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Using Eye Movement Desensitization and Reprocessing (EMDR) and Compassion-Focused Therapy (CFT) to Support Persons Experiencing Intimate Partner Violence

Lucretzia Appavoo[1]

Abstract

A high prevalence of intimate partner violence (IPV) amongst individuals in Canada, a variety of mental health consequences, and lower quality of life requires a need for effective treatments. This research aims to explore how EMDR and compassion-focused therapy (CFT) together can support and treat individuals who have experienced IPV. A literature review is conducted to examine current and past literature examining the effectiveness of EMDR and CFT for individuals who have experienced IPV. Findings from the literature review show that EMDR is helpful in treating PTSD symptoms and that CFT is helpful in treating components of PTSD and shame in those who have suffered from IPV. A framework is proposed that integrates both compassion-focused and EMDR principles into a single model aimed at treating IPV by targeting PTSD symptoms through EMDR and utilizing a compassion-focused lens and techniques to target shame and guilt. By targeting these two areas, EMDR along with CFT could help in reducing mental health issues after IPV and may increase quality of life.

Keywords: Compassion-Focused Therapy, EMDR, Intimate Partner Violence, PTSD, Trauma

Introduction

According to the World Health Organization (WHO) (2022), intimate partner violence (IPV) is a worldwide issue leading to infringement of fundamental human rights, serious physical and mental health consequences and leading behind in its wake broken relationships and affected children is a form of gender-based violence that describes different forms of harm including emotional, verbal, sexual, financial, religious, and mental abuse caused by a current or former intimate partner or spouse (Government of Canada, 2022). IPV is considered gender-based violence due to its prevalence affecting females more so than males (Government of Canada, 2022). Although domestic violence is a term that is used interchangeably with IPV, the two terms differ in that domestic violence includes harm of one family member on another and usually includes all types of family violence (elder abuse, child abuse) whereas IPV is limited to abuse between intimate partners (American Psychological Association, 1996; Stewart et al., 2021). For the purposes of this article, intimate partners in the context of IPV include spouses, common-law partners or dating partners whether they live together or separately and whether or not sexual intimacy is present. IPV partners can include any gender or sexual orientation andcan include partners who may or may not live together or are sexually intimate together (Government of Canada, 2022).

The prevalence of IPV in Canada is significant, with more than 4 out of 10 women and 1 out of 3 men having experienced some form of IPV in their lifetime according to Cotter (2021). This translates into 6.2 million Canadian women in (where) and 4.9 million Canadian men who have experienced IPV in their lifetime (Cotter, 2021). The prevalence of IPV is higher amongst certain populations including Indigenous women (Heidinger, 2021), LGBTQ2 women (Jaffray. 2021a), LGBTQ2 men (Jaffray 2021b), women with disabilities (Savage, 2021a), and young women (Savage, 2021b).

Survivors of intimate partner violence face serious consequences which include health issues and social and economic problems (Micklitz et al., 2024). IPV experiences could lead to depression, anxiety, PTSD, antisocial personality disorder (APD), and borderline personality disorder (BPD) (Spencer et al., 2019). According to Trabold (2020), therapeutic interventions that are effective for cases of IPV include empowerment-based advocacy and

[1]Master of Counselling, City University of Seattle, Canada.

cognitively focused clinical interventions. Advocacy interventions were rooted in empowerment theory and focused on community referrals, safety planning, and support of the abuse/violence experienced (Trabold, 2020).

Research Question

The purpose of this research is to explore the mental health effects of experiencing IPV, the prevalence of PTSD, shame and guilt as an outcome of IPV, how EMDR and CFT can treat persons who have experienced IPV, and to identify how EMDR therapy and CFT can be used together to treat individuals who have experienced IPV. This article will examine the following research question: *how can eye movement desensitization and reprocessing (EMDR) and compassion-focused therapy (CFT) support persons experiencing intimate partner violence (IPV).*

Theoretical/Conceptual Framework

The theoretical framework utilized in this article to explain IPV is the Control Balance Theory. The Control Balance Theory explains that violence–whether it be emotional, mental, physical, or sexual originates from the need to control and abuse occurs if there is an imbalance of control in a person's environment (Tittle, 1995). Control Balance Theory suggests that perpetrators of IPV enact violence against their victims because they are in control of their environment and that their victims are required to be contained by the boundaries of control or else it will upset the balance of power which is a threat to perpetrators (Cassidy, 1995). Additionally, the Control Balance Theory could explain why blaming the victim often occurs; due to the balance of power that is prominent in our patriarchal society (Tittle, 1995). Although this theory is historical, it is in line with the Duluth Model that is used today to explain why individuals abuse others (Bohall et al., 2016).

Methodology

Materials

The literature used for this article was collected from online databases. These databases included City University of Seattle library database and the Google Scholar database. Filters that were used included the type of literature specifically, journals and the date of publication from 2019 to present. Results that did not offer relevant literature after filters were utilized were then searched without the year of publication filter.

Methods

A comprehensive review of relevant research including meta-analyses, literature reviews, quantitative research, and qualitative research was conducted. The key terms used to find s included "intimate partner violence and trauma", "intimate partner violence and PTSD", "IPV and EMDR", "IPV and CFT". These topics were searched separately, then in combinations to yield specific information on the topic.

Contribution to Field

Although there is research examining the topic of mental health consequences of IPV, there is less literature that examines psychotherapy treatments for victims of IPV and even less research that combines CFT and EMDR that evaluates whether these two therapies can collectively treat and improve symptoms for persons who have experienced IPV (Shayani et al., 2022). This gap in literature, despite the prevalence of IPV in Canada, demonstrates the continued need for this article to be conducted. Psychologists require accurate information and practical, evidence-based, treatment strategies to help clients who suffer from mental health concerns following IPV (Canadian Psychological Association [CPA], 2017). Psychologists also require information regarding treatment and support for individuals who have experienced IPV to reduce the risk of severe mental health issues, substance use, or self-harm and/or suicide to improve quality of life and to reduce harm in clinical practice (CPA, 2017). This article aims to address the information gap regarding treatment following IPV and explore the potential of EMDR and CFT together as a practical treatment. This article also aims to raise awareness of the epidemic of IPV in Canada and the lack of knowledge and research on the topic of IPV through focus and education on the topic of IPV and the statistical prevalence of the issue within different populations.

