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A Study of Dialectical Behavior Therapy Skills Training for Spanish-Speaking Latina Survivors of Intimate Partner Violence

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by

Cyndy Guadalupe Soto-Lopez

Dr. Lorraine T. Benuto/Dissertation Advisor

Dr. Jane E. Fisher/Dissertation Co-Advisor

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We recommend that the dissertation
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DOCTOR OF PHILOSOPHY

Jane E. Fisher

Advisor

Lorraine T. Benuto

Co-advisor

William T. O'Donohue

Committee Member

Melanie P. Duckworth

Committee Member

Julie E. Lucero

Graduate School Representative

David W. Zeh, Ph.D., Dean
Graduate School

May 2021

Abstract

Introduction: There is a paucity of research investigating the efficacy of psychological treatments for survivors of intimate partner violence (IPV), although evidence is growing for Dialectical Behavior Therapy (DBT) as an effective transdiagnostic approach. Despite the exponential growth of the Latinx population and literature suggesting that Latinx survivors experience the adverse mental health and physical effects of IPV disproportionately, the greater part of the extant intervention research has been conducted with non-Latinx White (NLW) samples. The present dissertation sought to address gaps in the literature by evaluating treatment outcomes among Latina survivors of IPV who underwent DBT for IPV skills training in Spanish. Idiographic contextual factors among survivors, sequelae of IPV, and culturally-relevant characteristics were explored. We speculated that the transdiagnostic nature of DBT would effectively accommodate the heterogeneity of sequelae among sample participants. **Methods:** Data for 19 Latinx female participants who received treatment at a community-based outpatient mental health clinic were examined via archival record review. The effects of DBT for IPV on symptoms of depression and anxiety as measured by PHQ-9 and GAD-7 scores from baseline to treatment completion were evaluated via matched pair t-tests. Clinical significance and high-end state functioning were calculated. **Results:** Seven participants completed treatment while three participants dropped out and nine participants were in ongoing treatment at the time of analysis. Among treatment completers, there was a statistically significant difference between pre- and post- treatment scores on the PHQ-9 (95% CI, 7.17, 19.98, $t [6] = 5.185$, $p < .05$) and on the GAD-7 (95% CI, 5.84, 18.16, $t [6] = 4.768$, $p < .05$). **Discussion:** Most participants exhibited clinically significant change and met criteria for high-end state

functioning. Overall, study participants endorsed characteristics consistent with what has been documented in the literature about Latinx IPV survivors including low SES and a lack of previous behavioral health service utilization. Given the improvement in depression and anxiety symptomatology experienced by study participants, DBT skills training appears to be an effective intervention for Latinx IPV survivors. The low drop-out rate provides evidence for the acceptability of DBT with this population.

Dedication

This dissertation is dedicated to my immigrant parents; thank you for all the sacrifices you have made for our family in pursuit of the American Dream and for instilling in me your values of hard-work, education, and helping others. Your unconditional love and support have given me the strength to achieve my goals. I would not be where I am today without you. ¡Sí se pudo!

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Chapter 1: Introduction

Intimate partner violence (IPV) is alarmingly common in the U.S., with estimates suggesting that 1 in 3 women have experienced IPV during their life-time (Smith et al., 2018). What is more, over half of female homicides in the U.S. are perpetrated by a current or former intimate male partner (Jack et al., 2018). Even for those women who survive IPV, they remain at an increased risk of experiencing a myriad of negative physical as well as mental health consequences (Trabold et al., 2020). Violence perpetrated by an intimate partner often affects those in the survivor's social environment as well, including family members, friends, and children, who may even be secondary victims themselves. Not only can IPV wreak havoc on a survivor's immediate social circle but on the nation's economy as well, with the annual costs of IPV estimated to surpass $5.8 billion accounting for the direct costs of care (medical and mental health) as well as indirect costs (e.g., lost productivity) (CDC, 2003). Thus, the issue of intimate partner violence is a significant public health concern.

Presently, there is a paucity of empirically supported psychological treatments for survivors of intimate partner violence, although the body of research is growing. A complicating factor appears to be the heterogeneity of the population, as intimate partner violence can lead to a number of mental health consequences including, but not limited to, depression, anxiety, posttraumatic stress disorder, eating disorders, substance abuse disorders, sleep disturbance, and suicide attempts (Trabold et al., 2020). Thus, the traditional research approach of evaluating the effectiveness of a particular intervention to treat problems associated with a particular diagnosis may be hindering progress in garnering empirical evidence for the treatment of problems associated with intimate partner

violence. Notwithstanding, the extant literature suggests evidence for Cognitive Behavior Therapy (CBT) interventions in individual or group settings in reducing symptoms of depression, anxiety, and trauma/PTSD (Trabold et al., 2020). In particular, there is growing evidence for Dialectical Behavior Therapy (DBT) as an effective transdiagnostic approach for treating survivors of IPV (Iverson et al., 2009; Lee & Fruzzetti, 2017; Newlands & Benuto, 2021). Of note, the majority of the existing research concerning survivors of IPV has been conducted with largely non-Latinx White samples.

Latinxs are the largest growing ethnic minority in the U.S. (US Census Bureau, 2019). The term Latinx refers to all individuals of Latino ethnicity and is meant to be inclusive of those who fall outside of the male/female gender binary. While Latinx women experience IPV at similar rates to other women, they do appear to be disproportionately impacted in regards to the negative physical and mental health consequences (Alvarez & Fedock, 2018). For example, compared to non-Latinx Whites, Latinx survivors of IPV have a greater likelihood of experiencing severe adverse effects such as depression and physical ailments (Edelson, Hodoka, & Ramos-Lira, 2007). Specific to intimate partner homicide, the extant data suggest that Latinx women have a higher likelihood of death by intimate partner violence than their African American and White non-Latinx peers (Swatt & Sabina, 2013). Moreover, Latinx women are less likely to seek formal support services compared to their non-Latinx peers and face a myriad of barriers to seeking formal support on an individual, cultural, and institutional level (Alvarez & Fedock, 2018). Thus, Latinx women represent a group who may have an increased vulnerability to the sequelae of IPV yet are less likely to seek formal services. Accordingly, it is imperative that future

research investigating effective treatments for survivors of intimate partner violence include Latinx women to address the current gaps in the literature.

Given the aforementioned issues, we will explore four main research questions with a sample of Latina women with a history of exposure to intimate partner violence seen at an outpatient community clinic:

Question 1: What are the idiographic contextual factors among Latina survivors of IPV?

Question 2: What are the sequelae of IPV among treatment-seeking Latina survivors of IPV?

Question 3: What are the culturally-relevant characteristics of Latina survivors of IPV?

Question 4: What are the treatment outcomes among Latina survivors of IPV who underwent DBT for IPV skills training?

Chapter 2: Literature Review

Intimate Partner Violence

Intimate partner violence (IPV) is an umbrella term that has been defined by the CDC as "physical violence, sexual violence, stalking, or psychological harm by a current or former partner or spouse" (CDC, 2020). It further comprises threats of physical or sexual violence as well as psychological aggression and/or coercion (Black et al., 2011). In the U.S., it is estimated that an average of over 10 million persons a year experience IPV while at least 20 people per minute are physically harmed by an intimate partner (Black et al., 2011; National Coalition Against Domestic Violence, 2020).

Idiographic Contextual Factors among Survivors of IPV

The following section will address two survivor populations: primary and secondary survivors. The majority of survivors of IPV experience their first instance of violence before age 25, with 1 in 4 women and 1 in 7 men in the U.S. first experiencing IPV before the age of 18 (Smith et al., 2018). This is especially concerning as existing data suggest that a childhood and/or adolescent history of IPV renders an individual at greater risk of repeated victimization in adulthood (Smith et al., 2018). While the lifetime prevalence of IPV is similar for men (33.6%) and women (36.4%), a larger proportion of women are more likely to experience various types of intimate partner violence such as rape, sexual violence, and stalking compared to men (Smith et al., 2018). Furthermore, the impact of IPV may be greater for women as 1 in 4 women reported experiencing some type of IPV-related outcome compared to 1 in 10 men (Smith et al., 2018). Indeed, with regard to homicide (arguably the most serious consequence of IPV), approximately 50.1% of female homicide victims are murdered by a current or former spouse/intimate partner while

the same is true for 7.5% of male homicide victims (Ertl, 2019). Thus, IPV seems to disproportionately impact women. The available data indicate that IPV revictimization is fairly common even after a survivor leaves their perpetrator (Iverson et al., 2013). Moreover, even the experience of non-partner violence have also been identified as a strong risk factor of future IPV for women (Abramsky et al., 2011). The consequences of violence often have an effect on the woman's social environment as well, particularly when there are children in the home who may witness or perhaps even experience the violence themselves.

Aside from the direct harm of physically experiencing violence, the trauma of being exposed to intimate partner violence as a secondary victim can leave children at a higher risk for an array of difficulties in the future. Children who witness IPV are more likely to exhibit internalizing (i.e., anxiety and depression) and externalizing behaviors (i.e., delinquency and violence) as well as poorer academic performance compared to children who were not exposed to IPV (Wood & Sommers, 2011). Furthermore, they are at greater risk of developing mental health difficulties such as depression, PTSD, and disruptive behavior disorders as well as general difficulties in social and vocational areas (Wood & Sommers, 2011; Grasso, Stover, & Whitaker, 2019). Childhood exposure to IPV has been labeled by some as a "gateway" to later violence and as previously noted, a childhood history of IPV significantly increases a person's risk of experiencing IPV in adulthood (Grasso, Stover, & Whitaker, 2019). Furthermore, there appears to be an intergenerational transmission of violence as research examining the characteristics of perpetrators of IPV indicates that they are considerably more prone to having witnessed IPV themselves as children compared to non-perpetrators (Ernst et al., 2009). *Given the above, the*

proposed study will focus on women and will involve an examination of the idiographic contextual factors that the women in our sample experience with regard to victimization.

Sequelae of IPV

While many survivors of IPV experience acute physical injuries such as lacerations and contusions as a direct consequence of physical abuse, IPV is also strongly associated with broader health outcomes. Survivors of IPV are more likely to experience chronic pain, gastrointestinal disorders, chronic disease, and a higher endorsement of physical symptoms (i.e., shortness of breath) in general (Sugg, 2015). Exposure to IPV may also hinder a woman's ability to ensure the safety of children in the home, in turn, yielding the threat of legal consequences and/or the involvement of social services (Rizo, Reynolds, Macy, & Ermentrout, 2016). Furthermore, exposure to IPV can also significantly increase a woman's risk of mental health difficulties such as post-traumatic stress disorder (PTSD), depression, eating disorders, substance abuse disorders, sleep disturbance, and suicide (Iverson et al., 2011; Golding, 1999; Danielson, Moffitt, Caspi, & Silva, 1998; Breiding et al., 2014; Sugg, 2015; Trabold et al., 2020). *Given the above, the proposed study will include an examination of the sequelae of IPV among treatment-seeking woman survivors of IPV.*

Latinxs & IPV

The Latinx population is the largest growing ethnic minority group in the U.S. and was comprised of approximately half (52%) of overall population growth between 2010-2019 (U.S. Census Bureau, 2019; Noe-Bustamante, Lopez, & Krogstad, 2020). Since 2010, the Latinx population has increased by 20% compared to a 4.3% increase of the non-Latinx White population (NLW; U.S. Census Bureau, 2020). Moreover, Latinxs

represent one of the youngest groups of the population with a median age of 29.8 years compared to the median age of 39.5 for the NLW population, although notably all racial and ethnic groups have displayed an increase in median age since 2010 (U.S. Census Bureau, 2020). Yet despite this exponential growth in recent decades and the fact that Latinxs represent one of the youngest population groups, which as previously noted age is a significant risk factor for IPV, the greater part of the extant research related to IPV has been conducted with largely NLW samples (Benuto, O'Donohue, Bennett, & Casas, 2019).

