $\beta = .12$, $t(76) = 1.05$, $p = .298$; crimes as victim and anxiety, $\beta = -.09$, $t(76) = -.83$, $p = .408$; hours in TIR and anxiety, $\beta = -.07$, $t(76) = -.64$, $p = .525$; and auxiliary services and anxiety, $\beta = -.09$, $t(76) = -.82$, $p = .416$.

There was a significant relationship between the total number of crimes as a victim and the depression treatment outcome, $\beta = -.25$, $t(76) = -2.27$, $p = .026$, after controlling for race, hours in TIR, and auxiliary services, see Table 9. For outcome variable depression, three of the predictors were not significant, see Table 9.
Table 9:

*Outcome of Depression Difference Scores*

<table>
<thead>
<tr>
<th>Model</th>
<th>Unstandardized Coefficients</th>
<th>Standardized Coefficients</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>B</td>
<td>Std. Error</td>
</tr>
<tr>
<td>Race</td>
<td>1.27</td>
<td>4.28</td>
</tr>
<tr>
<td>Crimes as Victim</td>
<td>-2.36</td>
<td>1.04</td>
</tr>
<tr>
<td>Hours in TIR</td>
<td>-.56</td>
<td>.29</td>
</tr>
<tr>
<td>Auxiliary Services</td>
<td>-2.64</td>
<td>3.23</td>
</tr>
</tbody>
</table>

*Note:* *p < .05   **p < .01   ***p < .001

Dependent Variable = Difference in Depression (Depression _post – Depression _pre)

To further investigate the results of the significance the total number of crimes as a victim was regressed just on the pretreatment depression scores, $\beta = .21$, $t(92) = 2.03$, $p = .045$, see Table 10. The data support that as the total number of crimes goes up 1 unit the pretreatment depression score goes up 1.8 units.

Table 10:

*Outcome of Pretreatment Depression Difference Scores*

<table>
<thead>
<tr>
<th>Model</th>
<th>Unstandardized Coefficients</th>
<th>Standardized Coefficients</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>B</td>
<td>Std. Error</td>
</tr>
<tr>
<td>Number of Crimes</td>
<td>1.83</td>
<td>.90</td>
</tr>
</tbody>
</table>

*Note:* *p < .05   **p < .01   ***p < .001

Dependent Variable = Difference in Depression (Depression _post – Depression _pre)

There were no significant differences between Latina and African American women across the dependent variables. The data supported the hypothesis that both groups of women would have a positive relationship in treatment success. The next
hypothesis was as the number of traumatic events experienced increased, the PTSD, anxiety, and depression symptoms would increase, and the self-concept scores would decrease. The data only supported this relationship on the depression measures. Thus, the more crimes committed against the participant, the higher the depression pretreatment score. This measured the relationship between number of crimes and depression, not accounting for any population differences. The initial analysis yielded that as the number of crimes increased, the difference score (post minus pre depression score) decreased and so did the post treatment scores. A positive relationship between the number of hours in TIR treatment and treatment success was also hypothesized and only significant on the Self-concept measure. Specifically, as the number of hours in TIR increased the difference score (post minus pre self-concept score) for self-concept increased. Lastly, it was hypothesized that those individuals who received auxiliary services in conjunction with TIR would have better post treatment outcomes than those who had only received TIR. The data did not support this hypothesis.

Are there significant differences between those participants who remained in TIR treatment versus those who terminated services prematurely? Specifically, were the following variables factors in early termination: Age of the participant, Geographic Location of where the participant resided, Country of Origin, or pretreatment scores on the PTSD, Self-Concept, Anxiety, and Depression.

Chi square tests of independence were performed to determine if geographic location from treatment center and country of origin were factors in termination of treatment prematurely. Geographic location was determined by the participant’s zip code
and was tested in five-mile increments. No significant results were found for geographic location, $X^2(20, N = 107) = 50.43, p = .303$, nor where there significant results for country of origin, $X^2(20, N = 107) = 28.11, p = .107$. Thus, the hypothesis that geographic location was a factor in premature termination was not supported. Country of origin was also not a significant factor in premature termination, leaving that hypothesis unsupported.

After examining the distribution of zip codes for geographic location, it was determined that the participants could be dichotomized into two groups, those who were within zero to ten miles and eleven or miles away from the treatment center. Another chi square test of independence was conducted. No significant results were found, suggesting that distance did not have a factor in whether or not a participant remained in treatment $X^2(1, N = 98) = .039, p = .844$. Again, the hypothesis that geographic location was a factor in premature termination was not a significant factor.

Next, $t$-tests were conducted to determine if age and PTSD, self-concept, anxiety, and depression pretreatment scores were factors in termination of treatment prematurely. No significant results were found for age, $t(105) = 1.68, p = .096$. Additionally, no significant results were found for the pretreatment scores. Pretreatment scores were treated as dichotomous: using the following clinical cutoff scores: PTSD (PCL-C = 50 or more is the clinical cutoff), self-concept (GESS = 113 is the average score for women, anything below was treated as the clinical cutoff), anxiety (CAS = 30 or more is the clinical cutoff), and depression (CES-D = 10 or more is the clinical cutoff). They are as follows: PTSD, $t(104) = 1.32, p = .191$; self-concept, $t(104) = -.10, p = .922$; anxiety, $t(104) = .04, p = .965$; and lastly, depression, $t(104) = .18, p = .856$. The hypothesis that
age would predict those who stayed in treatment versus those who did not was not supported. The hypotheses that pretreatment scores would be factors in premature termination were also not supported by the data.
Chapter V: Discussion

The mental health field is in need of efficacious and cost effective interventions designed to assist women survivors of intimate partner violence. Moreover, there is a need for treatment modalities responsive to the needs of racially and ethnically diverse populations. This study sought to integrate related research and theory of trauma with current IPV literature and to test the utility of a brief trauma-based approach in reducing trauma related symptomatology in a predominantly Latina and African American clinical sample. I aimed to build upon past research and theory of Traumatic Incident Reduction (TIR) by Gerbode (1995), Valentine (1997), Bisbey, (1995), and more currently, Descilo, et al., (2010). By taking this approach, this research sought to add to the emerging literature on the effects of TIR in alleviating symptoms associated with trauma exposure. Furthermore, this study also sought to increase the knowledge base in this area of psychology and generate information of practical value for service providers looking to assist Latina and African American women IPV survivors in our communities.