This research will contribute to knowledge acquisition within the psychology field by providing a framework of a treatment that incorporates CFT and EMDR as a treatment that psychologists will be able to utilize in practice for their clients who have experienced IPV.

Literature Review

The Traumatic Nature of IPV

The definition of IPV that is used in this article is also the definition used by the Canadian government which defines IPV as behavioural patterns in an intimate relationship (spouse or significant other) that causes harm to a person's physical/sexual being or psyche and can include physical abuse, sexual coercion, emotional/verbal abuse and controlling behaviours (Statistics Canada, 2022). This definition encompasses a wide variety of interpersonal violence including emotional, mental, physical, and sexual components.

When looking at whether IPV can be traumatic, studies have shown that individuals who have experienced IPV experience symptoms of PTSD. For example, according to Cotter (2021), in a self-reported survey focusing on the Canadian population examining the prevalence, constitution, and effects of IPV amongst men and women, 13% of women had symptoms consistent with symptoms of PTSD, whereas 6% of men had symptoms of PTSD, demonstrating a large proportion of women experiencing PTSD symptoms due to IPV. Additionally, this study identified that women who experienced IPV at least once in the past 12 months had symptoms of PTSD but that women who experienced IPV on a more chronic basis whereby they experienced IPV more than once a month, increased their PTSD experiences by approximately 30% (Cotter, 2021). The results of this study suggest the traumatic impact of IPV as well as the correlation of increased frequency of IPV with higher chance of experiencing PTSD symptoms (Cotter, 2021).

The study by Cotter (2021) utilized the Primary Care PTSD Screen (PC-PTSD) instrument which is a front-line assessment tool to determine if individuals need to be referred to further psychological treatment for PTSD (Cotter, 2021). This instrument is a 20-item self-report questionnaire examining if individuals display re-experiencing, numbing, avoidance and hyperarousal however is unable to diagnose PTSD rather, it is used for suspecting the presence of PTSD and identifying key areas of the disorder according to the DSM-5 (Cotter, 2021). Additionally, according to Kagee et al. (2021) and deRoon-Cassini et al. (2019), this instrument demonstrated high reliability and validity in trauma participants and is one of the most commonly used and researched PTSD symptom screeners used in healthcare. The study defined IPV as psychological violence, physical violence, and sexual violence which encompasses all components of IPV described by the Canadian government (Cotter, 2021). A limitation of this qualitative study was the use of self-report and thus subjected to the possibility of bias from participants. Strengths of the study include the validity of the PC-PTSD-5 tool and high levels of diagnostic accuracy (Bovin et al., 2021). The results of this study are important for psychologists since it demonstrates that clients who have presenting concerns of IPV may have to be assessed for PTSD and that treatment of PTSD and trauma-informed care may be required.

The following study rather than utilizing a self-report measure, utilized a rating questionnaire. The study was a longitudinal study by Ford-Gilboe et al. (2022) which examined changes in women's mental and physical health after leaving an abusive partner. The study analyzed trajectories of depression and PTSD as well as chronic pain over a 4-year period affected by IPV (Ford-Gilboe et al., 2022). The participant pool included a sample of 309 English-speaking, Canadian women between 18–65 of age, from British Columbia, Ontario, and New Brunswick. (Ford-Gilboe et al., 2022). IPV severity was measured using the Index of Spouse Abuse which is a 30-item questionnaire in which participants report the frequency of abusive acts (consisting of emotional, physical, and mental abuse consistent with the Canadian government's definition of IPV) they experienced on a scale ranging from never (0) to very frequently (4) (Ford-Gilboe et al., 2022). PTSD symptoms were examined using the Davidson Trauma Scale which is a 17-item scale that assesses symptoms according to the DSM-IV and evaluates frequency of symptoms and severity ranging from 0 (not at all/not at all distressing) to 4 (every day/distressing every day) (Ford-Gilboe et al., 2022). The Davidson Trauma scale has also demonstrated high validity, internal consistency, and test-retest reliability (Mason et al., 2013). The results showed that although women's health improved significantly over time, PTSD, depression, and chronic pain levels remained at the end of the 4-year period thus demonstrating correlation between IPV and long-term PTSD (Ford-Gilboe et al., 2022). The study's strengths included the utilization of reliable and valid instruments as well as a diverse participant pool that included Canadian women that varied in age, level of education, and socio-economic status (Ford-Gilboe et al., 2022). Weaknesses of the study included a lack of information on the ethnic background of the participants which would help in identifying if the study has cross-cultural reliability and the possibility of confounding variables such as other life events and stressors post-separation (such as harassment from the partner, stalking, financial difficulties, changes in lifestyle, etc) leading to PTSD symptoms. Another weakness of the study includes the Davidson Trauma Scale due to studies on the reliability and validity being more than 10 years old and a lack of studies examining its validity and reliability in more recent times (Ford-Gilboe et al., 2022).