While estimates of the lifetime prevalence of experiencing IPV suggest that Latinx women are exposed to IPV at comparable levels to NLW women (37.1% vs. 34.6%) which is consistent with the overall prevalence estimate for women of 36.4% (Black et al., 2011; Smith et al., 2018), a systematic review of the literature on prevalence of interpersonal violence among Latinas indicated that a wide range of prevalence rates for interpersonal violence with up to 83% of Latinas experiencing interpersonal violence across studies (Gonzalez et al. 2018). Nevertheless, the existing (albeit, limited) research suggests that Latinx survivors of IPV may experience the adverse mental health and physical health effects of IPV disproportionately. Certainly, with regard to intimate partner homicide (IPH), the data indicate that Latinx women have significantly greater odds (70.5) of succumbing to IPH compared to other types of homicide than White (27) and African American (32.7) women (Swatt & Sabina, 2013).

In a telephone survey of 3,429 women randomly sampled from a major U.S. healthcare system in the Pacific Northwest, Bonomi, Anderson, Slesnick, and Rodriguez (2009) assessed for the occurrence of IPV (past year, past 5 years, and lifetime) as well as

current physical and mental health. The sample consisted of 4% (N= 139) English-speaking Latinx participants whom, consistent with the current population trends, were younger than NLW participants. Some differences were observed within the Latinx participants; mainly, Latinx women with exposure to IPV had more somatic symptoms and were twice as likely to report symptoms of depression compared to Latinx women with no lifetime history of IPV. Furthermore, even when accounting for race/ethnicity, Latinx women with a history of IPV displayed more significant depression, more significant psychological symptomatology, and overall poor physical health. These findings were maintained even when comparing Latinx IPV survivors with non-Latinx IPV survivors. Given the exploratory nature of the Bonomi et al. study coupled with the small proportion of Latinx participants, these results should be interpreted with caution and warrant further assessment.

In a telephone survey of 2,000 Latinx women in the U.S. utilizing random digit dial methodology, Cuevas, Sabina, and Picard (2010) evaluated exposure to different kinds of interpersonal violence as well as their relationship with mental health. Their finding that Latinx survivors may be more likely to exhibit anxious and dissociative symptoms yields support that helps substantiate the “ataque de nervios” syndrome as a cultural reaction to trauma. Overall, the available data highlighting the differences between these groups indicate that Latinx women comprise a population that may have a more pronounced vulnerability to the consequences of IPV yet are less likely to seek formal services compared to their non-Latinx White peers (Alvarez & Fedock, 2018).

A myriad of barriers may contribute to hesitance to seek formal services within the ever-diverse Latinx population including low mental health literacy, lower

socioeconomic status, and immigration status (specifically, fear of deportation among undocumented survivors) (Benuto, Gonzalez, Reinosa-Segovia, & Duckworth, 2019; Gonzalez-Guarda, Cummings, Becerra, Fernandez & Mesa, 2013; Kasturirangan & Williams, 2003). Additionally, limited English proficiency (Foiles Sifuentes et al., 2020) may limit an individual's ability to navigate the necessary systems in seeking formal help due to the dearth of Spanish-speaking providers (Derr, 2016). Furthermore, certain cultural values may discourage the seeking of formal support services. *Marianismo*, for example, emphasizes the importance of a woman's passivity and obedience to her husband while machismo places a high value on male domination (Amerson, Whittington, & Duggan, 2014). These beliefs and associated behaviors could potentially lead a survivor to perceive IPV as perhaps normative or feel pressured to remain in a marriage with their perpetrator in keeping with cultural norms (Vidales, 2010; Gonzalez-Guarda et al., 2013; Kasturirangan & Williams, 2003). *Given the findings of higher rates of IPV and serious negative sequelae experienced by Latina survivors, the proposed study will include Latina survivors of IPV and will include an examination of symptomology (among treatment-seeking Latina survivors of IPV). Additionally, as the data allow, we will also descriptively examine cultural factors/characteristics of Latina survivors of IPV.*

Psychological Interventions for IPV

At the moment, there is a dearth of intervention research aimed at addressing the mental health consequences for survivors of intimate partner violence. This is partly fueled by the variance in type of violence that is assessed (i.e., some studies only include sexual abuse or physical abuse and thus, individuals may be omitted if they exclusively experienced psychological abuse) as well as the inconsistent use of terminology to

describe IPV (domestic violence, sexual violence, abuse, etc.) which complicates identifying and comparing interventions across studies (Hegarty, Tarzia, Hooker, & Taft, 2016). Furthermore, there are two general classes of intervention: advocacy and therapeutic. While advocacy mainly includes empowerment, support, and case management, it can also involve harm reduction and safety planning, which overlap with some therapeutic interventions making it difficult to tease apart the effective mechanisms in some cases (Trabold et al., 2020).

As previously noted, the sequelae of IPV include a myriad of negative psychological outcomes, only some of which are captured by criteria outlined for various DSM-5 disorders. At the same time, many therapeutic intervention studies revolve around treating survivors who meet specific diagnostic criteria for a DSM-5 diagnosis consequent to IPV (Trabold et al., 2020). In recognition of this issue, the World Health Organization (WHO) recommends that all survivors of IPV with diagnosable DSM-5 disorders receive the same evidence-based treatments that individuals without exposure to IPV would receive for those same disorders, particularly for those experiencing symptoms of Major Depressive Disorder, Generalized Anxiety Disorder, and Post-traumatic Stress Disorder (PTSD) (World Health Organization, 2013; Hegarty, Tarzia, Hooker, & Taft, 2016). Citing evidence from five studies as support demonstrating the effectiveness of individual Cognitive Behavior Therapy (CBT) in reducing symptoms of PTSD and depression among survivors of IPV, the WHO specifically recommends CBT as a psychological intervention for women with a history of IPV who are no longer experiencing violence (2013). Thus, despite all of the aforementioned issues that pose significant difficulty to synthesizing information across intervention research for IPV, the limited (but growing) data available

indicate that CBT interventions are effective in addressing many of the IPV-related outcomes.

Hegarty and colleagues (2016) analyzed systematic reviews that were published between 2013 and 2015 in addition to conducting a supplementary literature review with the goal of ascertaining evidence for interventions relevant to recovery from IPV in primary care. Specific to psychological treatments, they concluded that CBT and Trauma informed CBT were among the strongest interventions while recommending Exposure and Eye Movement Desensitization and Reprocessing Interventions for targeting sexual assault. Similarly, Trabold et al., (2020) conducted a systematic review to investigate the efficacy and effectiveness of treatments for survivors of IPV pertaining to mental and physical health and revictimization. Based on the available data, the authors concluded that cognitive focused/CBT interventions had the most promising evidence, particularly for reducing revictimization and symptoms of depression, anxiety, and trauma/PTSD thereby improving mental health (Trabold et al., 2020). Concerns that were raised by authors of both of the aforementioned reviews included the general lack of quality studies such as well controlled randomized trials (many of the studies reviewed were pilot studies with high attrition rates) as well as lack of diversity in samples, noting that most were comprised of predominantly non-Latinx White women.

Arroyo et al. (2017) conducted a systematic review and meta-analysis with the aim of identifying effective short-term treatments for survivors of IPV. While the authors noted the same concerns about the rigor of the bulk of available outcome studies and the lack of diversity in the vast majority of the samples, they did review a larger proportion of studies including Latinx participants. These studies provided some evidence for the

effectiveness of CBT and exposure therapy, a treatment relapse prevention and relationship safety group, and Interpersonal Psychotherapy (IPT) utilizing samples that were entirely or mostly Latinx women (Alonso & Labrador, 2010; Gilbert et al., 2006; Labrador & Alonso, 2007; Zlotnick, Capezza, & Parker, 2011). Of note, many of these studies had small samples (N<50) and lacked a control group. Among the authors' conclusions was the recommendation of CBT as a "frontline intervention" for survivors of IPV (p. 168, 2017).

In their systematic review and meta-analysis, Tirado-Muñoz et al. (2014) examined 12 randomized controlled trials (RCT's) and concluded that both advocacy and therapeutic (CBT) interventions were effective in reducing physical symptoms as well as psychological symptoms among IPV survivors. While this highlighted stronger evidence for CBT interventions in the treatment of IPV survivors, bolstering the extant literature, the majority of participants in study samples were non-Latinx. Thus, while there is some preliminary evidence that CBT interventions may be effective in the treatment of Latinx survivors, there is still a significant gap. Additionally, the aforementioned studies did not include a discussion of relevant psychological factors that are associated with the experience of IPV, and certain psychological factors (i.e., emotion regulation) may represent highly relevant treatment targets.

Relevant Psychological Factors in the Context of IPV and its Treatment

The Role of Emotion Regulation

The complexity of the sequelae of exposure to IPV poses a significant challenge for accurately and efficiently identifying psychological interventions that address the specific needs of survivors of IPV. There are commonalities across this population that may serve

as better targets for intervention than the various symptom criteria within the traditional DSM-defined diagnoses associated with IPV. For instance, one of the central problems recognized as stemming from IPV is difficulties with emotion regulation (Iverson, Shenk, & Fruzzetti, 2009). *Emotion dysregulation* denotes a deficit in an individual's ability to manage their emotional reaction that is, the intensity and/or duration of the person's negative emotional arousal is such that it impairs their ability to organize their behavior in a way that is compatible with their goals and general self-control (Fruzzetti, Crook, Erikson, Lee, & Worrall, 2009). In that vein, chronic emotion dysregulation influences a myriad of maladaptive coping responses including but not limited to suicidality, non-suicidal self-injury, substance abuse, depression, eating disorders anxiety, violence and aggression, impulsivity, couple and family distress, poor decision-making, and general psychological distress (Linnehan, 1993; Fruzzetti et al., 2009). Furthermore, persons who are chronically dysregulated tend to face significant adversity in their interpersonal relationships, which are often described as "chaotic and dysfunctional" (Linnehan & Wilks, 2015; Fruzzetti et al., 2009, p. 175). There has been increased interest as of late in the concept of emotion regulation as the underlying issue pertaining to an array of psychological problems (Barlow, Allen, & Choate, 2016).