This study began with a series of questions and concerns regarding the experience and possible amelioration of trauma related symptoms among Latina and African American women survivors of intimate partner violence. Data obtained from clinical records of 106 IPV survivors who had received treatment for trauma related symptoms were used to evaluate reported levels of various symptoms before and after treatment. The results showed TIR participation to be associated with significant reductions in reported symptoms of depression, PTSD, and anxiety. In addition, the clients reported important gains in self-concept following treatment. Thus, it is reasonable to conclude that TIR treatment was of benefit to the IPV survivors in this sample.
Concerning the relative impact of TIR on specific clinical variables, we found greater observed changes on self-reported levels of depression and PTSD than for anxiety and self-concept following treatment. Among the variables of interest in this study, as hypothesized, PTSD, anxiety, and depression were all positively related to each other and self-concept was negatively related to the aforementioned outcome variables.

The above mentioned findings are consistent with prior research on the treatment efficacy for TIR. Specifically, Valentine (2000) found that TIR reduced symptoms of depression, anxiety, and PTSD in sample of 123 female inmates. Moreover, they found that the participant’s self-concept also increased throughout the course of treatment (Valentine, 2000; Valentine & Smith, 2001). In another study, Bisbey (1995) noted that in comparison to a no-treatment control group and a direct exposure therapy group, participants in the TIR treatment showed greater symptom reduction. Descillo et al. (2010) also found TIR to be effective in the treatment of at-risk youth. Youth in TIR treatment showed a significant decrease from pretreatment to post treatment scores for PTSD and depression, and a significant increase in self-concept (Descillo, et al., 2010). A sample of unaccompanied refugee minors also demonstrated similar gains following TIR treatment (Descillo, et al., 2010).

In addition to the general effects of treatment in self-reported levels anxiety, depression, PTSD, and self-concept, we also explored the potential effects of key contextual variables (e.g., race, number of traumatic events, and number of treatment hours) on treatment outcome. Our evaluation of these variables showed a significant
relationship between the number of treatment hours and positive changes in self-concept. Thus, the more hours clients spent in treatment, the better they felt about themselves. This finding is consistent with the core theoretical and practical tenets of the approach. In respecting the authority of the client, TIR facilitators help the “viewers,” and in doing so, endorse the metapsychology stance (Gerbode, 2006, p. 154). Moreover, clients actively participate in creating a narrative of the traumatic experiences they can live with and in the process, develop a better appreciation for their own contribution to the amelioration of symptoms.

We also looked at the relationship between clients’ histories of crime victimization and their reported levels of symptoms both prior to and following treatment. Here we found that the more crimes our female clients experienced the more depressive symptoms they reported prior to treatment. Furthermore, the strength of this association dissipated following treatment, suggesting that participation in TIR treatment may have led to important reductions in reported levels of depressive symptoms for these women. Thus, it appears that TIR was particularly helpful to women with more severe histories of crime victimization in our sample.

Disorganization is one of trauma’s main effects, leading to a system overload for the person, where she is unable adequately to process the traumatic event (Valentine, 1995; Waites, 1993). The exposure to multiple stressors greatly decreases a person’s ability to cope successfully with her environment (Sourander, 1998). As expected, the women in this study who experienced more crimes, or traumatic events, yielded poorer psychological outcomes on the pretreatment depression measure. Interestingly, reports of PTSD and anxiety symptoms were not significantly affected by the history of crime
victimization, as the research literature would suggest. It is possible that the time lag between the clients experiences of these events and their participation in treatment may have served to lessen the symptoms of anxiety and PTSD, which by their very nature, tend to be more reactive to ongoing stressful conditions than depressive symptoms may be. The TIR criteria for inclusion in treatment may have also biased the results in this direction, since TIR tends to exclude people who are having great difficulty managing emotions surfacing soon after a traumatic event. The ideal client for TIR needs to have both access and adequate levels of and control over her emotions to make the best use of treatment.

As race did not exhibit any significant differences between Latina and African American women, TIR appears efficacious for use with both populations. Generalizability of these results to other urban US cities with similar characteristics to those of the TRC treatment seekers in Miami, FL would most likely be applicable. While the auxiliary services may indeed benefit the women on dimensions not measured, statistically on measured outcomes the utility of auxiliary services were not supported.

Lastly, we evaluated the differences between who remained in treatment and those who did not. Pretreatment scores for the outcome variables were analyzed and no major differences were found between these groups. It is possible that women who chose to terminate treatment prematurely did not feel comfortable with the TIR treatment modality. It is also possible that some of this women were simply not ready at the time to enter a trauma-based treatment like TIR.
Limitations of Study

There are various issues that may have influenced the results of this study. First, there is the issue that the data used in this study was obtained from records completed for clinical purposes. As comprehensive as these records are, clinical reality often dictates that data gathering procedures be subordinated to the clinical demands at hand. For the purpose of this study, the lack of standardization in data gathering procedures characteristic of research protocols could be assumed to have had an unknown impact on data. For instance, the records included a fair amount of missing data. We suspect that this concern will dissipate over time as TRC continues to refine their research and evaluation capacities in coordination with University of Miami researchers.

As part of the treatment, TRC had obtained research consents in order to measure outcome variables at pretreatment, mid treatment, and post treatment intervals. It is possible that participants learned something from the repeated administration of the evaluation forms. Refinement of test-taking skills, familiarity with the content of the test items and the format of the tests, reduction in test anxiety may have influenced the scores over time masquerading the effect of the predicting variables. However, given previous support for the treatment efficacy of TIR model we are inclined to believe the effects of repetition and practice to be minimal.

It could be also argued that the findings of this study may have been limited by the way the data was collected. Specifically, post treatment scores were collected during the termination phase of therapy. A more methodologically sound and elegant design would include an additional wave of data collection some time following participation in treatment.
Potentially relevant variables such as acculturation were not included in this study. Level of acculturation has been noted by mental health researchers to be an important factor to consider in the treatment of ethically diverse populations (Guarnaccia, Canino, Rubio-Stipec, & Bravo, 1993; Pole, Gone, Kulkarni, 2008; Ortega & Rosenheck, 2000). Given the large number of immigrant women in this study, it could be argued that knowledge about their acculturation to American society could help us make more refined observations about their response to treatment.