The following study also examined the emotional and mental effects of abuse on women and measured symptoms of PTSD. This study by Yalch & Rickman (2022) found a correlation between IPV and PTSD. Yalch & Rickman (2022) examined the effects of physical, sexual, and psychological IPV on PTSD symptoms and substance abuse in 793 women from the United States. The researchers found that the cumulation of all three types of IPV were correlated closely with diagnostic levels of PTSD (Yalch & Rickman, 2022). The study removed participant responses that were extreme to ensure accuracy of results was maintained (Yalch & Rickman, 2022). Participants were on average 32 years old and were mostly Caucasian (78%), followed by Black (8%), Asian (6%), multiracial (6%), and other (3%) (Yalch & Rickmanwe, 2022). Measures that were utilized included Severity of Violence Against Women Scale for measuring IPV and PTSD Checklist for DSM-5 to measure PTSD symptoms (Yalch & Rickman, 2022). This study highlighted cultural similarities of participants which supports generalization of results in the exploration of this research question. Strengths of this study included a large participant pool which is effective for reducing sampling bias through reliable, valid, and highconsistency instrument measures thus providing a more accurate understanding of the link between PTSD and IPV (Eryalçin et al., 2020; Kurvers et al., 2021; Roberts et al., 2021). Weaknesses of the study included the inability to generalize the findings to other ethnicities due to the participant pool being majority Caucasian and the lack of specification of the type of intimate relationship that participants experienced with IPV which could reveal more information and a more nuanced result. The results of this study are valuable for psychologists since it offers information on the type of mental health concerns that individuals who have experienced IPV may struggle with, thus psychologists are better able to determine appropriate treatments such as psychotherapies that are effective for treating PTSD symptoms.

Another study by Sabri (2021) found a positive correlation between IPV and both mild and moderate symptoms of PTSD. Sabri (202) conducted the study with the goal of examining the correlation of IPV with depression and PTSD severity amongst married females. The study utilized a definition of IPV according to the Composite Abuse Scale (CAS) which included harassment, physical violence, emotional violence, and sexual violence (Sabri, 2021). The study was a cross-sectional analysis conducted at the Mansoura University Hospitals (MUH) from November 2020 to April 2021 and utilized 100 female employees at the Mansoura University Hospitals (Sabri, 2021). Inclusion criteria for participants in this study included being female, married, between the ages of 25–45, and no past or family history of depression before marriage. The results of the study show that the highest prevalence consisted of mild PTSD (41.1%), 22.2% had severe PTSD, and 11.1% had moderate PTSD; thus, there was a positive correlation between IPV and PTSD symptoms (Sabri, 2021). This study helps to provide knowledge to psychologists that women are likely to suffer from mild PTSD symptoms to IPV thus psychologists could ensure that they are assessing for PTSD symptoms with their clients who come in with similar presenting concerns.

The instrument used in the Sabri (2021) study was the Composite Abuse Scale (CAS) which has been shown to have good reliability, validity, and consistency (Vasiliauskaitė & Geffner, 2021). Another strength of the study included the participant pool which is a good size to reduce sampling bias. A weakness of the study consisted of the participant pool being primarily Middle Eastern thus leading to a lack of generalizability to other populations and regions due to differences in culture, stigma, gender roles, etc. that could influence variability of results. Another weakness of the study included the exclusion criteria which fails to state that participants should not have a history of PTSD prior to the study; this lack of exclusion criteria denotes the possibility of skewed results due to past history of trauma from factors unrelated to IPV. The results of this study are important for the psychology field to be aware of the higher likelihood of severe PTSD due to chronic IPV so that psychologists are able to curate their treatment plans accordingly.

Similarly to the previous study by Sabri (2021), the study by Cannon et al. (2023) highlighted the substantial (60%) prevalence of PTSD symptoms in a sample of women who had experienced IPV in a rural region of Louisiana during the COVID-19 pandemic. This study involved interviewing 77 females who have experienced IPV who have filed restraining orders. IPV survivors were individually interviewed to assess their self-reported levels of perceived stress, resilience, potential PTSD, COVID-19 experiences, and sociodemographic characteristics (Cannon et al., 2023). Results were divided into two categories, the first category being non-PTSD symptoms and the second category being the probability of PTSD (Cannon et al., 2023). Results suggested that the majority of participants reported PTSD (Cannon et al., 2023). Around 57% of participants scored in the range of likely having PTSD on the PC-PTSD-5 thus demonstrating a link between IPV experiences and PTSD (Cannon et al., 2023). The strengths of the study included usage of an instrument measure that is reliable and valid with victims/survivors of IPV (Lathan et al., 2023). Weaknesses included possible confounding variables such as the COVID-19 pandemic possibly perpetuating or worsening PTSD symptoms. Another weakness was the participant pool which did not state the ethnicity or specific demographic information such as occupation or age which would be important in understanding the effects of IPV-

related PTSD within specific populations. The results of this study are important for psychologists since it indicates that trauma work and PTSD assessment would be helpful with treatment for individuals who have experienced IPV.

In summary of the research explored of the traumatic nature of IPV, as demonstrated by Cotter (2021), Ford-Gilboe et al. (2022), Yalch & Rickmanwe (2022), Sabri (2021), and Cannon et al. (2023), PTSD is correlated with experiences of IPV. This is likely due to the lack of safety, loss of control, and helplessness that is felt during IPV (Karakut, 2014). Similarities of the research in this section include the majority of the studies focusing on female victims of IPV and utilization of self-report questionnaires when examining IPV. This demonstrates a need for more studies examining the effects of IPV on males and the need for varied instruments to measure IPV. The major difference within these studies is the variation of prevalence of individuals who developed PTSD symptoms after experiencing IPV which ranged from 13% to 60% The research within this section revealed insights such as the occurrence of PTSD symptoms after experiencing IPV and that chronic IPV may be representative of more symptoms of PTSD compared to single incidents.