A transactional model has been posited by researchers to explicate the genesis of chronic emotion dysregulation (Linehan, 1993; Fruzzetti & Worrall, 2010). As per this transactional model, impairments in emotion regulation are derivative of a constant exchange between a person's own emotional vulnerability (i.e., difficulties experiencing, expressing, and/or modulating emotion, interpersonal deficits, low distress tolerance, etc.) and invalidating social responses that are experienced as punishing. Specifically

pertaining to IPV, a survivor's emotional vulnerability (which can be perceived as hyper-vigilance) contends with responses from her partner that are invalidating (i.e., rejection, disrespect, criticism, contempt, distrust, etc.) and characteristic of relationships with IPV. This ongoing exchange inevitably results in pervasive distress and emotion dysregulation as the pathologizing and punishment of the survivor's experience and behaviors further amplifies her emotional arousal, fueling further emotion dysregulation (Iverson, Shenk, & Fruzzetti, 2009). Thus, emotion regulation is believed to represent an important treatment target among survivors of IPV.

Dialectical Behavior Therapy as a Transdiagnostic Treatment for IPV Survivors

Given this conceptualization of IPV as a problem of emotion regulation, the negative mental health impact of which transcends diagnostic categories, coupled with the general support for Cognitive Behavior Therapy (CBT) interventions for improving mental health outcomes of survivors, the available evidence suggests that a successful intervention for this population would be comprised of a transdiagnostic CBT approach targeting emotion regulation. This may be particularly true for the Latinx population as recent evidence indicates transdiagnostic treatments as promising in alleviating some of the cultural and systemic barriers to seeking and accessing mental health treatment (Caplan, 2019; Clark, 2009). Thus, future research exploring the effectiveness of transdiagnostic treatments for Latinx IPV survivors is warranted.

One such transdiagnostic intervention is Dialectical Behavior Therapy (DBT), a wide-ranging CBT treatment that was initially developed for the treatment of pervasively suicidal women with borderline personality disorder, self-harming behaviors, and a range of co-morbid problems. A central aim of DBT is to improve mental health outcomes and

general quality of life for individuals experiencing multiple problems related to pervasive emotion dysregulation (Linehan, Armstrong, Suarez, Allmon, & Heard, 1991; Linehan, 1993; Linehan & Wilks, 2015). Since its introduction, DBT has been shown to be effective in treating a wide range of problems across the lifespan, including trauma/PTSD, ADHD, couple distress, substance abuse, eating disorders, and chronic depression in older adults (Harned et al., 2014; Feigenbaum, 2007; Fruzzetti & Iverson, 2006; Chapman, 2006; Linehan & Wilks, 2015). The support for DBT in the literature as an effective intervention for a variety of problems with a number of populations supports the notion that DBT is a strong transdiagnostic CBT approach targeting emotion regulation. Indeed, DBT skill use altogether has demonstrated success in enhancing emotion regulation (Neacsiu, Rizvi, & Linnehan, 2010).

In recognition of the severity of IPV as a public health concern and the general lack of comprehensive interventions addressing the specific needs of IPV survivors, Iverson, Shenk, and Fruzzetti (2009) conducted the first evaluation of DBT as a treatment for survivors of IPV. In their pilot study, the researchers delivered a 12-week DBT skills training group adapted for survivors of IPV to a sample of 31 women with a history of exposure to IPV. Iverson, Shenk, and Fruzzetti (2009) reported significant reductions in participants' symptoms of depression as well as general psychiatric distress and hopelessness after the 12-week treatment, providing preliminary support for the utility of DBT in the treatment of survivors of IPV. However, the study was not without limitations, including but not limited to the small, heterogenous sample (mostly White women), lack of control group, and high attrition rate (33%).

Given the preliminary support found for DBT as a comprehensive treatment for addressing the specific needs of survivors of IPV and in recognition of traditionally low retention rates with this population, Lee and Fruzzetti (2017) developed and evaluated a 2-day DBT group program with 72 women with a history of exposure IPV. The authors compared the 2-day group to the 12-week group and concluded that the 2-day format significantly reduced attrition rate without sacrificing efficacy as outcome changes were similar across both studies including at the 3-month follow up (Lee & Fruzzetti, 2017). In recognition of the general difficulty of establishing contact between clients and clinicians, Newlands and Benuto (2021) developed video intervention adjuncts (VIAs) with the aim of enhancing DBT skills exposure for IPV survivors while decreasing burden for clients and providers. In their pilot trial, the researchers randomly assigned a sample of 24 women to one of two groups: a 2-day DBT for IPV skills group with the VIAs or a 2-day DBT for IPV skills group without the VIAs. The results indicated that the VIAs were viewed favorably and feasible to implement and participants who received the VIAs in addition to the group demonstrated greater frequency of skill use (emotion regulation, distress tolerance, interpersonal effectiveness, validation, and mindfulness skills, although only the differences in mindfulness skills use were statistically significant) as well as greater improvements on clinical measures, providing support for the utility of the addition of the VIAs. While these last two studies included a larger proportion of Latinx women in their samples (15.7% and 16%), the samples were still comprised of predominantly White non-Latinx women. Nevertheless, together the three aforementioned studies provided the groundwork for the utility of DBT interventions in increasing skill use among IPV survivors and warrant further research.

Transdiagnostic Treatments for Latinx Population

There is some evidence to suggest that the Latinx population especially may benefit from transdiagnostic approaches to treatment. Firstly, the extant data indicate that Latinxs in the U.S. experience high rates of co-morbid anxiety and depression, the two most common mental health diagnoses in the U.S, yet cultural beliefs may impact their behavior health seeking efforts and subsequent access (Caplan, 2019; Nelson, Ayers, Sun, & Zhang, 2020). Compared to non-Latinx Whites, Latinxs tend to have overall poorer mental health literacy, greater stigma, and a reduced proportion of behavior health service use (Benuto et al., 2019). This may be influenced in part by a tendency of Latinxs to perceive the source of pathology as physiological (e.g., somatic; Escovar et al., 2019) or spiritual in nature (Caplan, 2019) in addition to the general lack of dissemination of empirically supported treatments available (Castro, Barrera, & Holleran Steiker, 2010). Conversely, benefits of transdiagnostic treatments include facility of dissemination due to the time and cost saving inherent in utilizing a single protocol to treat the common underlying pathology across various diagnoses rather than focusing on unique protocols for treating the symptomatology of discrete disorders, which may in turn render treatment as more acceptable to Latinxs (Clark, 2009). Thus, transdiagnostic approaches demonstrate great potential for addressing some of the disparities in behavior health service utilization observed among the Latinx population by enhancing access to and feasibility of evidence-based treatments. *Given the evidence suggesting DBT as promising diagnostic treatment for IPV survivors, the general dearth of intervention research with Latinx IPV survivors, and the notion that the Latinx population may especially benefit from transdiagnostic*

approaches to treatment, the proposed study will examine treatment outcomes among Latina survivors of IPV who underwent DBT for IPV skills training.

Current Study

Intimate partner violence is a pervasive public health concern in the U.S. that has deleterious physical and mental health consequences for survivors. Given the limited, albeit growing, body of research evidencing empirical support for psychological treatments to improve outcomes for survivors of intimate partner violence, studies contributing to this research are greatly needed. The growing evidence for Dialectical Behavior Therapy (DBT) as an effective transdiagnostic approach for treating survivors of IPV (Iverson et al., 2009; Lee & Fruzzetti, 2017; Newlands & Benuto 2021) coupled with the dearth of research including Latinx survivors of IPV and the disproportionate effects of IPV on Latinxs indicates a clear need for the evaluation DBT for IPV with the Latinx population. The present study aims to contribute to filling the gaps in this area of research and provide preliminary data that may justify a more rigorous evaluation of the effectiveness of DBT for IPV with the Latinx population. We explored four main research questions with a sample of Latina women with a history of exposure to intimate partner violence seen at an outpatient community clinic.

Question 1: What are the idiographic contextual factors among Latina survivors of IPV?

Question 2: What are the sequelae of IPV among treatment-seeking woman survivors of IPV?

Question 3: What are the culturally-relevant characteristics of Latina survivors of IPV?

Question 4: What are the treatment outcomes among Latina survivors of IPV who underwent DBT for IPV skills training?

Chapter 3: Methodology

This is an archival record review study. The source of the records is La Cliníca V.I.V.A: Una Cliníca para Personas que han sido **V**ictimas de Violencia **I**nterpersonal o **V**ictimas de **A**buso, a culturally specific clinic devoted to helping Latinos and other cultural minorities who have been victims of interpersonal violence heal and recover through evidence-based, culturally sensitive behavioral health services. La Clinica VIVA is a community-based outpatient mental health clinic located on the University of Nevada-Reno campus. Data were gathered from de-identified client records. All records from August 2019 to February 2021 were reviewed for cases that met inclusion criteria. Inclusion criteria were as follows: self-identification as a Latina woman, history of exposure to intimate partner violence (IPV), and receipt of DBT skills training.

Participants

Participants were 19 female, Spanish-speaking Latinxs. Participants ranged in age from 29 to 61 years (M = 45.84; SD = 12.16). All participants self-identified as heterosexual (n = 19). The majority of participants endorsed Mexico as their country of origin (n = 15) while 3 participants indicated El Salvador and 1 participant was from Guatemala.

While this study was not adequately powered to evaluate control variables, an analysis of the demographic data suggests that treatment completers had the following characteristics: no current employment (n = 5; 71.4%), relationship status of married (n = 4; 57.1%) or single (n=1; 14.3%) (see Table 2); documented immigration status (n = 5; 71.4%) (see Table 6.2); witnessed parental IPV (n = 3; 42.9%) (see Table 3.1); education level higher than 5th grade but lower than a bachelor's degree (BA/BS); income less

than $10,000 per year and no greater than $40,000 per year (see Table 2); first experience of IPV before the age of 20 (see Table 3.4); and experience physical and psychological abuse (but not sexual abuse) (see Table 3.3).

Procedure

This study is a record review study which was determined to be exempt by the university's Institutional Review Board (#1321268). Data for this study were gathered from de-identified client records taken from a database (i.e., program evaluation) of all clients who were seen at La Cliníca V.I.V.A. Standard clinic procedure dictates that interested clients who contact the clinic for services are screened via phone for symptoms and assigned to a therapist by the clinic coordinator. All clients are seen by a doctoral student clinician (N = 4) directly supervised by the clinic director, a licensed clinical psychologist. The clinician administers baseline assessment measures, conducts a thorough intake to establish diagnostic impression, and develops a treatment plan in collaboration with the client. Assessment measures (listed below) are administered again upon treatment completion to evaluate treatment outcome and whether further treatment is warranted. For the purposes of this record review, basic demographic information, diagnostic impression, history of IPV, treatments employed, number of sessions attended, culturally relevant characteristics, treatment outcome, and scores from administered measures were collected from the database. All records from August 2019 to February 2021 were reviewed for cases that met inclusion criteria. All study participants received DBT for IPV at La Cliníca V.I.V.A. Inclusion criteria were as follows: self-identification as a Latina woman, history of exposure to intimate partner violence (IPV), and receipt of DBT skills

training. All data were entered into a database via the Statistical Package for Social Sciences (SPSS) version 24.