Each of the women who participated in TIR also received individual and/or group therapies. While TIR has been shown to be effective in this study and others, perhaps future designs could compare pre to post treatment measures against those who participated in both TIR and individual therapies. As it stands, it is difficult to discern the unique contribution of individual and group interventions in the clients’ mental health. The inclusion of a comparison group into the design of future TIR research would aid in the process of isolating where the changes in symptom presentation and increases in healthy behaviors are located. Additionally, the independent variables would need to be operationally defined, since the comparison and treatment groups would represent a different population, thus affecting the generalizability of the results. Ultimately, the inclusion of a comparison group would add to the validity of the results. By examining the pretreatment characteristics, post treatment group differences that emerge, such as maturation, selection, selection interactions, and mortality, could be explained with more ease.

Another perhaps, more esoteric issue to consider, has to do with untangling the effect of sharing one’s story from other treatment effects. The telling of the story, the
elaboration of the narrative, the development of mastery over the story, and the modification of the story over time can all be theorized to have therapeutic effects. Moreover, clients may respond to a particular aspect of this narrative approach differently. Finally, another factor to consider are potential facilitator effects. While each of the therapists have received certification and supervision, it would be interesting to explore whether those who have more experience treating trauma victims were more effective (i.e., better treatment outcomes, lower premature termination rates) than their less experienced counterparts.

Implications for Future Research

This study extends research on TIR treatment efficacy for Latina and African American IPV survivors. Further research is needed to identify and test other variables that may be relevant in treatment of ethnic minority survivors of IPV. The standardization of the data collection process, the inclusion of acculturation models, and completion of appropriate post treatment follow up assessments would be an improvement over the current study, allowing greater confidence to speak of long term treatment efficacy.

Previous literature (Goodman, 2004; Rousseau et al., 1998) has identified the advantage of understanding the cultural meanings attributed to traumatic situations and the culturally based coping strategies employed by the survivors. These findings underscore the importance of comprehending the belief systems and cultural foundations of trauma, symptoms, and coping (Goodman, 2004). Such information emphasizes the importance of using a person-centered treatment methodology to address the individual needs of a trauma survivor. Thus, the incorporation of acculturation into further testing
the efficacy of TIR seems paramount in light of the high number of foreign-born individuals seeking treatment at TRC.

The inclusion appropriate follow-up assessments of outcome variables would provide valuable information about the long-term benefits of TIR. Moreover, it could help us learn something about the extent to which TIR techniques have a positive impact in peoples’ lives beyond the concerns that brought them to treatment in the first place. Since TIR is user-friendly, it remains to be seen whether individuals who had success in TIR will apply the treatment methodology to future traumatic events. Specifically, this could help us understand if TIR techniques help people cope better and overcome life obstacles.

**Clinical Implications and Concluding Thoughts**

As the demographic landscape of the US continues to evolve into a more culturally diverse portrait, it has become paramount to identify the shifts in symptom presentation and efficacious treatment modalities. The results of this study have indicated an exciting opportunity for mental health providers to broaden their therapeutic perspectives into the realms of TIR. As TIR has been used in conjunction with traditional individual and group therapies, a realm of new possibilities has emerged, focusing on specific techniques that have exhibited positive treatment outcomes (Bisbey, 1995; Descillo, Greenwald, Schmitt, & Reslan, 2010; Valentine, 2000; Valentine & Smith, 2001).

Due to current economic strain the US is facing and the budget cuts targeting mental health service provision, more emphasis has been placed on finding cost-effective treatment interventions. TIR average treatment length and certification of facilitators
falls within the scope of the imposing financial restrictions posed on the mental health field. While many facilitators of TIR possess the benefits of formal education in psychology and social work, it is not necessary to successfully administer treatment. Thus, for individuals who require various and obscure linguistic needs where translators have typically been the norm for resolution of traumatic events, TIR offers an alternative. Translators can be located and trained in TIR methodology to successfully meet the needs of various treatment seekers through direct communication.

With IPV having an associated total annual cost of $127 billion for the rape/sexual assault of adult women and men (Martin, Macy, & Young, 2011), methods of decreasing such staggering numbers becomes of importance. A review of current literature suggests that a great deal of emphasis is already placed on treating survivors of IPV. However, what is currently missing is a treatment methodology that will decrease outgoing expenditures. TIR represents a favorable treatment for mental health providers to utilize in meeting the needs for culturally diverse survivors of IPV.

This study showed positive results for TRC treatment seekers in Miami. Specifically, TIR promotes a person-centered and non-invasive approach to trauma resolution for survivors of IPV. For the Miami community, a tremendous resource has been uncovered. Thus, persons living within this community have an affordable and validated treatment option that is centrally located.

The greater psychological community can also benefit from the results of this study. TIR has gained increased support as a brief model of trauma resolution. Additionally, the significant results from those who completed treatment are promising.
As indicated here, TIR can be seen as method of treatment for women originating from various cultures.

This study sought to test the utility of a trauma-based intervention for Latina and African American survivors of IPV. However, we did not address the societal determinants affecting Latina and African American women. Education and interventions aimed at targeting youth would increase the knowledge base as well as lessen any inaccurate assumptions that may have been formed and endorsed within the family unit. Violence in any relationship is unacceptable and the long lasting psychological consequences can have profound negative repercussions. However, in order to evoke change, a social support system that embraces healthy and adaptive values needs to be operational and accessible. Intimate partner violence is a shared problem that can only be met with a community solution that promotes participation and support from all in order to successfully seek its abolition.
### APPENDIX A:

#### Trauma Resolution Center

**In-Depth Psychosocial Assessment for Adults**

| LOCATION: _________________________        DATE: __________________ |
| TIME AT START OF SESSION: ___________ AM/PM |

#### IDENTIFYING INFORMATION

| Date: _______________________ | Client: _____________________________ | Referred by: ___________________________ |
| DOB: _______ | Age: _____ | Sex ______ | SS#: ___________________________ | Race: ___________________________ |
| Country of Origin: ___________________________ |
| How long in US? _______ | Language preferred: ___________ | Tel: (H)______________ (W)___________________ (B)________________ |
| Marital status (circle): NM LT M S D W (C) |
| Current Address: _________________________________ | Apt # _____ | City: ___________________________ |
| Permanent Address: _________________________________ | Apt #: _____ | City: ___________________________ |
| Emergency Contact: _______________________________ | Relationship: ___________________________ |
| Tel: ___________________________ |
| Address: (to f/u in case you move) ____________________________________________________________________________ |

May VSC call you at home?  Y  N  If NO, where may we safely contact you?