EMDR as a Treatment for Trauma

This section will examine the effectiveness of Eye Movement Desensitization and Reprocessing (EMDR) as a treatment for IPV-related trauma. EMDR is a type of psychotherapy that utilizes bilateral stimulation to reprocess traumatic memories, thus reducing traumatic symptoms. The study by Schwarz et al. (2021) examined trauma related to IPV (described as sexual violence or repeated acts of violence) through a mixed-methods study that utilized a participant pool of 41 women that were 18 years or older. The participant pool, which lacked significant ethnic diversity, were recruited from a nonprofit community agency offering therapy and identified as African American (n=7), Asian (n = 1), Biracial (n = 1), White (n = 22), and Latina (n = 10) (Schwarz et al., 2021). Quantitative assessment of depression, anxiety, and PTSD were utilized using Beck Depression Inventory-II, Generalized Anxiety Disorder–7, PTSD Checklist (PLC-5) for DSM–5, and the Outcome Questionnaire after eight sessions of EMDR (Schwarz et al., 2021). These assessment tools have demonstrated reputable results according to Blanchard (2023), Dhira (2021), and García-Batista (2018). Results showed significant improvement in depression, anxiety, and PTSD (Schwarz et al., 2021). Qualitative analysis was also conducted through semi-structured interviews after which EMDR was found to improve assertiveness, self-control, functionality, and self-acceptance (Schwarz et al., 2021). A challenge of this study was the small participant pool which leaves room for sampling bias. Another weakness is the lack of generalizability due to the participant pool being majority Caucasian thus there is a lack of generalizability with individuals of ethnic minorities. The strength of this study included reliability and validity of the instrument measures used in the analysis portion of the research (Wang & Gorenstein, 2021; Dhira et al, 2021; Geier et al., 2019). Another strength of the study included usage of both qualitative and quantitative analysis thus examining the research question through a more holistic lens and creating a more nuanced view of the results. This study demonstrated that EMDR can be used to effectively treat PTSD symptoms in individuals who have experienced IPV by decreasing symptoms such as depression, anxiety, and PTSD through the use of bilateral eye movements. The results of this study are valuable for psychologists so they are aware of the benefits of EMDR on clients who have experienced IPV and so that they can take steps to become trained in this type of psychotherapy so as to help more clients. Furthermore, the results of this study in combination with other studies in this section demonstrated the common theme of EMDR being effective in treating symptoms of PTSD within individuals who have experienced IPV.

Similarly to the study Schwarz et al. (2021), the following study examined sexual violence as the type of IPV in relation to symptoms of post-traumatic stress (symptoms of PTSD according to DSM-5-TR). The study by Covers et al. (2021) examined the effectiveness of EMDR therapy in reducing symptoms of PTSD for victims of rape–a category of IPV as described earlier in this article. The study defined rape as vaginal, oral, or anal penetration without consent. The study was a randomized controlled trial with a participant pool of 57 who were assigned to two sessions of EMDR therapy or "regular" treatment (watchful waiting) (Covers et al., 2021). Participants experienced sexual violence (rape) within 14 and 28 days before starting treatment (Covers et al., 2021). Psychological symptoms of the participants were assessed at pre-treatment, post-treatment, 8 weeks after being raped and 12 weeks after being raped (Covers et al., 2021). The results of the study found that EMDR was effective in reducing PTSD symptoms and that EMDR was more effective than "watchful waiting" (wait and see approach) in reducing anxiety and dissociative symptoms. However, the reduction of anxiety and dissociative symptoms returned after some time (Covers et al., 2021). The strengths of this study included the study's use of a randomized control trial which is simple yet demonstrates clear results and differences in treatment categories. Another strength was the various assessments after EMDR treatment which gave way to a more accurate examination of effects of EMDR over time. A weakness of the study constitutes the small participant pool, a larger participant pool may have been more effective in identifying

effects of EMDR on IPV and possibly less chance of sampling bias. Another weakness was the time frame in which participants experienced sexual violence since it does not align with the diagnostic criteria for PTSD which states that symptoms should be experienced for at least one month. The results of this study relate to the research question by demonstrating the effectiveness of EMDR therapy as a treatment for individuals suffering from PTSD symptoms particularly–the symptom of dissociation–after recently experiencing IPV. This study is important to psychologists since the information provided could encourage them in choosing EMDR therapy for their clients who are experiencing dissociation after IPV especially in relation to recent experiences of sexual violence.

There is limited research highlighting the effectiveness of EMDR in reducing PTSD symptoms in individuals who have experienced IPV compared to research examining the effectiveness of EMDR for trauma unrelated to IPV(Schwarz et al., 2019). Despite this, the limited studies have found effectiveness in EMDR treating PTSD symptoms in individuals with intimate partner violence (Schwarz et al., 2019). However, despite these challenges, the World Health Organization (WHO) has recognized EMDR as an effective and evidence-based therapy for the treatment of PTSD in children, teenagers, and adults due to the extensive research noting the effectiveness of EMDR for PTSD (World Health Organization, 2013).

CFT as a Treatment for Trauma

Compassion-focused therapy (CFT) is a recently developed form of psychotherapy that was founded by Paul Gilbert (2000) in response to the recognition that individuals, especially those who experience high levels of shame and self-criticism, struggle to initiate and maintain positive, self-encouraging, and kind inner voices when participating in traditional therapy (Leaviss & Uttley, 2015). Thus, CFT was created for individuals who struggle with mental health problems linked to high levels of shame and self-criticism (Leaviss & Uttley, 2015). The goal of CFT is to help individuals incite compassionate feelings towards themselves and a compassionate inner voice (Leaviss & Uttley, 2015). Furthermore, CFT defines compassion as sensitivity to suffering within oneself and others in addition to a dedication to alleviating and preventing such suffering; this definition comes from the Buddhist religion (Stuntzner, 2017). The strengths of CFT include growing evidential support for the effectiveness of CFT for a variety of mental health concerns such as anxiety, depression, eating disorders, and PTSD (Ashfield, Chan & Lee, 2021) and the ability of CFT to gain skills in adaptive regulation which increases the drive to process traumatic memories essential for treatment success (Brewin, 2014). When relating CFT to the research question, since individuals who have experienced IPV tend to endure shame and self-blame as a result of violence they have experienced and IPV includes emotional violence which also encompasses shaming, blaming, and criticizing it is possible that CFT would be effective in treating the effects of IPV (Statistics Canada, 2022; Camp, 2022).