Measures

Patient Health Questionnaire-9 (PHQ-9). The PHQ-9 is the most commonly used tool for screening for depression in primary care (Levis, Benedetti, & Thombs, 2019). It is a short measure of depression severity whereby individuals rate how frequently they have experienced each of nine symptoms of depression using a 4-point Likert scale (Kroenke, Spitzer, & Williams, 2001). A recent meta-analysis has evidenced that the PHQ-9 has strong sensitivity and specificity (Levis, Benedetti, & Thombs, 2019). Existing evidence further indicates that in addition to the PHQ-9's strong psychometric properties (internal consistency, predictive validity, sensitivity, specificity) there is support for its appropriate use with the Latinx population, including rural, Spanish speaking persons (Arrieta et al., 2017).

Generalized Anxiety Disorder-7 (GAD-7). The GAD-7 is a short measure of anxiety wherein individuals rate how frequently they have experienced each of seven symptoms of anxiety using a 4-point Likert scale (Spitzer, Kroenke, Williams, & Löwe, 2006). A recent meta-analysis suggests adequate sensitivity and specificity (Plummer, Manea, Trepel, & McMillan, 2016) while further evidence indicates strong test-retest reliability and adequacy in screening for generalized anxiety disorder, social anxiety disorder, panic disorder, and PTSD (Kroenke, Spitzer, Williams, Monahan, & Löwe, 2007). These strong psychometric properties, particularly sensitivity and specificity, have been found for the Spanish version of GAD-7 as well (Muñoz-Navarro et al., 2017).

The PTSD Checklist for DSM-5 (PCL-5). The PCL-5 is a measure of Post-traumatic Stress Disorder (PTSD) symptomatology wherein individuals rate how much they have been bothered by each of twenty DSM-5 symptoms of PTSD using a 5-point Likert scale (Weathers et al., 2013). In their initial psychometric evaluation, which has since been supported by additional research, Blevins and colleagues (2015) found strong psychometric properties of the PCL-5 including reliability (test-retest reliability and internal consistency), and validity (convergent validity and discriminant validity).

Difficulties in Emotion Regulation Scale- Short Form (DERS-SF). The DERS-SF is an 18-item self-report measure of emotion regulation deficits whereby individuals rate how frequently they experience each of eighteen emotion regulation difficulties using a 5-point Likert scale (Kaufman et al., 2016). It yields six sub-scales measuring the individual's nonacceptance of emotional responses, difficulty engaging in goal-directed behavior, impulse control difficulties, lack of emotional awareness, limited access to emotion regulation strategies, and lack of emotional clarity. While it is a shortened version of the original 36 item measure, the DERS-SF has been demonstrated to have similarly strong psychometric properties including reliability and validity (Victor & Klonsky, 2016). Of note, the DERS-SF has not been evaluated for use with Spanish-speaking populations in the U.S.

Distress Tolerance Scale (DTS). The DTS is a 15-item self-report measure of distress tolerance wherein individuals rate the degree to which they agree or disagree with each of fifteen statements about distress tolerance on a 5-point Likert scale (Simons & Gaher, 2005). The DTS is comprised of four sub-scales: tolerability and aversiveness, tendency to absorb attention and disrupt functioning, appraisal and acceptability, and

regulation of emotions. The DTS has been shown to have sound psychometric properties, including convergent, discriminant, and criterion validity (Simons & Gaher, 2005). Furthermore, the Spanish language DTS has been validated and demonstrated to have useful psychometric properties as well including reliability, convergent, and discriminant validity (Sandin, Simons, Valiente, Simons, & Chorot, 2017).

Five Facet Mindfulness Questionnaire-15 (FFMQ-15). The FFMQ-15 is a 15-item self-report measure whereby individuals rate the frequency with which they are able to engage in mindfulness on a 5-point Likert scale (Baer, Carmody, & Hunsinger, 2012). The FFMQ-15 contains five mindfulness sub-scales: observing, describing, non-judging of inner experience, acting with awareness, and non-reactivity to inner experience. While it is a shortened version of the original 39 item measure, the FFMQ-15 has been shown to have strong psychometric properties including reliability and validity (Gu et al., 2016).

Acceptance and Action Questionnaire-II (AAQ-II). The AAQ-II is a 7 item self-report measure of psychological inflexibility and distress wherein individuals rate the frequency with which they experience each of seven items on a 7-point Likert scale (Bond et al., 2011). In addition to demonstrating adequate internal consistency, test-retest reliability, and external validity, the available evidence indicates that the AAQ-II is appropriate for use with ethnically diverse samples (Correa-Fernández et al., 2020).

Attitudes Toward Seeking Professional Psychological Help-Short Form (ATSPPH-SF). The ATSPPH-SF is a 10 item self-report measure of help seeking attitudes whereby individuals indicate their degree of agreement with each of ten items on a 4-point Likert scale (Fischer & Farina, 1995). The ATSPPH-SF yields three factors: 1) openness and 2) value in seeking professional help and 3) preference for coping without help. The

ATSPPH-SF has demonstrated strong psychometric properties including internal consistency in addition to utility with Latinx adults (Torres, Magnus, & Najar, 2020).

Intervention

The present study utilized the DBT for IPV protocol developed by Iverson, Shenk, and Fruzzetti (2009) and further employed by Lee and Fruzzetti (2017), and Newlands and Benuto (2021). Details regarding the sequence of skills addressed within the protocol are included in Table 1.

Table 1

Module	Skills/Corresponding Handouts
Mindfulness	Goals of Mindfulness; States of Mind/Wise Mind; "What" Skills; "How" Skills
Emotion Regulation	What emotions do for you; What makes it hard to regulate your emotions; Check the Facts; Opposite Action; Problem Solving; Reducing Vulnerability to Emotion Mind
Validation	What is validation and why is it important; What and when to validate; How to validate; Validation Practice; Self-validation; Self-affirmations; Recovering from Invalidation
Interpersonal Effectiveness	Goals of Interpersonal Effectiveness; Factors that get in the way of IE; DEAR MAN; FAST; GIVE
Distress Tolerance	Goals of Distress Tolerance; When to use crisis survival skills; TIP; Self-soothe; Radical Acceptance; Willingness; Half Smiling and Willing Hands

Data Analyses

The present study aimed to address gaps in research with Latinx IPV survivors by providing preliminary data that could inform a more rigorous exploration of the effectiveness of DBT for IPV with Latinx survivors. We evaluated four main research questions with a sample of Latina women with a history of exposure to intimate partner violence seen at an outpatient community clinic.

Research Question 1. *What are the idiographic contextual factors among Latina survivors of IPV?* To answer Research Question 1, we applied descriptive statistics to provide information about the participants' demographic characteristics (i.e., education, income) and victimization-specific characteristics.

Research Question 2. *What are the sequelae of IPV among treatment-seeking woman survivors of IPV?* To answer Research Question 2, we applied descriptive statistics to provide information about participants' symptomatology (diagnoses), mindfulness, emotional distress tolerance, emotion regulation, clinically relevant distress and flexibility, and physical health concerns. We also examined participants' history of help-seeking.

Research Question 3. *What are the culturally-relevant characteristics of Latina survivors of IPV?* To answer Research Question 3, we used descriptive statistics to examine participants' characteristics English language fluency, immigration status, endorsement of cultural values, and attitudes towards seeking professional help.

Research Question 4. *What are the treatment outcomes among Latina survivors of IPV who underwent DBT for IPV skills training?* To investigate this question, we evaluated the effects of DBT for IPV on depression and anxiety symptoms as measured by PHQ-9 and GAD-7 total scores from baseline to treatment completion via matched pair t-

tests. When data allowed, also examined pre- to post- changes in emotion regulation, distress tolerance, psychological flexibility, and mindfulness.

Data Analysis Plan

To investigate the four questions of the proposed archival study, quantitative data analyses were run via the Statistical Package for Social Sciences (SPSS) version 24. Descriptive statistics (i.e., means, standard deviations, ranges) were calculated for all relevant demographic variables. An independent samples t-test was employed to examine differences in pre-treatment scores on baseline measures between participants who completed the treatment and participants who did not complete treatment. Paired samples t-tests were employed to examine differences from pre-treatment to post-treatment on the baseline and post-treatment measures (PHQ-9, GAD-7) and to describe any statistically significant change in symptom endorsement following the intervention. Cohen's d was calculated to determine effect sizes. Also, we calculated clinically significant change (CSC) using the following formula as per Jacobson and Truax (1991). A review of the literature on the GAD-7 indicated that, among a community sample of Spanish-speakers, the mean GAD-7 score was 5.68 (SD = 05.74) (Mills et al., 2014). The mean PHQ-9 score among a sample of Spanish-speaking, community-dwelling Latinas was 4.58 (SD = 4.87) (Merz et al., 2011). Thus, the CSC Cutoff was calculated:

$$\text{CSC Cutoff} = \frac{M_1 + M_2}{2} \qquad \text{PHQ-9} = \frac{4.58 + 13.74}{2} = 9.16 \qquad \text{GAD-7} = \frac{5.68 + 12.79}{2} = 9.23$$

Those who responded to treatment were further identified by computing the percentage of participants that had subclinical symptoms of depression and anxiety post-treatment. Furthermore, as per Farchione and colleagues (2012) we determined which participants achieved high-end state functioning (HESF) by identifying those who 1) no

longer met diagnostic criteria after treatment was completed; and 2) exhibited a 30% or greater improvement on their PHQ-9 (depression) and GAD-7 (anxiety) scores.

Chapter 4: Results

Feasibility

Seventeen participants met inclusion criteria for the study; two additional participants were included given their history of exposure to violence despite lack of exposure to IPV. The two aforementioned clients met all other inclusion criteria, had similar sequela as IPV survivors, and experienced a significant history of violence such as childhood physical abuse or sexual abuse as well as additional violence as adults (home invasion by strangers, physical assault by an adult child, and harassment from a former son-in-law). Three participants (15.8%) dropped out of treatment, 7 (36.8%) completed treatment, and 9 (47.4%) are still participating in ongoing treatment. Participants who dropped out of treatment attended a mean of 8.00 (SD = 2.00; range 6-10) sessions, while participants who completed treatment attended a mean of 16.29 (SD = 5.91; range 9-27) sessions, and participants in ongoing treatment have attended a mean of 11.89 (SD = 6.81; range 4-24) sessions. Among the three participants who terminated treatment early, two only completed one Module while the third completed four Modules. Pre-treatment baseline scores on the PHQ-9 of participants who dropped out of treatment had a mean of 7.67 (SD = 5.03; range 3-13) (mild symptom severity) while the participants who completed treatment had a mean of 15.71(SD = 6.97; range 5-25) (moderately severe symptom severity) and the participants that are still in treatment had a mean of 14.22 (SD = 6.53; range 5-23) (moderate symptom severity). Pre-treatment baseline scores on the GAD-7 of participants who dropped out of treatment had a mean of 7.00 (SD = 4.58; range 3-12) (mild symptom severity) while the participants who completed treatment had a mean of 13.86 (SD = 6.47; range 5-20) (moderate symptom severity) and the

participants that are still in treatment had a mean of 13.89 (SD = 3.26; range 10-21) (moderate symptom severity). Pre-treatment baseline scores on the PCL-5 of participants who dropped out of treatment ranged from 18 to 38 (M = 28.00; SD = 14.14) (subclinical symptoms) while the scores of participants who completed treatment ranged from 37 to 48 (M = 43.33; SD = 5.69) (exceeding the cutoff for symptoms consistent with PTSD) and scores among participants that are still in treatment ranged from 13 to 50 (M = 28.00; SD = 15.61) (subclinical symptoms). Sample sizes precluded meaningful statistical analysis of differences between treatment completers and non-completers

Research Question 1. *What are the idiographic contextual factors among Latina survivors of IPV?* To answer Research Question 1, we computed descriptive statistics on participant' demographic characteristics (i.e., education, income) and victimization-specific characteristics. The majority of participants were unemployed at the time they sought treatment (n = 10) and had obtained a 6th grade level of education or less (n = 10). Almost half of the participants were married (n = 9) and all participants endorsed earning an annual income of less than $39,999. Of the 9 married participants, 2 had no lifetime exposure to IPV and the remaining 7 identified experiencing psychological/emotional abuse/coercion perpetrated by their current spouse. All 7 participants adamantly denied any physical and/or sexual abuse perpetrated by their current spouse; 2 of those 7 participants reported previously experiencing physical and/or sexual abuse perpetrated by a former partner. Drop out did not appear to be related to relationship status as the 3 participants who dropped out were either divorced or separated from their perpetrator. Full participant demographic characteristics can be found in Table 2.