---

**Event(s) that caused you to seek counseling:**

Has a similar event happened in the past?

---

Primary presenting problem: ___________________________  Secondary: ___________________________

Adm. Staff: ___________________________

#### FUNDING INFORMATION

- P-VC___ VC eligible ___ VC form signed ___ LER collected ___ Client – LER? ___ VSC – LER? ___OVC ___ VWF ___ MB ___ FFP ___ OCED ___ FIAC ___ Self Pay _____ ($ Per session) _____ NFS _____ Other _______

Type of Insurance ______ Make enlarged copy of info (ONLY if payment is possible, or PPO or if client is VC eligible)

#### LEGAL INVOLVEMENT

If event that caused client to seek counseling is a crime (including domestic violence), complete the following information even if there is no LER for the current crime.
Type of crime: ________________________________ Date of crime: ______________

Were you physically injured, however slightly?  Y   N

Give details: ___________________________________________________ Did you need medical attention?  Y   N  Did you get it?   Y    N

If you needed it, and did not get it, why not?
________________________________________________________________________

What is the address where it happened? __________________________________________________________________________

Police report made?  Y   N

Date: ________________  Police Dept.:_________________________ Case #: __________________ Copy of police report?  Y   N  Perpetrator arrested?  Y   N

Is the case being prosecuted? ________ Who is the Assistant State Attorney?

_________________________________________ Phone: ___________________

Has the case gone to trial?  Y   N  When is the trial scheduled? ________________ Do you know the perpetrator?  Y    N

(If yes): Name: _______________________________________________ DOB: ___________________
  Relationship: _________________________

NOTE: If taking information from a parent or a child victim or witness to a crime, include:

Names, DOB & SS #'s for all children AND FOR THE PARENT.

1. Are you legally married to the perpetrator?  Y   N
2. Are you living with the perpetrator?  Y   N
3. Do you have children together?  Y   N
4. Do you have children from a previous relationship?  Y   N
5. Have the children witnessed (circle) verbal fights/physical abuse?  Y   N
6. If yes, when were the incidents witnessed? Dates:
________________________________________________________________________

7. Are the children currently exposed to domestic violence at home?  Y   N
8. Have the children been in the house, but not in the room when domestic violence occurred?  Y   N
9. Have any or all been the victims of (circle types of abuse) physical, verbal, sexual and/or emotional abuse or neglect?  Y   N

Name of child: ___________________________ DOB: ________________ SS#: ____________
Types of Abuse:

Name of child: ___________________________ DOB: ________________ SS#: ____________
Types of Abuse:

Name of child: ___________________________ DOB: ________________ SS#: ____________
Types of Abuse:

Name of child: ___________________________ DOB: ________________ SS#: ____________
Types of Abuse:

9. Has an abuse report already been made to the Abuse Hotline?  Y   N  If yes, when and by whom?
10. Did the police report the incident to DCF for investigation? Y N When?
11. Has DCF investigated? Y N What was the outcome?
If the any of the answers to questions 5-8 are in the affirmative, you are mandated by F.S, 39.201 to report this to the Florida Abuse Hotline. Please call 1-800-96ABUSE and fill out the Abuse Report Log
   If report made by us, date/time: _______________ Name of hotline staff: _______________
   Report #: ____________________

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<th>NAME</th>
<th>RELATIONSHIP</th>
<th>NATURE OF RELATIONSHIP (GIVE DETAILS)</th>
<th>CLIENT AGE @ DEATH</th>
<th>STEP / ADOPTED</th>
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Have your parents ever been separated or divorced? Y N How old were you? _______________
How did you feel about it?

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<th>SIGNIFICANT ROMANTIC RELATIONSHIPS</th>
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<td>DIV. / SEP?</td>
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Who do you live with now? _______________ What is your sexual preference?
(Heterosexual, Homosexual, Bisexual, Other) _______________
Do you now, or have you ever had any sexual problems?  Y  N
Explain:
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Do you now, or have you ever had relationship difficulties with your partner?  Y  N
Explain:
_________________________________________________________________________________________________
_________________________________________________________________________________________________
__________________________________________________________________________________

If you or your partner is in a high-risk group for AIDS, Have you been tested?  N/A
Y  N

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**DEATHS THAT HAVE AFFECTED YOU**

**OTHER SEVERE LOSSES**

(Pets, economic, friendships, etc.)

**EDUCATION**

Highest grade completed: ____________

Did you fail to achieve anything due to problems of learning or study?  Y  N
Explain:

How do you feel about learning / studying?

Are you in school?  Y  N
If not, do you plan to return to school in the future?  Y  N

If so, what is your major? __________________________
How do you currently make a living? __________________________
Where do you currently work? __________________________
Work address: __________________________
Phone: __________________________
Any work difficulties?  Y  N

Explain:

How do you feel about your job?

MAIN JOBS

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<th>TYPE</th>
<th>WHEN</th>
<th>FOR HOW LONG?</th>
<th>NOTES</th>
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HOBBIES / INTERESTS

MEDICAL &/OR PSYCHIATRIC
Have you ever seen a psychiatrist? Y N Psychiatrist’s name: ____________________________ Telephone: ________________________________
Name of Clinic: _____________________________ Address: _____________________________
If so why?
_________________________________________________________________________________________________
_________________________________________________________________________________________________

Do you have access to a doctor? Y N
Doctor’s name / Clinic name: _____________________________
Address: _____________________________________________
Telephone: (      ) ______________________

**Current Medications (Medical or Psychiatric)**

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<th>REASON / DOSAGE / EFFECTS</th>
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Have you EVER taken any psychotropic medication? Y N If so, what? ____________________________

If applicable, what medical &/or psychiatric hospitalizations have you had?