There exists research exploring the intersectionality of CFT, trauma and IPV. The study by Daneshvar et al. (2022), examined the effects of CFT on avoidance, meaning of life (changes in cognition and beliefs), and sense of coherence (dissociation). Avoidance, meaning of life, and sense of coherence, are all components of PTSD according to the DSM 5-TR-in women suffering from PTSD due to IPV (American Psychological Association, 2022). The study utilized a participant pool of 42 women whowere divided randomly into two groups: experimental and control (Daneshvar et al., 2022). The participants completed questionnaires measuring experiential avoidance, meaning-of-life, and sense of coherence as pre-test measures (Daneshvar et al., 2022). The experimental group received eight sessions of CFT whereas the controls did not receive any treatment (Daneshvar et al., 2022). Afterwards, participants completed the questionnaires again after which, the data was analyzed using one-way repeated measures MANOVA (Daneshvar et al., 2022). Results showed that participants in the experimental group had a reduction in post-test scores of experiential avoidance, a significant rise in the level of meaning-in-life, and no change in sense of coherence compared to the controls (Daneshvar et al., 2022). The result of this study demonstrates that CFT can be effective in treating components of PTSD; particularly avoidance, negative beliefs, and changes in belief systems in individuals who have experienced IPV.

The challenges of this study included having a small participant pool that led to sampling bias and a participant pool that consisted of Iranian women thus leading to a lack of generalizability to other ethnic backgrounds, and a lack of diagnostic tools to examine PTSD rather than the use of self-report and review of clinical medical records. Strengths of the study included a simple and easy-to-follow procedure using a one-group post-test design and reduction of confounding variables by excluding comorbid diagnosis such as major depressive disorder. As indicated in the literature review, avoidance and changes in cognitive beliefs have correlations with IPV experiences. Thus, this study demonstrated a correlation that CFT can alleviate certain components of PTSD–most notably–avoidance and negative changes in cognition and beliefs (Daneshvar et al., 2022). The insights gained from his study are valuable for

psychologists to know since it provides them with modalities to use with clients that are likely to be effective in treating PTSD symptoms in individuals who have experienced IPV.

The following research identified results that demonstrate the effectiveness of CFT for individuals experiencing PTSD who have past experience of PTSD. The cross-sectional survey study was conducted by Cabrera et al. (2021) with a participant pool of 141 female and male survivors of IPV (83.7% female) that were on average 19 years old and of which 69.5% were Caucasian. The study was conducted via anonymous, internet-based study (Cabrera et al., 2021). Participants completed measures that assessed for trauma history, self-compassion, trauma-related shame, and valued living (Cabrera et al., 2021). Results indicated significant effects of indirect lack of compassionate self-responding relating to trauma-related shame and blocking of values (Cabrera et al., 2021). Thus, this study identified the role that compassion plays in quality of life and recovery in cases of trauma leading to the conclusion of the value and need for CFT for treating IPV-induced PTSD (Cabrera et al., 2021). The weaknesses of this study included a lack of ethnic and age-related diversity in the participant pool leading to inability to generalize to other populations. This study gives insight into this research question by identifying the role that CFT could play in treating mental health of individuals having experienced IPV which can shed light on how EMDR can treat the aspects that CFT may not be ideal to treat.

Another study by Valdez & Lilly et al. (2015), examined measures of post-traumatic stress (according to the DSM 5) and self-compassion in 63 female trauma survivors. Participants completed a trauma-specific interview which consisted of discussing their trauma after which they completed measures of anxiety and affectivity (the level of ability experiencing emotions) (Valdez & Lilly et al., 2015). The study found a correlation between greater self-compassion and less post-traumatic stress symptoms (Valdez & Lilly et al., 2015). The study also found that increased self-kindness and mindfulness was linked to less anxiety and negative affectivity in the controls (Valdez & Lilly et al., 2015). In the analytic processing condition, greater self-kindness correlated with less negative affectivity, whereas mindfulness correlated with less anxiety and negative affectivity and greater positive affectivity (Valdez & Lilly et al., 2015). A challenge of this study included having a small sample size which may lead to sampling bias and difficulty generalizing results to bigger and more diverse populations. The results of this study demonstrated that it can be correlated that CFT is beneficial for treating components of PTSD consisting of anxiety and negative emotions which psychologists can utilize in therapy for clients that have PTSD and have experienced IPV.

In another study by Bhuptan & Messman (2021), the researchers examined the effect of self-compassion on PTSD, depression, and shame due to sexual violence, a component of IPV, using path analysis in MPlus version 7.3 (Bhuptan& Messman, 2021). The study used a participant pool of 305 college women who completed online surveys examining rape, self-compassion, rape-related shame, PTSD (DSM 5 version), and depression (Bhuptan & Messman, 2021). Results indicated that self-compassion was negatively correlated with shame related to IPV, which was positively associated with PTSD and depression (Bhuptan & Messman, 2021). The study also identified the positive effect of self-compassion on PTSD and depression caused by rape-related shame (Bhuptan & Messman, 2021). Shortcomings of this study included only focusing on a narrow view of sexual violence rather than other forms of IPV and failing to define specificities of shame that victims experienced such as victim blaming, self-responsibility, body shame, etc. To conclude, the findings confirmed the role of self-compassion to reduce rape or IPV-related shame thus reducing PTSD and depression symptoms and confirming the advantage of incorporating CFT when treating IPV-induced trauma. Psychologists would have to be careful not to generalize these findings to other forms of IPV such as emotional abuse so as to minimize the risk of treatment not being effective if the psychologist were to address shame in victims with other types of IPV.