Table 2

Participant Demographic Characteristics

	Total Sample		Tx Completer		Drop-out		In Treatment	
Employment	N	%	N	%	N	%	N	%
Currently Employed	9	47.4%	2	28.6%	2	66.7%	5	55.6%
Disability	N	%	N	%	N	%	N	%
Physical Disability	2	10.5%	1	14.3%	0	0.0%	1	11.1%
Income	N	%	N	%	N	%	N	%
<$10,000	7	36.8%	1	14.3%	1	33.3%	5	55.6%
$10,000-19,999	4	21.1%	2	28.6%	2	66.7%	0	0.0%
$20,000-29,999	5	26.3%	3	42.9%	0	0.0%	2	22.2%
$30,000-39,999	3	15.8%	1	14.3%	0	0.0%	2	22.2%
Relationship Status	N	%	N	%	N	%	N	%
Single	1	5.3%	1	14.3%	0	0.0%	0	0.0%
Married	9	47.4%	4	57.1%	0	0.0%	5	55.6%
Separated	4	21.1%	1	14.3%	1	33.3%	2	22.2%
Divorced	4	21.1%	0	0.0%	2	66.7%	2	22.2%
Widowed	1	5.3%	1	14.3%	0	0.0%	0	0.0%

Table 2 (Continued)

Participant Demographic Characteristics

Education	N	%	N	%	N	%	N	%
≤ Kindergarten	1	5.3%	0	0.0%	0	0.0%	1	11.1%
2nd grade	1	5.3%	0	0.0%	1	33.3%	0	0.0%
5th grade	1	5.3%	0	0.0%	0	0.0%	1	11.1%
6th grade	7	36.8 %	3	42.9%	0	0.0%	4	44.4%
8th grade	1	5.3%	1	14.3%	0	0.0%	0	0.0%
9th grade	1	5.3%	0	0.0%	0	0.0%	1	11.1%
10th grade	1	5.3%	1	14.3%	0	0.0%	0	0.0%
11th grade	1	5.3%	1	14.3%	0	0.0%	0	0.0%
High School	3	15.8 %	0	0.0%	1	33.3%	2	22.2%
Some College	1	5.3%	1	14.3%	0	0.0%	0	0.0%
BA/BS	1	5.3%	0	0.0%	1	33.3%	0	0.0%

The majority of participants endorsed experiencing child abuse or being secondary victims of family violence as children (n = 14). Of those participants, most indicated that their experience of childhood abuse continued for an extended period of time (n = 13) and was perpetrated by their parents (n = 8). While two participants endorsed having multiple abusers, one participant indicated two distinct sexual assaults by separate perpetrators at ages 4 and 7. Age at first experience of IPV ranged from 17 to 59 years (M = 27.94; SD = 12.29) with all participants reporting experiencing abuse for an extended period of time ranging from 1 to 37 years (M = 12.71; SD = 11.37). A total of 94.1% of

participants who experienced IPV (n = 16) identified their first perpetrator as Latinx. Age at most recent experience of IPV ranged from 17 to 59 years (M = 30.18; SD = 12.65) with only 1 participant experiencing an isolated incident of abuse within the context of a second IPV relationship (after experiencing abuse for an extended period of time with her first perpetrator) and duration of ongoing abuse for remaining participants (n = 16) ranging from 1 to 37 years (M = 12.44; SD = 11.33). All participants who experienced IPV identified their most recent perpetrator as Latinx (n = 17). Most participants (n = 12) noted their children were present during their experiences of IPV and, thus, were secondary victims. Over 25% of participants (n = 5) experienced further violence outside of the context of IPV with age at experience of that violence ranging from 16 to 58 years (M = 28.80; SD = 18.10). Of those 5 participants, 2 experienced a second instance of violence outside of the context of IPV with age at experience of that violence ranging from 29 to 57 years (M = 43.00; SD = 19.80). Details of participant victimization characteristics can be found in Tables 3.1-3.4, which follow on the subsequent pages.

Table 3.1

Participant Victimization Characteristics

	Total Sample		Tx Completer		Drop-out		In Treatment	
Childhood Abuse	N	%	N	%	N	%	N	%
Sexual Abuse	4	21.1%	0	0.0%	2	66.7%	2	22.2%
Physical Abuse/Neglect	4	21.1%	2	28.6%	1	33.3%	1	11.1%
Psychologi-cal/Emotional	4	21.1%	1	14.3%	1	33.3%	2	22.2%
Witnessed Pa-rental Violence	4	21.1%	3	42.9%	0	0.0%	1	11.1%
Extended abuse	13	68.4%	6	85.7%	2	66.7%	5	55.6%
Perpetrated by Parent	8	42.1%	4	57.1%	1	33.3%	3	33.3%
Perpetrated by Step-parent	2	10.5%	0	0.0%	2	66.7%	0	0.0%
Perpetrated by Other Relative	6	31.6%	2	28.6%	1	33.3%	3	33.3%
Perpetrated by Family Friend	1	5.3%	0	0.0%	0	0.0%	1	11.1%
Bullying	5	26.3%	3	42.9%	1	33.3%	1	11.1%

Table 3.2

Participant Victimization Characteristics, Continued

# of IPV Rela-tionships	Total Sample		Tx Completer		Drop-out		In Treatment	
-	N	%	N	%	N	%	N	%
0	2	10.5%	1	14.3%	0	0.0%	1	11.1%
1	13	68.4%	4	57.1%	2	66.7%	7	77.8%
2	4	21.1%	2	28.6%	1	33.3%	1	11.1%

Table 3.3

Participant Victimization Characteristics, Continued

	Total Sample		Tx Completer		Drop-out		In Treatment	
First IPV Type	N	%	N	%	N	%	N	%
Sexual Abuse	4	21.1%	0	0.0%	2	66.7%	2	22.2%
Physical Abuse	11	57.9%	4	57.1%	3	100.0%	4	44.4%
Psychological/Emotional Abuse	17	89.5%	6	85.7%	3	100.0%	8	88.9%
First IPV Perpetrator	N	%	N	%	N	%	N	%
Spouse	13	68.4%	2	28.6%	3	100.0%	8	88.9%
Domestic Partner	2	10.5%	2	28.6%	0	0.0%	0	0.0%
Romantic Partner (not cohabitating)	1	5.3%	1	14.3%	0	0.0%	0	0.0%
Unknown	3	15.8%	2	28.6%	0	0.0%	1	11.1%
Recent IPV Type	N	%	N	%	N	%	N	%
Sexual Abuse	3	15.8%	0	0.0%	2	66.7%	1	11.1%
Physical Abuse	7	36.8%	2	28.6%	2	66.7%	2	22.2%
Psychological/Emotional Abuse	15	78.9%	5	71.4%	2	66.7%	7	77.8%
Stalking/Harassment	1	5.3%	1	14.3%	0	0.0%	0	0.0%

Table 3.3 (Continued)
Participant Victimization Characteristics, Continued

Recent IPV Perpetrator	N	%	N	%	N	%	N	%
Spouse	13	68.4%	4	57.1%	2	66.7%	7	77.8%
Domestic Partner	2	10.5%	1	14.3%	1	33.3%	0	0.0%
Romantic Partner (not cohabitating)	2	10.5%	1	14.3%	0	0.0%	1	11.1%
Unknown	2	10.5%	1	14.3%	0	0.0%	1	11.1%
Other Victimization	N	%	N	%	N	%	N	%
Sexual Abuse	1	5.3%	1	14.3%	0	0.0%	0	0.0%
Physical Assault	4	21.1%	0	0.0%	1	33.3%	3	33.3%
Psychological/Emotional Abuse	1	5.3%	0	0.0%	0	0.0%	1	11.1%
Stalking/Harassment	1	5.3%	0	0.0%	0	0.0%	1	11.1%
Human Trafficking	1	5.3%	1	14.3%	0	0.0%	0	0.0%
Other Perpetrator	N	%	N	%	N	%	N	%
Adult Child	1	5.3%	0	0.0%	0	0.0%	1	11.1%
Other Relative (non-parent)	6	31.6%	2	28.6%	1	33.3%	2	22.2%

Table 3.4

Participant Victimization Characteristics, Continued

	Total Sample		Treatment Completer		Drop-out		In Treatment	
Age at 1st IPV	N	%	N	%	N	%	N	%
Under 18 years old	3	15.8 %	2	28.6%	0	0.0%	1	11.1%
18-25 years old	5	26.3 %	2	28.6%	1	33.3%	2	22.2%
26 years old +	8	42.1 %	1	14.3%	2	66.7%	5	55.6%
Unknown	3	15.8 %	2	28.6%	0	0.0%	1	11.1%
# of IPV Incidents (1st IPV)	N	%	N	%	N	%	N	%
Extended/Multiple	17	89.5 %	6	85.7%	3	100.0%	8	88.9%
Unknown	2	10.5 %	1	14.3%	0	0.0%	1	11.1%
Past IPV Type	N	%	N	%	N	%	N	%
Sexual Abuse	4	21.1 %	0	0.0%	2	66.7%	2	22.2%
Physical Abuse	11	57.9	4	57.1%	3	100.0%	4	44.4%
Psychologi-cal/Emotional Abuse	17	89.5 %	6	85.7%	3	100.0%	8	88.9%
Stalking/Harass-ment	0	0.0%	0	0.0%	0	0.0%	0	0.0%

Table 3.4 (Continued)
Participant Victimization Characteristics, Continued

# of IPV Incidents (Recent)	N	%	N	%	N	%	N	%
Single Incident	1	5.2%	0	0.0%	1	33.3%	0	0.0%
Extended/Multiple	16	84.2 %	6	85.7%	2	66.7%	8	88.9%
Unknown	2	10.5 %	1	14.3%	0	0.0%	1	11.1%
Endorsed Children in the Home During IPV	N	%	N	%	N	%	N	%
N/A	4	5.3%	1	14.3%	2	66.7%	1	11.1%
Yes	12	21.1 %	5	71.4%	1	33.3%	6	66.7%
Unknown	3	5.3%	1	14.3%	0	0.0%	2	22.2%

Research Question 2. *What are the sequelae of IPV among treatment-seeking woman survivors of IPV?* To answer Research Question 2, we computed descriptive statistics so as to provide information about participants' sequelae (diagnoses), mindfulness, emotional distress tolerance, emotion regulation, clinically relevant distress and flexibility, and physical health concerns. The majority of participants presented to treatment meeting criteria for primary diagnosis of an anxiety or stress related disorder (n = 16), 3 of whom also met diagnostic criteria for co-morbid depression. Most participants had no history of seeking behavioral health treatment (n = 13) and the most commonly endorsed physical health problem was somatic pain. Indeed, the majority of participants (n = 8) were

referred to treatment by a medical provider. Over half of participants (n = 10) had a history of suicidal ideation. Full participant sequelae can be found in Table 4.1-4.5.