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**PREVIOUS THERAPY/COUNSELING**

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Have you had any involvement with alternative practices or therapies?  Y  N
Details:
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
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**HEALTH**

How well do you sleep? ________________  How much? ________________
Do you have any sleep disturbances?  Y  N
Explain: ________________________________  Do you take anything to help you sleep?  Y  N
What: ________________
Are there perceptual problems that run in your family?  Y  N  Details:
Has anyone in your family suffered from mental problems?  Y  N  Details: 

What is your attitude towards illness / medical treatment / doctors / hospitals? 

Do you sometimes worry about some loss or other event that may occur to adversely affect your life?  Y  N 

Explain: 

Have you any compulsions, or things you feel you must do?  Y  N 

Explain: 

Have you anything that you feel you must avoid, or not do?  Y  N 

Explain: 

Have you any fears, phobias, or anything that you try and prevent from happening?  Y  N 

Explain: 

What do you see as your strengths and resources? 

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

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Do you know if your mother used alcohol when she was pregnant with you? 

Y  N 

-----or drugs?  Y  N 

When was the last time you used alcohol or drugs?

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</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>SUPPORT SYSTEMS</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>background?</td>
<td></td>
</tr>
<tr>
<td>current religious beliefs?</td>
<td></td>
</tr>
</tbody>
</table>
Do you belong to a church?  Y   N  Do you attend regularly?  Y   N  
Do you attend other church activities?  Y   N  Notes:  
________________________________________________________________________

Do you belong to any clubs / organizations?  Y   N  Where?  
________________________________________________________________________

MILITARY SERVICE
Have you ever served in the military?  Y   N  
Branch: __________________  How long? ___________________________
Have you ever been in combat?  Y   N  Notes:  
________________________________________________________________________

Were your parents in the military?  Y   N  Who / Branch / How long?  
________________________________________________________________________

CRIMES AS VICTIM

<table>
<thead>
<tr>
<th>TYPE (SEXUAL BATTERY, DV, BATTER, ETC.)</th>
<th>WHEN</th>
<th>DETAILS</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tr>
</tbody>
</table>

Have you ever committed a crime?:  
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
### TRAUMATIC INCIDENTS

<table>
<thead>
<tr>
<th>Have you ever been a witness to severe traumatic incidents (i.e. war time experiences, violent crimes, accidents or deaths)?</th>
<th>Y</th>
<th>N</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>TYPE</th>
<th>WHEN</th>
<th>DETAILS</th>
</tr>
</thead>
</table>

### HAVE YOU EVER CONSIDERED OR ATTEMPTED SUICIDE?

<table>
<thead>
<tr>
<th>WHEN</th>
<th>HOW</th>
<th>WHAT WERE THE CIRCUMSTANCES?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tr>
</tbody>
</table>

### FITNESS / DIET

<table>
<thead>
<tr>
<th>How would you estimate your current physical fitness?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Do any physical problems run in your family?</th>
<th>Y</th>
<th>N</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Details:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Does your partner have any physical problems / disabilities?</th>
<th>Y</th>
<th>N</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Details:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>What is your usual diet?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fruit / Vegetables?</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Do you take nutritional supplements?</th>
<th>Y</th>
<th>N</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>What kinds?</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Is anyone objecting to your getting counseling?</th>
<th>Y</th>
<th>N</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Explain:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
<tr>
<td>Question</td>
</tr>
<tr>
<td>-------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Has anyone insisted that you get counseling?</td>
</tr>
<tr>
<td>Does anyone not like the way that you are?</td>
</tr>
<tr>
<td>Has anyone ever tried to make you change or be different?</td>
</tr>
<tr>
<td>Are you cross or upset with anyone at this time?</td>
</tr>
<tr>
<td>Are you in any particular danger at this time?</td>
</tr>
<tr>
<td>Do you have a tendency toward violent behavior?</td>
</tr>
<tr>
<td>What do you want to accomplish in counseling?</td>
</tr>
<tr>
<td>Is there anything else that you would like the counselor and/or supervisor to know?</td>
</tr>
<tr>
<td>Is there anything that we have covered in this interview that your attention is still on?</td>
</tr>
</tbody>
</table>

**INTEGRATED SUMMARY**
Prioritizes problems and service needs, evaluates past interventions and current symptoms based on history and assessment information:

<table>
<thead>
<tr>
<th>Summary</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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<td></td>
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<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**DIAGNOSIS:**

**TENTATIVE DISCHARGE CRITERIA:**
AXIS I: 

AXIS II: 

AXIS III: 

AXIS IV: 

AXIS V (GAF): _____________

MASTER’S LEVEL PRACTITIONER COMPLETING ASSESSMENT:

Print Name: _____________________________________ 
Signature/Credential: _____________________________________

TIME OF COMPLETION: ___________________AM/PM

Review of the In-Depth Assessment

Check Box

I concur with this In-Depth Assessment and the provisional diagnosis. □

I do not concur. The following alternative treatment recommendations are being made. □
APPENDIX B:

PTSD Self-Assessment Scale

Name: ___________________________ Date: ______________________

INSTRUCTIONS TO PATIENT: Below is a list of problems and complaints that people sometimes have in response to stressful experiences. Please read each one carefully, put an X in the box to indicate how much you have been bothered by that problem in the past month.

<table>
<thead>
<tr>
<th></th>
<th>Not at all</th>
<th>A little bit</th>
<th>Moderately</th>
<th>Quite a bit</th>
<th>Extremely</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Repeated, disturbing memories, thoughts, or images of a stressful experience?</td>
<td>1 2 3 4 5</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Repeated, disturbing dreams of a stressful experience?</td>
<td>1 2 3 4 5</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Suddenly acting or feeling as if a stressful experience were happening again (as if you were reliving it)?</td>
<td>1 2 3 4 5</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Feeling very upset when something reminded you of a stressful experience?</td>
<td>1 2 3 4 5</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Having physical reactions (e.g., heart pounding, trouble breathing,</td>
<td>1 2 3 4 5</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
6. Avoiding thinking about or talking about a stressful experience or avoiding having feelings related to it?  
   1  2  3  4  5