When exploring how PTSD manifests in individuals who are victims of IPV, research explored the role of self-compassion in PTSD due to IPV (Crapolicchio et al., 2021). The study by Crapolicchio et al. (2021), explored self-criticism felt by women who have experienced IPV and who exhibit DSM 5 PTSD symptomology (Crapolicchio et al., 2021). This study relates to the research question since it examines if women experience self-criticism as a result of their experiences with IPV thus by examining this idea, researchers and psychologists can determine whether CFT would be effective in supporting individuals with these experiences. The study examined self-acceptance and self-efficacy as the moderating factor. Results found that self-criticism was indirectly associated with greater PTSD symptomology caused by lower levels of self-acceptance (Crapolicchio et al., 2021). The correlation was indirect since the effect was only seen with individuals who had low self-efficacy (Crapolicchio et al., 2021). The result of this study provides an alternate view of the effect of CFT on PTSD; demonstrating a variability of the link between components of self-compassion and trauma caused by IPV and arguing against the idea of the effectiveness of CFT for IPV-induced PTSD (Crapolicchio et al., 2021).

Discussion

Limitations

There were several limitations that were identified in the studies from the literature review. The first limitation is the varied results of studies examining the traumatic nature of PTSD. For example, the study by Cotter (2021) determined that 13% of women had symptoms consistent with PTSD and 6% of men had symptoms of PTSD after experiencing IPV. These results are in contrast by Sabri (2021) in which results found mild PTSD for 41.1% of participants, 22.2% for severe PTSD, and 11.1% for moderate PTSD after IPV. More so, the study by Cannon et al. (2023) found an even higher prevalence of 60% of participants experiencing PTSD symptoms after IPV. Thus, this variation of results, although there appears to be a possibility and prevalence of PTSD amongst individuals who have experienced IPV, there appears to be a significant variation of the prevalence of PTSD. Further research would have to be conducted to examine what factors are causing these variations and whether these factors are due to biological or individual factors, gender, environment, types of IPV, severity of IPV, frequency of IPV, etc. Identification of variation factors would be helpful in offering valuable information to psychologists who can then determine risk of mental health issues with their clients, can provide information on chosen treatments, and can implement prevention strategies.

Finally, the lack of diversity of participant pools utilized by studies provides issues with external validity. External validity examines whether the results of a study can be generalized to other contexts and/or populations (Egger et al., 2008). Random sampling is representative of the population, demonstrating good external validity (Andrade, 2018). Studies that utilize sociodemographic limitations, that exclude theseriously ill and suicidal individuals, individuals with other severe mental health concerns such as personality disorders or substance abuse, or studies with short-term examination may not be generalizable to other populations or contexts (Andrade, 2018). The studies in the literature review tend to focus on Caucasian individuals along with female individuals. The oversaturation of Caucasian female participants causes a lack of generalizability of results to other populations, ethnic backgrounds, genders, and contexts.

Appreciations

Appreciations are defined as utilizing instrument tools that have been proven to be reliable, consistent and valid. Another appreciation of the literature review is that certain studies utilized mixed research methods that are both qualitative and quantitative. For example, the study by Schwarz et al. (2021) utilized both quantitative research through the use of questionnaires and quantitative research through interviews of participants. This method of integrating both types of methodologies provides an improved understanding and a more holistic view of the effects of IPV on individuals' mental health by identifying quantitative results along with conceptual themes.

Highlights and Insights

The highlights and insights from the literature review include the presence of PTSD symptoms for a substantial proportion of women and men who have experienced IPV. Although results from studies demonstrate variability in the severity of PTSD symptoms, PTSD still appears to be a consequence of IPV along with other mental health concerns. The literature review also highlighted the effectiveness of EMDR in treating PTSD symptoms such as dissociation, anxiety, and depression in victims who have experienced IPV. Another insight from the literature review is the effectiveness of CFT in treating individuals who have experienced IPV. In particular, CFT is effective in targeting shame, traumatic avoidance, negative changes in cognition and beliefs, and dissociation.

Current Literature on Integration of CFT and EMDR

The literature that examines and proposes a framework for the integration of CFT and EMDR includes Beaumont & Hollins Martin (2013), who proposed the integration of compassion in resource installation. The model by Beaumont & Hollins Martin (2013), proposed the utilization of compassionate mind training as a resource during EMDR to reduce feelings of guilt and shame associated with traumatic loss. Compassionate mind training strategies that were utilized included compassionate imagery, compassionate letter writing, mindful breathing exercises, and compassion-focused homework that were incorporated into EMDR phases (Beaumont & Hollins Martin, 2013). Beaumont & Hollins Martin (2013) also assessed the effectiveness of their proposal and found that reductions in anxiety, depression, post-traumatic stress, and low self-compassion occurred after treatment. The strengths of this model include proven effectiveness according to the case study with the subject and measures reporting lowered levels of anxiety, negative cognitions, and somatic PTSD symptoms and flexibility with regard to compassion-focused techniques that could be incorporated into the EMDR. The weakness of this model includes a lack of insight

regarding long-term effects and the effectiveness of this integrated psychotherapy for larger and more varied populations.Despite the historical nature of this model, the relevance of this model is still important today since it offers established and evidence-based compassion-focused techniques and EMDR that are still utilized today (Daneshvar, 2022; Schwarz, 2021).