Table 4.1

Sequelae of IPV

	Total Sample		Tx Completer		Drop-out		In Treatment	
Primary Diagnosis	N	%	N	%	N	%	N	%
Generalized Anxiety Disorder	3	15.8%	0	0.0%	0	0.0%	3	33.3%
Posttraumatic Stress Disorder	3	15.8%	1	14.3%	1	33.3%	1	11.1%
Other-Specified Trauma and Stressor-Related Disorder	6	31.6%	2	28.6%	2	66.7%	2	22.2%
Other Specified Anxiety	1	5.3%	0	0.0%	0	0.0%	1	11.1%
Adjustment Disorder	3	15.8%	2	28.6%	0	0.0%	1	11.1%
Depression (MDD, PDD)	3	15.8%	2	28.6%	0	0.0%	1	11.1%
Secondary Dx	N	%	N	%	N	%	N	%
Depression (MDD, PDD)	2	10.5%		63.6%	0	0.0%	2	22.2%
Generalized Anxiety Disorder	3	15.8%	2	28.6%	0	0.0%	1	11.1%
Other-Specified Trauma and Stressor-Related Disorder	1	5.3%	0	0.0%	0	0.0%	1	11.1%
None	13	68.4%	5	71.4%	3	100.0 %	5	55.6%

Table 4. 1 Continued
Sequelae of IPV

Tertiary Diagnosis	N	%	N	%	N	%	N	%
Depression (MDD, PDD)	1	5.3%	0	0.0%	0	0.0%	1	11.1%
None	18	94.7%	7	100.0%	3	100.0 %	8	88.9%

Table 4.2

Sequelae of IPV, continued

	Total Sample		Treatment Completer		Drop-out		In Treatment	
History of Legal Difficulties	N	%	N	%	N	%	N	%
Physical Assault	2	10.5 %	1	14.3%	1	33.3%	0	0.0%
DUI	1	5.3%	0	0.0%	1	33.3%	0	0.0%
TPO	3	15.8 %	1	14.3%	1	33.3%	1	11.1%
None	13	68.4 %	5	71.4%	0	0.0%	8	88.9%

Table 4.3

Sequelae of IPV, continued

	Total Sample		Tx Completer		Drop-out		In Treatment	
History of Seeking Treatment	N	%	N	%	N	%	N	%
Therapy/Counseling	1	5.3%	0	0.0%	0	0.0%	1	11.1%
Psychotropic Medication	2	10.5%	1	14.3%	0	0.0%	1	11.1%
Medication + Therapy	3	15.8%	2	28.6%	0	0.0%	1	11.1%
None	13	68.4%	4	57.1%	3	100.0%	6	66.7%
History of Substance Abuse	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**
None	16	84.2%	6	85.7%	2	66.7%	8	88.9%
Past (stimulants)	1	5.3%	0	0.0%	0	0.0%	1	11.1%
Past (depressants)	2	10.5%	1	14.3%	1	33.3%	0	0.0%

Table 4.4

Sequelae of IPV, continued

	Total Sample		Tx Completer		Drop-out		In Treatment	
Physical Health Problems	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**
Thyroid	1	5.3%	0	0.0%	0	0.0%	1	11.1%
Psychotropic Med Side Effects	1	5.3%	1	14.3%	0	0.0%	0	0.0%
Headaches/dizziness/vision	3	15.8%	1	14.3%	1	33.3%	1	11.1%
Epilepsy	1	5.3%	0	0.0%	1	33.3%	0	0.0%
Somatic Pain	3	15.8%	2	28.6%	1	33.3%	0	0.0%
Cirrhosis	1	5.3%	1	14.3%	0	0.0%	0	0.0%
Fibromyalgia	1	5.3%	0	0.0%	0	0.0%	1	11.1%
Cardiovascular (hypertension, cholesterol)	1	5.3%	0	0	0	0.0%	1	11.1%
Diabetes	2	10.5%	0	0.0%	0	0.0%	2	22.2%
Stroke	1	5.3%	1	14.3%	0	0.0%	0	0.0%
Sciatica	1	5.3%	0	0.0%	0	0.0%	1	11.1%
None	6	31.6%	2	28.6%	0	0.0%	4	44.4%

Table 4.4 Continued

Sequelae of IPV, continued

History of Suicidal Ideation	N	%	N	%	N	%	N	%
None	9	47.4%	2	28.6%	3	100.0 %	4	44.4%
Current, passive	5	26.3%	5	71.4%	0	0.0%	4	44.4%
Past, active	3	15.8%	1	14.3%	0	0.0%	2	22.2%
Past, attempt	2	10.5	0	0.0%	0	0.0%	2	22.2%

Table 4.5

Sequelae of IPV, continued

	Total Sample		Tx Completer		Drop-out		In Treatment	
Referral Source	N	%	N	%	N	%	N	%
Friend/Family	2	10.5%	1	14.3%	0	0.0%	1	11.1%
Medical	8	42.1%	3	42.9%	1	33.3%	4	44.4%
Lawyer	1	5.3%	0	0.0%	0	0.0%	1	11.1%
Police/Law En-forcement	2	10.5%	0	0.0%	1	33.3%	1	11.1%
Clergy	3	15.8%	2	28.6%	1	33.3%	0	0.0%
Self	1	5.3%	0	0.0%	0	0.0%	1	11.1%
CPS	1	5.3%	1	14.3%	0	0.0%	0	0.0%
Advocacy Services	1	5.3%	0	0	0	0.0%	1	11.1%

Participants' pre-treatment baseline measure scores indicated symptoms of depression and anxiety consistent with moderate range as well as generally positive attitudes toward seeking professional psychological help and some difficulty with emotion regulation. While participants' baseline measures revealed average levels of mindfulness, scores also indicate low distress tolerance, as well as clinically relevant levels of psychological distress and inflexibility. Participant pre-treatment scores can be found in Table 5.

Table 5

	Pre-Treatment Scores		
	M	SD	Range
GAD-7	12.79	5.26	3-21
PHQ-9	13.74	6.77	3-25
ATSPPH	24.50	4.60	17-29
DERS-SF	49.46	19.78	28-83
FFMQ-15	43.46	8.12	33-62
AAQ-II	32.92	13.49	12-49
DTS	38.75	16.32	19-71
PCL-5	33.00	13.74	13-50

Research Question 3. *What are the culturally-relevant characteristics of Latina survivors of IPV?* To answer Research Question 3, we used descriptive statistics to examine information about participants' characteristics including English language fluency, immigration status, endorsement of cultural values, and attitudes towards seeking professional help. All participants (n = 19) had limited English language fluency and received

Spanish services. The majority of participants (n = 10) endorsed cultural idioms of distress such as "*nervios"* and cultural values such as *marianismo* while almost half of participants (n = 9) endorsed other values such as *machismo*. Eight participants were undocumented; of those 8, 5 received a letter from their therapist documenting that they suffered substantial harm as a victim of crime in support of their petition for a U-Visa. Participants generally had a positive attitude toward seeking treatment (see Table 5). For a full description of culturally-relevant characteristics, see Table 6.1-6.2.

Table 6.1

Culturally Relevant Characteristics

	Total Sample		Tx Completer		Drop-out		In Treatment	
Limited English Fluency	N	%	N	%	N	%	N	%
Yes	19	100.0%	7	100.0%	3	100.0 %	9	100.0 %
No	0	0.0%	0	0.0%	0	0.0%	0	0.0%

Table 6.2

Culturally Relevant Characteristics, continued

Endorsed Cultural Idioms of Distress	Total Sample		Tx Completer		Drop-out		In Treatment	
	N	%	N	%	N	%	N	%
Endorsed *Nervios*	10	31.6%	3	42.9%	1	33.3%	6	66.7%
Endorsed *Machismo*	N	%	N	%	N	%	N	%
Yes	9	47.4%	3	42.9%	1	33.3%	5	55.6%
Unknown	10	52.6%	4	57.1%	2	66.7%	4	44.4%
Endorsed Marianismo	N	%	N	%	N	%	N	%
Yes	10	52.6%	3	42.9%	1	33.3%	6	66.7%
Unknown	9	47.4%	4	57.1%	2	66.7%	3	33.3%

Table 6.2 (Continued)
Culturally Relevant Characteristics, continued

	Total Sample		Tx Completer		Drop-out		In Treatment	
Immigration Status	N	%	N	%	N	%	N	%
Citizen (Naturalized)	2	10.5%	2	28.6%	0	0.0%	0	0.0%
Permanent Resident	7	36.8%	3	42.9%	1	33.3%	3	33.3%
Documented (Other)	2	10.5%	0	0.0%	1	33.3%	1	11.1%
Undocumented	8	42.1%	2	28.6%	1	33.3%	5	55.6%
Received Visa-U Letter	N	%	N	%	N	%	N	%
Yes	5	26.3%	0	0.0%	1	33.3%	4	44.4%
No	4	21.1%	2	28.6%	1	33.3%	1	11.1%
N/A	10	52.6%	5	71.4%	1	33.3%	4	44.4%

Preliminary Efficacy: ***Research Question 4.*** *What are the treatment outcomes among Latina survivors of IPV who underwent DBT for IPV skills training?*

Among treatment completers, there was a statistically significant difference between pre- and post- treatment scores on the PHQ-9 (95% CI, 7.17, 19.98, t [6] = 5.185, $p < .05$) and on the GAD-7 (95% CI, 5.84, 18.16, t [6] = 4.768, $p < .05$). For means and standard deviations, see Table 7.1. The difference scores between pre- and post- treatment scores on the PHQ-9 and GAD-7 were normally distributed, as assessed by Shapiro-Wilk's test

($p = .557$; $p = .502$). The data met all assumptions with the exception of one outlier that was detected for PHQ-9 final scores that was more than 1.5 box-lengths from the edges of the box in a boxplot; however, inspection of values did not reveal them to be extreme and they were kept in the analysis. The effect size was large for both the PHQ-9 and the GAD-7; we calculated Cohen's D (Cohen, 1988) using the following formula:

Cohen's D Formula

$$d = \frac{M1-M2}{SD}$$

Cohen's D for the PHQ-9

$$d = \frac{13.57}{6.93} = 1.96$$

Cohen's D for the GAD-7

$$d = \frac{12.00}{6.66} = 1.80$$

Of the 7 participants who completed treatment, 4 initiated treatment in person prior to the COVID-19 pandemic and transitioned to telehealth during their treatment while 3 participants initiated treatment via telehealth. During the transition to telehealth, the standard assessment battery was temporarily suspended and clients were only administered the PHQ-9, GAD-7, and PCL-5. Thus, the number of participants who completed the post-treatment assessments was significantly limited. (See Figure 1).