7. Avoiding activities or situations because they reminded you of a stressful experience?  
   1  2  3  4  5

8. Trouble remembering important parts of a stressful experience?  
   1  2  3  4  5

<table>
<thead>
<tr>
<th></th>
<th>Not at all</th>
<th>A little bit</th>
<th>Moderately</th>
<th>Quite a bit</th>
<th>Extremely</th>
</tr>
</thead>
<tbody>
<tr>
<td>9.</td>
<td><em>Loss of interest in activities that you used to enjoy?</em></td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>10.</td>
<td>Feeling <em>distant or cut off</em> from other people?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>Question</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>---</td>
<td>-------------------------------------------------------------------------</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>11.</td>
<td>Feeling emotionally numb or being unable to have loving feelings for those close to you?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12.</td>
<td>Feeling as if your future will somehow be cut short?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>13.</td>
<td>Trouble falling or staying asleep?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>14.</td>
<td>Feeling irritable or having angry outbursts?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>15.</td>
<td>Having difficulty concentrating?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>16.</td>
<td>Being &quot;super-alert&quot; or watchful or on guard?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>17.</td>
<td>Feeling jumpy or easily startled?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>
APPENDIX C:  
PTSD Self-Assessment Scale  
Nombre: ________________________________

(Escala de autoevaluación)

Fecha: ________________________________

INSTRUCCIONES (PACIENTE): En la tabla a continuación hay una lista de problemas y quejas que la gente demuestra en ocasiones como respuesta a experiencias estresantes. Por favor, lea cada una de ellas cuidadosamente y marque con una X el cuadro que indique la severidad con la que usted ha sido afectado/a por ese problema durante el mes pasado.

<table>
<thead>
<tr>
<th></th>
<th>Nada</th>
<th>Un poco</th>
<th>Moderadamente (ni poco, ni mucho)</th>
<th>Bastante</th>
<th>Demasiado</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Repetidos recuerdos, pensamientos o imágenes desagradables de una experiencia estresante.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>2.</td>
<td>Sueños repetidos y desagradables en relación a la experiencia estresante.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>3.</td>
<td>Comportamiento o sentimientos repentinos, como si la experiencia estuviera pasando otra vez (como si usted la estuviera reviviendo).</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Sentir ira y rabia cuando algo le recordó a la experiencia estresante.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
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</tr>
<tr>
<td>4.</td>
<td></td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th></th>
<th>Experimentar reacciones físicas cuando algo le recordó a la experiencia estresante (por ejemplo, el corazón latiendo fuerte, problemas al respirar, sudor)</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>5.</td>
<td></td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th></th>
<th>Evitar pensar o hablar de la experiencia estresante o reprimir sentimientos relacionados con la experiencia.</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>6.</td>
<td></td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th></th>
<th>Nada</th>
<th>Un poco</th>
<th>Moderadamente (ni poco, ni mucho)</th>
<th>Bastante</th>
<th>Demasiado</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th></th>
<th></th>
<th>Evitar actividades o situaciones porque le recuerdan a la experiencia estresante.</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>7.</td>
<td></td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
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<td></td>
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<td>---</td>
<td>---</td>
</tr>
<tr>
<td>8.</td>
<td>Incapacidad de recordar partes importantes de la experiencia estresante.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>9.</td>
<td>Perdida de interes en actividades que usted disfrutaba en el pasado.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>10.</td>
<td>Sentirse distante o separado de otra gente.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>11.</td>
<td>Sentirse emocionalmente entumecido o ser incapaz de sentir amor o cariño hacia seres cercanos.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>12.</td>
<td>Sentir que su futuro será acortado.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>13.</td>
<td>Problemas de sueño (no puede conciliar el sueño o permanecer dormido).</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>14.</td>
<td>Sentirse irritado o tener arrebatos de</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>enojo/ira.</td>
<td></td>
<td></td>
<td></td>
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<td>---</td>
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<td>---</td>
</tr>
<tr>
<td>15.</td>
<td>Tener problemas de concentracion (dificultad concentrandose).</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>16.</td>
<td>Sentirse extremadamente alerta o en guardia constantemente.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>17.</td>
<td>Se asusta facilmente.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>
This questionnaire is designed to measure how much anxiety you are currently feeling. It is not a test so there are no right or wrong answers. Answer each item and carefully and as accurately as you can by placing a number beside each one as follows:

1 = Rarely or none of the time
2 = A little of the time
3 = Some of the time
4 = A good part of the time
5 = Most of all of the time

___ 1. I feel calm.
___ 2. I feel tense.
___ 3. I feel suddenly scared for no reason.
___ 4. I feel nervous.
___ 5. I use tranquilizers or antidepressants to cope with my anxiety.
___ 6. I feel confident about the future.
___ 7. I am free from senseless or unpleasant thoughts.
___ 8. I feel afraid to go out alone.
___ 9. I feel relaxed and in control of myself.
___ 10. I have spells of terror or panic.
___ 11. I feel afraid in open spaces.
___ 12. I feel afraid I will faint in public.
___ 13. I am comfortable traveling on public transportation.
___ 14. I feel nervousness or shakiness inside.
___ 15. I feel comfortable in crowds.
___ 16. I feel comfortable when I am left alone.
___ 17. I feel afraid without good reason.
___ 18. Due to my fears, I unreasonably avoid certain animals, objects, or situations.
___ 19. I get upset easily or feel panicky unexpectedly.
___ 20. My hands, arms, or legs shake or tremble.
___ 21. Due to my fears, I avoid social situations, whenever possible.
___ 22. I experience sudden attacks of panic which catch me by surprise.
___ 23. I feel generally anxious.
___ 24. I am bothered by dizzy spells.
___ 25. Due to my fears, I avoid being alone, whenever possible.
APPENDIX E:

CAS

Este questionario está designado para medir que cantidad de ansiedad usted tiene ahora. No es prueba; no hay malas respuestas. Conteste cada uno con cuidado y lo más correcto que pueda. Ponga el numero al lado de cada uno usando la siguiente clave:

1 = Raro o poco del tiempo
2 = Poco del tiempo
3 = Parte del tiempo
4 = Mucho del tiempo
5 = Todo el tiempo