Another study by Whalley & Lee (2023), proposed the collaboration of CFT and EMDR by focusing on increasing desensitization of traumatic memories through EMDR using compassion-focused approaches. Whalley & Lee (2023) explained that bringing a traumatic memory to a compassionate mindset was likely to be more productive for recovery and will enable more adaptive information processing compared to bringing a traumatic memory to a threatened mindset. The proposal stated that the clinician should make an effort to develop the client's ability to engage imagery so that the client will be able to bring up images and emotions during traumatic memory processing (Whalley & Lee, 2023). This protocol integrated resource installation, window of tolerance, and reciprocal inhibition with the goal of preparation which includes giving information, compassion imagery exercises and techniques for merging a compassionate mindset into desensitization phases of EMDR (Whalley & Lee, 2023). Whalley & Lee (2023) stated that the client's ability to connect with compassion for themselves will be influenced by their past experiences of receiving care. Whalley & Lee (2023) also explained that clients will vary by how easily they are able to bring this self-compassion to the surface by remembering past experiences in which they felt soothed which will enable them to quickly incorporate this skill into EMDR desensitization while other clients may have more trouble and will need imagery exercises. The insights from this study relate to the research question since it offers valuable information on how past researchers have integrated EMDR and CFT into the desensitization and resource phases of EMDR which could be utilized by psychologists in the field and for individuals who have PTSD and have experienced IPV.

Another study proposes the integration of CFT into all 8 phases of EMDR with the goal of increasing the effectiveness of EMDR with clients suffering from shame (Kennedy, 2014). Kennedy's (2014) framework proposes integrating a therapeutic alliance, resourcing of a compassionate self, compassionate prompts from the psychologist, and compassionate reframing and bodywork.

Inclusion Criteria for Implementation of New Framework

Inclusion criteria for the implementation of CFT and EMDR as an integrated treatment for individuals who have experienced IPV include clients who have shame, self-blame, and self-criticism along with PTSD symptoms or who have experienced victim-blaming along with PTSD symptoms after IPV. This framework could also be used for clients who are experiencing depression and anxiety as a result of IPV.

Framework

This proposed novel framework called Compassion-Integrated EMDR (CI-EMDR) is described as an integration/collaboration of CFT and EMDR therapy to support individuals who have experienced IPV with differences to previous frameworks seen in current and past literature. CI-EMDR intersects with my research question by offering a potential therapeutic modality that aims to treat specific features of mental health concerns from experiences with IPV specifically, PTSD, shame, self-blame, and self-criticism. I believe that CI-EMDR could be an effective co-morbid therapy for IPV since it targets areas that individuals with IPV experience struggle with including symptoms of PTSD and problems with shame, self-blame, and self-criticism (Cotter, 2021; Crapolicchio et al., 2021; Bhuptan & Messman, 2021).CI-EMDR is a proposed therapeutic modality that aims to integrate compassion-focused theory into EMDR. The goal of CI-EMDR is to target and reduce symptoms of EMDR, shame, self-criticism, and self-blame while also implementing compassionate cognition and beliefs following experiences of IPV. Psychologists who have completed training in CI-EMDR and are certified in EMDR through an EMDRIA-approved program would be able to utilize this therapeutic modality. The components of this framework include establishing trust and a therapeutic alliance, implementation of CFT, implementation of EMDR, reintroduction of CFT, and a final pass of EMDR to eliminate remaining PTSD symptoms.The procedure of this framework is as follows:

Establish Trust and Therapeutic Alliance

This stage is part of EMDR and CFT and will occur after intake and assessment. The psychologist will utilize compassion, empathy, validation, affirmation, and non-judgmentalism to create trust with the client as well as, to build a therapeutic alliance with the client. The compassion that the psychologist enacts on the client serves also as healthy modelling so that the client will begin to see themselves with compassion. The psychologst, as part of the ethical code

stating respect for the dignity of persons, when hearing the individual's story should react with compassionate statements and should refrain from any shaming, victim-blaming, or critical statements (CPA, 2017).

Implementation of CFT

CFT techniques will be utilized on the client to reframe negative beliefs such as victim-blaming, self-blame, shame, and inappropriate responsibility of IPV that the client may have towards themself. Psychoeducation on the effects of shame, self-criticism, and self-blame after IPV, how IPV aims to make a victim feel about oneself, and how self-compassion can alleviate such shame, will also be conducted so that the client becomes aware of the value of changing one's own negative beliefs. At this stage of the framework, CFT may need more timealtering negative beliefs and shame for the client due to these emotions being held deeply and subconsciously. The goal of this stage is to start implementation of compassion within the client that will continue throughout therapy.

EMDR to Minimize PTSD Symptoms

After CFT is conducted to begin reframing the client's mindset into one that is more self-compassionate, EMDR will be utilized with the goal of reducing traumatic PTSD symptoms that may be affecting the client's quality of life and ability to function in social, educational, familial and/or occupational areas. Thus, this stage will focus on regulating the client's nervous system and resolving any somatic symptoms related to the client's experience of IPV. The goal of this stage is to reduce symptoms enough so that the client is able to maintain functionality in their day-to-day life and to resolve severe symptoms such as dissociation, flashbacks, severe depression, etc. Additionally, EMDR will be used to process the clients' negative changes in beliefs that are present in PTSD (American Psychological Association, 2013).

The assessment and installation phases of EMDR will be altered to include CFT. Specifically, positive cognitions that will come in contrast to the negative beliefs and will serve as aspirations that clients attempt to achieve will incorporate self-compassion. For example, a positive cognition for a negative cognition of "I am at fault" would be "I am not responsible" or "I am innocent" rather than "I take on appropriate responsibility". Additionally, during the installation phase, after the client states what has been unearthed due to bilateral stimulation, the clinician, instead of asking the client to process what has come up, would instead incorporate compassionate statements such as "it is okay to feel that way" etc. After, the psychologist would have the client process with bilateral stimulation. Furthermore, during the closure phase of EMDR, the clinician would incorporate compassionate imagery such as visualization of a person, animal or object offering compassion so as to create feelings of safety and reduce feelings of shame (Naismith et al., 2019).