Figure 1.

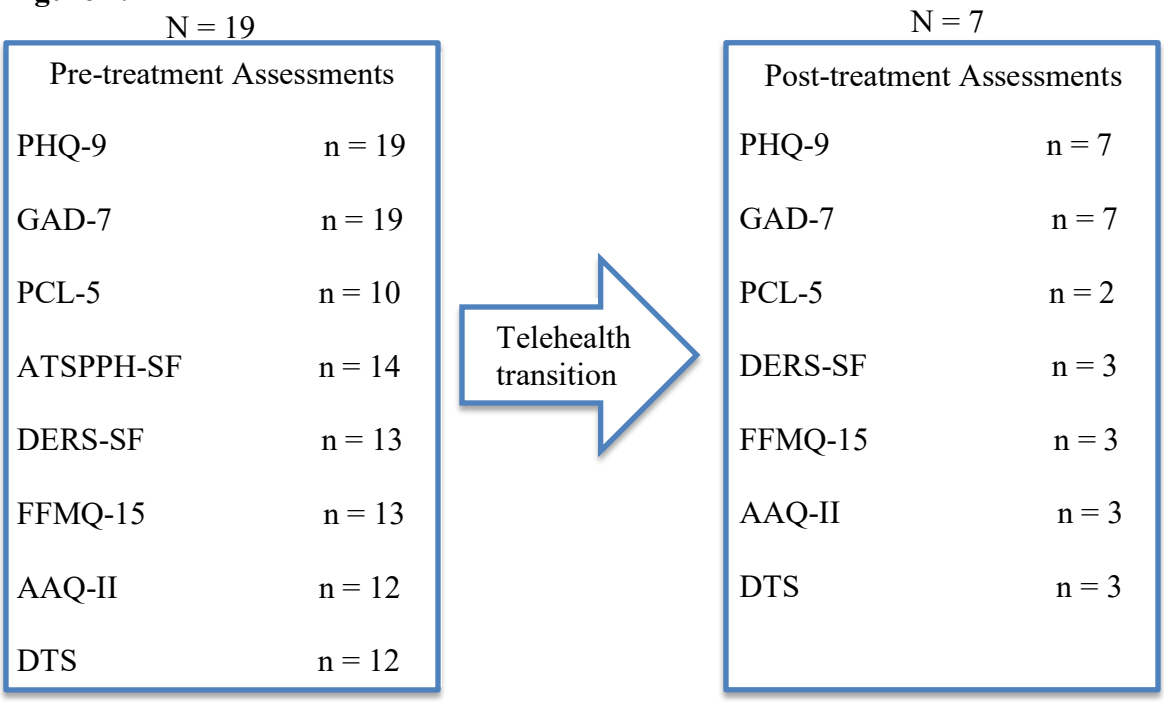

Table 7.1

Pre- and Post-Treatment Score for Treatment Completers

	Pre-Treatment Score			Post-Treatment Score		
	M	SD	Range	M	SD	Range
PHQ-9	15.71	6.97	5-25	2.14	2.80	0-8
GAD-7	13.86	6.47	5-20	1.86	1.57	0-4

Table 7.2

Pre- and Post-Treatment Score for Treatment Completers, (N =3)

	Pre-Treatment Score			Post-Treatment Score		
	M	SD	Range	M	SD	Range
DERS-SF	52.75	23.89	31-81	32.33	7.77	26-41
FFMQ-15	39.75	5.38	34-47	50.33	5.13	46-56
DTS	42.33	20.31	19-56	43.33	15.01	26-52
AAQ-II	29.50	15.5	12-44	22.00	10.15	13-33

Table 7.3

Pre- and Post-Treatment PCL-5 Score for Treatment Completers, (N =2)

	Pre-Treatment Score			Post-Treatment Score		
	M	SD	Range	M	SD	Range
PCL-5	43.33	5.69	37-48	1.00	1.41	0-2

Clinical Significance

Pertaining to treatment completers' symptoms of depression, five participants (71.43%) exhibited clinically significant change as per the cut-off scores computed under planned analyses (CSC = 9.16). In regard to symptoms of anxiety, four participants (57.14%) displayed clinically significant decreases as per the cut-off scores computed under planned analyses (CSC = 9.23). It is also noteworthy that all participants were experiencing only mild or minimal (i.e., subclinical) anxiety and depressive symptoms upon the completion of treatment suggesting that 100% of treatment completers responded to treatment (refer to Table 8 for additional information).

Lastly, a 30% reduction in rate of symptoms of anxiety and depression was found for each participant who completed treatment; specifically, 30% of their initial GAD-7 (M = 3.76; SD = 1.51) and PHQ-9 (M = 4.23; SD = 1.62) score was calculated. All participants experienced at least a 30% reduction in scores on the GAD-7 and PHQ-9. However, at the conclusion of treatment per the data supplied in the program evaluation, one participant still met diagnostic criteria for Other Specified Trauma-and Stressor-Related Disorder although they did not require additional treatment (as per documented agreement between the clinician and participant that treatment goals had been met coupled with minimal symptomatology endorsed on objective assessment measures). Thus, 6 (85.71%) of the treatment completers satisfied the criteria for high-end state functioning and, thus, responded to treatment.

Table
8

Pre- and Post-Treatment Symptom Severity for Treatment Completers

	Pre-Treatment				Post-Treatment			
	Minimal	Mild	Moderate	Severe	Minimal	Mild	Moderate	Severe
GAD-7	0	3	0	4	7	0	0	0
PHQ-9	0	1	3	3	6	1	0	0

Note. GAD-7 symptom severity: minimal<5, Mild=5-9, Moderate=10-14, Severe≥15
PHQ-9 symptom severity: minimal<5, Mild=5-9, Moderate=10-19, Severe≥20

Chapter 5: Discussion

This archival record review study was designed to evaluate treatment outcomes for Latinx women with a history of exposure to intimate partner violence who received DBT treatment at an outpatient community clinic. In addition, we sought to explore client repertoire and cultural characteristics associated with treatment outcomes. Overall, study participants endorsed characteristics consistent with what has been documented in the literature about Latinx IPV survivors such as a lower socioeconomic status and a lack of previous behavioral health service utilization. We speculated that the transdiagnostic nature of DBT would effectively accommodate the heterogeneity of sequelae observed among sample participants. Given the improvement in depression and anxiety symptomatology experienced by study participants, DBT skills training appears to be an effective intervention for Latinx IPV survivors. The low drop-out rate provides evidence for the acceptability of the use of DBT with this population.

Socioeconomic Status

Consistent with the literature (Gonzalez-Guarda, 2013) the majority of sample participants endorsed demographic variables characteristic of lower socioeconomic status. Specifically, over half of the sample indicated earning a household income of less than $19,000 per year which is below the poverty level for the state of Nevada (considering household size). This may be an artifact of the setting from which the sample was gathered—La Cliníca markets itself to persons of lower socioeconomic status. Over half of the sample participants reported that they were unemployed at the time they sought treatment, which may be indicative of their level of functional impairment related to their exposure to IPV. COVID-related employment challenges did not appear to have impacted

the employment status of the participants as a similar ratio of participants who completed treatment in person prior to the pandemic were employed compared to those who transitioned to telehealth during the pandemic as well as those who initiated treatment during the pandemic (telehealth only). Regarding education status, the majority of sample participants had completed no higher than 6th grade, which likely limited the income potential of those who were employed.

The drop-out rate was low, with only three out of 19 participants choosing to terminate their treatment early. Dropout may have been associated with challenges that accompany low socioeconomic status. Of note, the three participants who dropped out of treatment early were divorced or separated. One depended on her adult son financially and for transportation. The remaining two participants were employed, canceling multiple appointments with short notice due to conflicts with their work schedule, suggesting that conflicts with work schedule may have contributed to their decision to discontinue treatment.

Past Behavioral Health Service Utilization

Consistent with the literature documenting low behavioral health service utilization among Latinxs (Benuto, Gonzalez, Reinosa-Segovia, & Duckworth, 2019), the majority of participants had not sought treatment prior to presenting to La Clinica V.I.V.A. despite having a history of multiple victimizations. Indeed, over half of the sample had experienced ongoing child abuse that was perpetrated by a parent, step-parent, or other relative. This finding is converges with reports that childhood exposure to violence significantly increases a person's risk of experiencing repeated victimization adulthood (Smith et al., 2018). A large proportion of participants reported having children in the home during

either past or recent instances of IPV. The majority of participants endorsed experiencing IPV in the context of one or two distinct relationships with perpetrators with whom they were married or cohabitating with and five participants identified experiencing further victimization as adults outside of the context of IPV relationships. Congruent with the literature (Smith et al., 2018), of those participants who reported age at first instance of IPV most identified experiencing IPV prior to age 25.

Transdiagnostic treatments: Promise fulfilled?

The aforementioned SES-related factors provide further support for the importance of the accessibility of interventions for Latinx survivors of IPV. Specifically, cost of services is a significant barrier given low income levels. Extended hours are essential as well so as not to inadvertently exclude individuals who are employed. Given previous findings that transdiagnostic treatments are inherently more accessible compared to other treatments (Clark, 2009), it is increasingly important that transdiagnostic treatments be available in an effort to address low behavioral health service utilization. Indeed, the low drop-out rate appears to be a strength, suggesting that commitment to treatment may be high among this population when they do decide to seek formal help.

Heterogeneity of Sequelae

The variety and number of diagnoses assigned to sample participants are indicative of the heterogeneity of the sequelae of IPV among survivors in general. Furthermore, the majority of participants had a primary diagnosis that is typically assigned when an individual doesn't fully meet criteria for a specific diagnosis such as Post-traumatic Stress Disorder or a specific diagnosis of an anxiety (e.g., Generalized Anxiety Disorder) or mood disorder (e.g., Major Depressive Disorder). The observed heterogeneity is

consistent with reports in the literature and highlights the difficulty of precisely and effectively selecting psychological interventions that satisfy the unique needs of this population. Given the lack of randomized controlled trials evaluating interventions for "Other Specified" diagnostic categories, it is imperative that clinicians recognize that the most effective treatments for survivors of IPV will likely not be those that target specific diagnoses, rather, those that focus on common underlying targets (such as emotion regulation).

Over half of study participants had a history of suicidal ideation. Two participants had a history of aggressive behaviors and experienced legal consequences for physically assaulting an adult (non-perpetrator); one of those participants was court-mandated to attend treatment. Three participants had a history of substance abuse and two participants had received citations for Driving Under the Influence (DUI) of alcohol in the past. Two participants were referred to the clinic by police/law enforcement and one was referred by CPS. These characteristics are consistent with maladaptive coping responses that often result from chronic emotion dysregulation (i.e., suicidality, substance abuse, violence, and aggression). Of note, individuals who experience chronic emotional dysregulation tend to experience interpersonal difficulties that can pose a significant challenge for engaging in traditional therapeutic approaches (i.e., CBT).