___  1. Me siento en calma.
___  2. Me siento tenso(a).
___  3. De repente (por ninguna razón) me siento asustado(a).
___  4. Me siento nervioso(a).
___  5. Uso tranquilizantes o antidepresivos para hacerle frente a la ansiedad.
___  6. Me siento confiante sobre el futuro.
___  7. Me siento libre de malos pensamientos (o pensamientos inconscientes).
___  8. Me siento temeroso(a) salir de mi casa solo(a).
___  9. Me siento relajado(a) y que tengo control de mi vida.
___ 10. Tengo ratos de terror o pánico.
___ 11. Me siento temeroso(a) de los espacios abiertos o de estar en las calles.
___ 12. Me siento temeroso(a) de que me voy a desmayar en público.
___ 13. Estoy cómodo(a) viajando por autobús, tren subterráneo, o en tren regular.
___ 14. Me siento nervioso(a) o tembloroso(a) por dentro.
___ 15. Me siento cómodo(a) en muchedumbres, como yendo de compras o en el cine.
___ 16. Me siento cómodo(a) cuando estoy solo(a).
___ 17. Pocas veces me siento temeroso(a) sin razón.
___ 18. Por mis temores, sin razón evito algunos animales, objetos o situaciones.
___ 19. Me pongo aterrorizado(a) inesperadamente.
___ 20. Mis manos, brazos o piernas tiemblan.
___ 21. Por mis miedos, evito situaciones sociales cuando sea posible.
___ 22. De repente experimento ataques de pánico que me sorprenden.
___ 23. Me siento ansioso(a) generalmente.
___ 24. Me molestan mareos.
___ 25. Por mis miedos, evito estar solo(a) cuando es posible.
**APPENDIX F: CES - DEPRESSION SCALE**

**Instructions:** Circle the score (0, 1, 2 or 3) for each statement that best describes how often you felt this way during the past week.

<table>
<thead>
<tr>
<th></th>
<th>Rarely or none of the time (less than 1 day)</th>
<th>Some or a little of the time (1-2 days)</th>
<th>Occasionally or a moderate amount of the time (3-4 days)</th>
<th>Most or all of the time (5-7 days)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. I was bothered by things that usually don't bother me</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>2. I did not feel like eating; my appetite was poor</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>3. I felt that I could not shake off the blues even with help from my family &amp; friends</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>4. I felt that I was just as good as other people</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>5. I had trouble keeping my mind on what I was doing</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>6. I felt depressed</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>7. I felt that everything I did was an effort</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>8. I felt hopeful about the future</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>9. I felt my life had been a failure</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>10. I felt fearful</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>11. My sleep was restless</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>12. I was happy</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>13. I talked less than usual</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>14. I felt lonely</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>15. People were unfriendly</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>16. I enjoyed life</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>17. I had crying spells</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
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<tr>
<td>18. I felt sad</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>19. I felt that people disliked me</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>20. I could not 'get going'</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>
APPENDIX G

CES-D

Instrucciones. Le voy a leer unas frases que describen como usted se podría haber sentido. Favor, digame con que frecuencia se ha sentido de esta manera durante la semana pasada: raramente o ninguna vez; alguna o pocas veces: ocasionalmente o una buena parte del tiempo; o la mayor parte o todo el tiempo.

<table>
<thead>
<tr>
<th>Durante la semana pasada, eso es desde hasta el presente: (fecha)</th>
<th>Raramente o ninguna vez (Menos de un día)</th>
<th>Alguna o poca vez (1-2 días)</th>
<th>Ocasionalmente o una buena parte del tiempo (3-4 días)</th>
<th>La mayor parte o todo el tiempo (5-7 días)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Le molestaron cosas que usualmente no le molestan.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>2. No se sentía con ganas de comer; tenía mal apetito.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>3. Sentía que no podía quitarse de encima la tristeza aun con la ayuda de su familia o amigos.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>4. Sentía que Ud. era tan buena como cualquier otra persona.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>5. Tenía dificultad en mantener su mente en lo que estaba haciendo.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
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<tr>
<td>6. Se sentía deprimida</td>
<td>0</td>
<td>1</td>
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<tr>
<td>7. Sentía que todo lo que hacia era un esfuerzo.</td>
<td>0</td>
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<td>2</td>
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<tr>
<td>8. Se sentía optimista sobre el futuro.</td>
<td>0</td>
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<tr>
<td>9. Pensó que su vida había sido un fracaso.</td>
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<tr>
<td>10. Se sentía con miedo.</td>
<td>0</td>
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<tr>
<td>11. Su sueño era inquieto.</td>
<td>0</td>
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<td>3</td>
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<tr>
<td>Frase</td>
<td>0</td>
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<td>----------------------------------------------------------------------</td>
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<td>12. Estaba contenta.</td>
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<td>13. Hablo menos de lo usual.</td>
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<td>14. Se sintió sola.</td>
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<td>15. La gente no era amistosa.</td>
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<td>16. Disfruto de la vida.</td>
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<td>17. Paso ratos llorando.</td>
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<td>18. Se sintió triste.</td>
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<tr>
<td>19. Sentía que no le caía bien a la gente.</td>
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<tr>
<td>20. No tenía ganas de hacer nada.</td>
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<tr>
<td><strong>Para obtener total:</strong> Sume todos los números a los que hizo un círculo.</td>
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<tr>
<td><strong>Total:</strong></td>
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</table>
APPENDIX H:  
GESS  
Bobbie Fibel & W. Daniel Hale

Please indicate the degree to which you believe each statement would apply to you personally by indicating to the left of the item the appropriate number, according to the following key:

1 = Highly improbable (very unlikely)  
2 = Improbable (unlikely)  
3 = Equally improbable and probable, not sure (maybe yes, maybe no)  
4 = Probable (likely)  
5 = Highly probable (very likely)

In the future I expect that I will
  __ 1.  find that people don’t seem to understand what I am trying to say.  
  __ 2.  be discouraged about my ability to gain the respect of others.  
  __ 3.  be a good parent.  
  __ 4.  be unable to accomplish my goals.  
  __ 5.  have a stressful marital relationship.  
  __ 6.  deal poorly with emergency situations.  
  __ 7.  find my efforts to change situations I don’t like are ineffective.  
  __ 8.  not be very good at learning new skills.  
  __ 9.  carry through my responsibilities successfully.  
 __10.  discover that the good in life outweighs the bad.  
  __11.  handle unexpected problems successfully.  
  __12.  get the promotions I deserve.  
  __13.  succeed in the projects I undertake.  
  __14.  not make any significant contributions to society.  
  __15.  discover that my life is not getting much better.  
  __16.  be listened to when I speak.  
  __17.  discover that my plans don’t work out too well.  
  __18.  find that no matter how hard I try, things just don’t turn out the way I would like.  
  __19.  handle myself well in whatever situation I’m in.  
  __20.  be able to solve my own problems.  
  __21.  succeed at most things I try.  
  __22.  be successful in my endeavors in the long run.  
  __23.  be very successful working out my personal life.  
  __24.  experience many failures in my life.  
  __25.  make a good first impression on people I meet for the first time.  
  __26.  attain the career goals I have set for myself.  
  __27.  have difficulty dealing with my superiors.  
  __28.  have problems working with others.
29. be a good judge of what it takes to get ahead.
30. achieve recognition in my profession.
APPENDIX I:

GESS

Por favor, indique como usted cree que cada declaración sería aplicable a su experiencia personal. Para indicar a la izquierda del artículo el número apropiado, utilice la siguiente clave:

1 = Muy improbable
2 = Improbable
3 = Igual; probable y improbable (No estoy segura).
4 = Probable
5 = Muy probable

En el futuro, espero que yo

___ 1. podré encontrar que la gente no parece entender lo que trato de decir.
___ 2. estaré desanimada sobre mi capacidad de ganar el respecto de otros.
___ 3. seré buena madre.
___ 4. seré incapaz de alcanzar mis metas.
___ 5. tendré un matrimonio lleno de tensiones.
___ 6. trataré mal las situaciones de emergencias.
___ 7. encontraré ineficaz mis esfuerzos de cambiar las situaciones que no me gustan.
___ 8. no seré buena en aprender habilidades nuevas.
___ 9. cumpliré mis responsabilidades con buen éxito.
___ 10. descubriré que lo bueno en la vida pesa más que lo malo.
___ 11. atenderé problemas inesperados con buen éxito.
___ 12. recibiré las promociones que yo merezca.
___ 13. tendré buen éxito en los proyectos que emprendo (tomo a mi mano).
___ 14. no haré contribuciones significante a la sociedad.
___ 15. descubriré que mi vida no está mejorando mucho.
___ 16. otros me escucharán cuando yo hable.
___ 17. descubriré que mis planes no me sirven muy bien.
___ 18. encontraré que no importa con que persistencia trato yo, nada va a resultar en la manera que me gustaría.
___ 19. me atenderé bien a mi misma, no importa en que situacion me encuentre.
___ 20. seré capaz de resolver mis propios problemas.
___ 21. tendré buen éxito en lo que trate yo.
___ 22. tendré buen éxito en mis esfuerzos a la larga.
___ 23. tendré mucho éxito produciendo mi vida personal.
___ 24. sufriré muchos fracasos en mi vida.
___ 25. haré una buena impresión a la gente que me encuentro por primera vez.
___ 26. lograré las metas de la carrera que me he planteado para mí.
___ 27. tendré dificultad en comportarme con mis superiores.
28. tendré problemas trabajando con otras personas.
29. seré buen juez de lo que sea necesario ponerme adelante.
30. realizaré reconocimientos en mi carrera.
APPENDIX: J

Trauma Resolution Center

General Informed Consent and Agreement

Research: I hereby consent to participate in research being conducted by Trauma Resolution Center, Inc. (hereafter called TRC). This treatment consists of Traumatic Incident Reduction (TIR) to reduce the effects of trauma. I understand that my test scores and session records will be subject to study by a few qualified researchers. I also understand that the Medicaid may access my confidential records for audit, reporting and billing purposes.

Benefits and Risks: The treatment has been described to me by TRC personnel. Potential benefits of this treatment are the reduction and/or elimination of symptomatology associated with trauma. A potential risk is that treatment may not be effective in reducing or eliminating symptomatology associated with trauma. Treatment sessions will be held on a weekly basis and the duration of each session will be one or more hours. *I understand that my participation in this service is strictly voluntary and I can stop at any time.*

Confidentially: All information provided to TRC is confidential except if I tell a counselor that I intend to harm myself or someone else or that I know of abuse or neglect of a minor child. Florida state law requires that “any person...who knows, or has reasonable cause to suspect, that a child is an abused or neglected child shall report such knowledge or suspicion to” the state’s central abuse registry (FS 415.504). If am aware of any terrorist activity. Or if I am HIV positive and I am intentionally spreading the virus in order to cause harm to others.

Agreement: In order to obtain the most benefits from treatment, I agree that I will come for sessions well rested and fed, be available for one session per week that will last approximately two hours each and call in advance if I cannot attend a session. *I will not use alcohol, drugs or non-prescribed medication through my treatment at Trauma Resolution Center.*

I understand that information groups are an integral part of the program. I understand that all clients are expected to attend the group about the psychobiology of trauma that is presented monthly. *Domestic Violence clients must attend the 5 group series that cover all aspects of domestic violence as well as the psychobiology.* The groups should be attended prior to beginning individual sessions.

Financial Responsibility: I authorize TRC to release necessary information in discerning the status of claims to any third party payer if necessary. If applicable, Fees for services rendered by TRC will be submitted to the State of Florida, Victim’s Compensation Bureau for payment. If for any reason my application to the Victim’s Compensation Bureau is withdrawn from eligibility (i.e. I recover funds from the perpetrator in a lawsuit or do not cooperate with State of Florida by providing necessary information), I am solely responsible for payment of fees to TRC. If not Covered by existing grants, I may be required to pay fees on a sliding scale based on my income.

I understand that TRC has a waiting list that will directly effect the time in which a counselor will see me. If at anytime I feel that there is a life-threatening emergency I will contact 911 immediately. If I am experiencing a crisis I will contact Switch Board of Miami at 305-358-4357 as they are trained in providing over the phone crisis intervention. I understand that TRC does not and will not under any circumstances provide over the phone crisis intervention.

Trauma Resolution Center has provided me with a Domestic Violence Safety Plan.

<table>
<thead>
<tr>
<th>Date</th>
<th>Client</th>
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<tbody>
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</table>

<table>
<thead>
<tr>
<th>Printed Name of Client</th>
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<table>
<thead>
<tr>
<th>Date</th>
<th>Witness</th>
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</table>
References


Lee, A., Isaac, M., & Janca, Aleksandar, J. (2007). In, Monat, A., Lazarus, R.S.,