Utilization of CFT

After implementation of EMDR, the psychologist will utilize CFT once again with the client as shown in Figure 1, with the goal of targeting any residual shame, self-criticism, and self-blame. Techniques that will be utilized include safe places, compassionate others, compassionate imagery such as imagined characters, grounding exercises that incorporate compassion for the self, and for clients experiencing more somatic symptoms, practicing certain body postures and movements to support a more compassionate physiology and mentality (practicing different facial expressions) and/or soothing breathing practice. Thus, this stage of CI-EMDR will utilize compassionate-focused techniques to reduce shame, self-criticism, and self-blame for victims of IPV.

EMDR for Lingering Symptoms

The last stage of his framework is to identify any lingering negative beliefs, thoughts, feelings, or somatic sensations that will be eliminated through a final run-through of EMDR. This could include somatic symptoms that are still manifesting in the body, negative emotions, and/or lingering negative thoughts. It is important to note that psychologists would need to be trained and certified in providing EMDR through an EMDRIA-accredited program so as to ensure that this modality is conducted ethically and with proper competence.

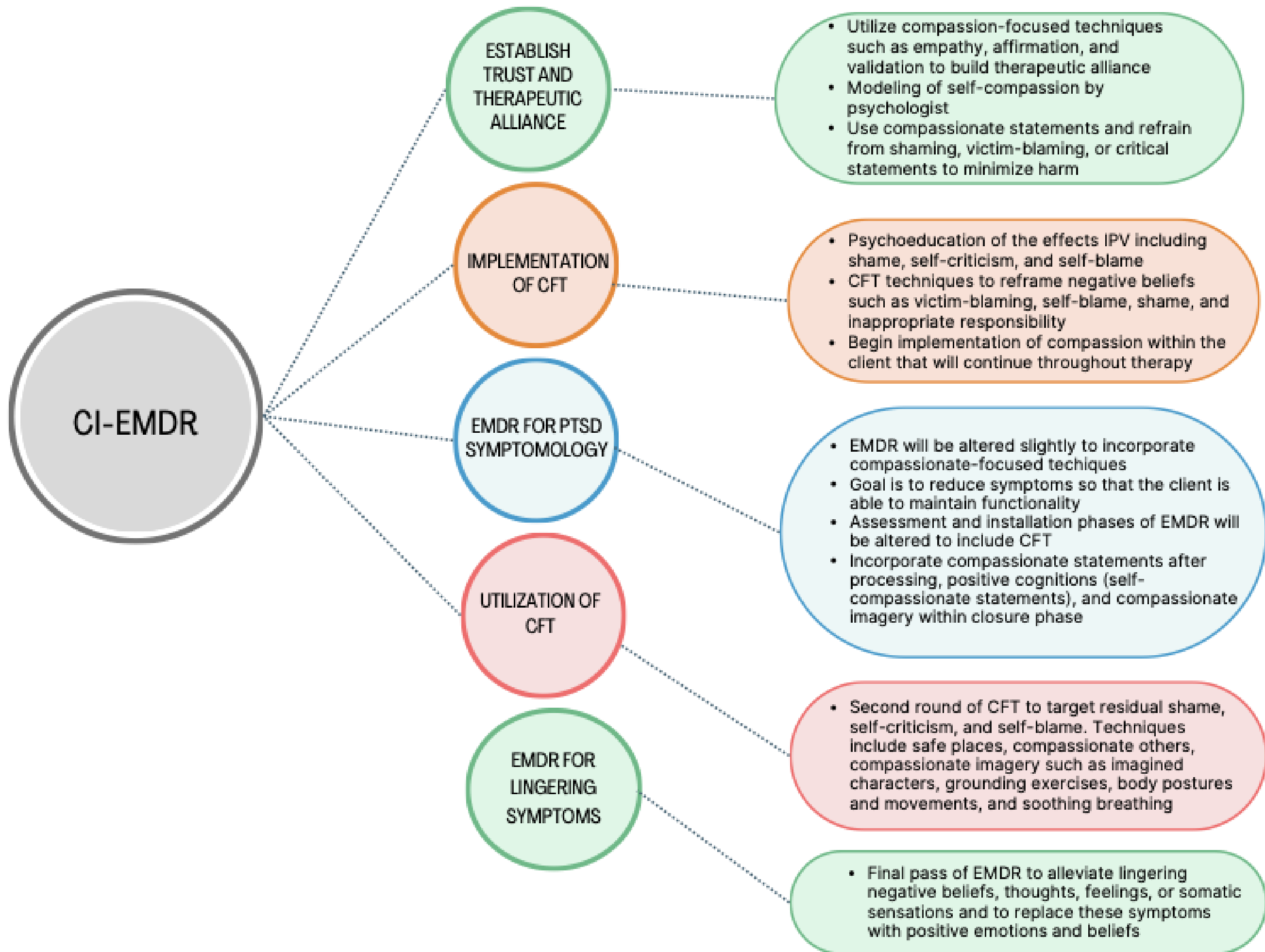

Figure 1: Stages of Compassion-Integrated EMDR

Conclusion

The novel framework that is proposed in this research demonstrates CFT and EMDR combined in a way that has not been outlined before specifically since previous approaches have integrated CFT into each phase of EMDR. CI-EMDR aims to provide a framework in which EMDR remains largely the same with few changes that integrates compassion-focused techniques while also preluding and concluding EMDR with compassion-focused techniques. For CI-EMDR to be a successful mixed therapeutic modality, successful training would have to be conducted before implementation of this therapeutic modality and psychologists would need to adhere to the steps provided in this research. A training program would have to be developed for CI-EMDR so that psychologists have adequate education and so that they can implement the modality with accuracy and efficacy. Additionally, further research examining the effectiveness of CI-EMDR would be beneficial in examining if this proposed model could be taught and utilized as psychotherapy for IPV victims.

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