Most participants indicated experiencing at least one health problem when they presented for treatment, consistent with the literature documenting the adverse physical health consequences among the sequelae of IPV (Sugg, 2015). The most commonly reported health problem was somatic pain, and the majority of study participants were referred to the clinic by their medical providers. This is consistent with the literature noting

the high proportion of somatic symptoms within Latinx populations (Bonomi, Anderson, Slesnick, & Rodriguez, 2009).

Study participants also presented with moderate symptoms of depression and anxiety and positive attitudes toward seeking professional help. The latter might have contributed to a large proportion of participants remaining in treatment and experiencing symptom improvement. Participant's DERS-SF scores did not indicate significant difficulties with emotion regulation at baseline despite some participants' histories reflecting behaviors consistent with chronic emotion dysregulation and the aforementioned maladaptive coping strategies (i.e., substance use) which are associated with emotion dysregulation (Linehan, 1993; Fruzzetti, Crook, Erikson, Lee, & Worrall, 2009). It is possible that low DERS-SF scores are related to a measurement issue as the DERS-SF has not been evaluated for use with Spanish-speaking populations in the U.S. Some research has reported support for the validity and reliability of Spanish translations of the DERS with adolescent and adult samples in Spain, Ecuadorian university students, and adolescents in Mexico City (Wolz et al., 2015; Gómez-Simón, Penelo, & de la Osa, 2014; Reivan-Ortiz, Ortiz Rodas, & Reivan Ortiz, 2020; Marín Tejeda, Robles García, Andrade Palos, & González-Forteza, 2012). Language can influence the manner in which respondents complete items and distort reports of symptom severity (Benuto, 2013). Considering that participant endorsement on the DTS did reflect low perceived distress tolerance among study participants as well as clinically relevant levels of psychological distress, it is possible that the DERS-SF did not fully capture the degree to which our participants were experiencing emotion dysregulation. Generally, persons experiencing high levels of distress who also have low perceived distress tolerance, can experience day to day life as chaotic,

which may interfere with treatment (i.e., attendance, homework completion). Thus, it is important to select treatments that target the underlying factors (i.e., emotion regulation) to maximize the individuals' engagement in treatment.

Culturally Relevant Characteristics

All study participants had limited English language fluency and were assigned to work with 1 of 4 Spanish-speaking therapists. All services (including questionnaires administered) were provided in the Spanish language. Even when individuals did have some English fluency which they utilized in other settings (i.e., workplace), they expressed a preference for receiving services in Spanish. While the behavioral health system in the U.S. is complex and arguably universally difficult to navigate for most individuals, it can be especially challenging for those who do not have a full grasp of the English language as many services and materials are simply unavailable in Spanish. This is especially true given the documentation in the literature of low mental health literacy among Latinxs (Benuto et al., 2019). Thus, availability of Spanish language materials and services is an important consideration in enhancing treatment acceptability for Latinx survivors of IPV and decreasing barriers to accessing said treatments.

Half of the sample participants indicated experiencing ongoing IPV for 12 years or longer, with a maximum of 37 years endorsed. The majority of participants expressed cultural idioms of distress such as "*nervios*" in addition to cultural values such as *marianismo* and *machismo*. It is possible that ascribing to and behaving consistently with these values may lead a survivor to remain in a marriage with their perpetrator to avoid anticipated or real consequences of breaking with cultural norms (Vidales, 2010; Gonzalez-Guarda, Cummings, Fernandez & Mesa, 2013; Kasturirangan & Williams, 2003). Indeed,

several participants who remained with their perpetrators cited electing to remain in the relationship despite not wanting to be with their partner as a self-sacrifice to preserve some sort of stability for their children (i.e., financial stability, shielding children from the perceived consequences of divorce). Moreover, some participants who did confide in close family members (e.g., mother) about the violence they were experiencing were advised to suffer in silence and comply with their duties as a wife. In working with these individuals, clinicians must be mindful that some traditional interventions (i.e., assertiveness, self-care, effective communication strategies) may seem contradictory to a person's gender role socialization and may even be met with resistance or punished by their extended family unit.

Forty-two percent of participants (N=8) were undocumented; 87% of those participants were employed at the time they sought treatment compared to 47% of the total sample. This may be related to the fact that undocumented Latinx immigrants are particularly vulnerable to financial hardship as they do not qualify for federal aid due to their immigration status. Furthermore, Latina immigrants in particular may be especially vulnerable to IPV as they may have limited (or no) access to resources available to the general population. Furthermore, limited English proficiency coupled with distrust of government and law enforcement related to the threat of deportation may pose significant barriers for an IPV survivor seeking formal help. Many participants reported becoming isolated after immigrating to U.S. with their perpetrators and not having any family or friends in the immediate area to which they immigrated. Four (50%) of undocumented participants reported refraining from calling the police as they were afraid they would be deported and were not aware of victim support services available to them. Thus, clinicians who work

with Latinx survivors need to be sensitive to these nuances particularly when making referrals to other services as individuals may not disclose their immigration status initially.

DBT as a Treatment for Latinx Survivors of IPV

Consistent with the available literature evaluating DBT for IPV, study participants exhibited improvement in symptoms of depression and anxiety after receiving DBT skills training (Iverson, Shenk, & Fruzzetti, 2009; Lee & Fruzzetti, 2017; Newlands and Benuto, 2021). For the majority of treatment completers the change in scores was clinically significant while all participants responded to treatment as evidenced by mild or minimal (i.e., subclinical) symptoms of anxiety and depression upon treatment completion. Further, accordant with findings at large, all three study participants for which post-treatment scores were available displayed increased mindfulness as well as improvement in emotion dysregulation, distress, and PTSD symptomatology. While research with DBT for Latinx survivors is limited, there is some research with self-harming and suicidal Latinx adolescents indicating that DBT skills training improves emotion regulation (Yeo et. al., 2020; German et. Al., 2015). Furthermore, in their case study of a 45-year-old Latina with a childhood history of sexual abuse, Mercado and Hinojosa (2017) found improvement in depression and anxiety symptomatology after applying culturally adapted DBT. The improvements observed in our sample participants in depression and anxiety symptomatology are also congruous with the available research on transdiagnostic treatments in general (Clark, 2009; Bell et al., 2016). Of note, transdiagnostic treatments have also found to be successful in improving emotion dysregulation (Osma et al., 2015). Thus, the present study adds to the limited literature currently available demonstrating the effectiveness of DBT with Latinx survivors of IPV.

Limitations

Given the exploratory nature of the study, there are several limitations that warrant consideration. First, the small sample size resulted in statistical analyses being significantly underpowered. Nevertheless, the fact that there were still statistical differences in treatment outcome measures may speak to the effectiveness of DBT as an intervention for IPV survivors. In addition to being small, the demographics of the sample were fairly homogenous (comprised entirely of low income, Spanish speaking, Latinx women) and there was no control group. Furthermore, given the retroactive nature of the study, many variables of interest such as cultural values, interpersonal difficulties, acculturation, and race-based traumatic stress were not formally assessed (i.e., via psychometrically sound assessment measures). Lastly, our study design did not allow us to disentangle variables that may be related to SES (i.e., immigration) which would allow for a more nuanced interpretation of results.

Future Directions

Given the promising results of this archival study, other studies documenting the effectiveness of DBT for IPV survivors should be replicated with the inclusion of Latinx samples. Specifically, the 12-week DBT skills training group, 2-day DBT group program, and video intervention adjuncts (VIAs) should be evaluated with Latinx IPV survivors (Iverson, Shenk, & Fruzzetti, 2009; Lee & Fruzzetti, 2017; Newlands and Benuto, 2021). Given the limited, but growing, research available, it would be interesting to compare differences between Latinx survivors and NLW survivors to determine if cultural tailoring would increase effectiveness of DBT skills training for the Latinx population. Furthermore, future research should include male survivors as well as this tends to be another

neglected group in the research literature. Given the proportion of the study sample who were still married to their perpetrator, it may be useful for future research to further explore the reasons why IPV survivors remain with their perpetrator.

Conclusion

The results of this study coupled with findings from other preliminary research support the need for a more rigorous evaluation of DBT skills training for IPV survivors. Furthermore, the results of this study lend support for the potential of transdiagnostic treatments in targeting underlying factors (i.e., emotion regulation). Transdiagnostic treatments may be more feasible in addressing the unique needs of IPV survivors than treatments based on diagnostic classification. Ultimately, the improvements observed in treatment outcomes for study participants suggest that DBT is an effective intervention for use with the Latinx population once treatment barriers are mitigated.

References

Abramsky, T., Watts, C. H., Garcia-Moreno, C., Devries, K., Kiss, L., Ellsberg, M., Jansen, H. A., & Heise, L. (2011). What factors are associated with recent intimate partner violence? findings from the WHO multi-country study on women's health and domestic violence. *BMC Public Health, 11*(1), 109-109. https://doi.org/10.1186/1471-2458-11-109

Alonso, E., & Labrador, F. J. (2010). Eficacia de un programa de intervención para el trastorno de estrés postraumático en mujeres inmigrantes vıctimas de violencia de pareja: Un estudio piloto/Efficacy of an intervention program for posttraumatic stress disorder in women immigrant victims of partner violence: A pilot study. *Interamerican Journal of Psychology, 44*, 547–559.

Alvarez, C., & Fedock, G. (2018). Addressing intimate partner violence with Latina women: A call for research. *Trauma, Violence, & Abuse, 19*(4), 488-493. doi:10.1177/1524838016669508

Amerson, R., Whittington, R., & Duggan, L. (2014). Intimate partner violence affecting Latina women and their children. *Journal of Emergency Nursing, 40*, 531–536. doi:10.1016/j.jen.2013.12.003

Arrieta, J., Aguerrebere, M., Raviola, G., Flores, H., Elliott, P., Espinosa, A., Reyes, A., Ortiz-Panozo, E., Rodriguez-Gutierrez, E. G., Mukherjee, J., Palazuelos, D., & Franke, M. F. (2017). Validity and utility of the patient health questionnaire (PHQ)-2 and PHQ-9 for screening and diagnosis of depression in rural Chiapas,

Mexico: A cross-sectional study. *Journal of Clinical Psychology, 73*(9), 1076–1090. https://doi.org/10.1002/jclp.22390

Arroyo, K., Lundahl, B., Butters, R., Vanderloo, M., & Wood, D. (2017). Short-term interventions for survivors of intimate partner violence: A systematic review and meta-analysis. *Trauma Violence Abuse, 18*(2), 155-171. doi: 10.1177/1524838015602736

Baer, R. A., Carmody, J., & Hunsinger, M. (2012). Weekly change in mindfulness and perceived stress in a mindfulness-based stress reduction program. *Journal of Clinical Psychology, 68*(7), 755–765. https://doi.org/10.1002/jclp.21865

Barlow, D. H., Allen, L. B., & Choate, M. L. (2016). Toward a unified treatment for emotional disorders – republished article. *Behavior Therapy, 47*(6), 838-853. https://doi.org/10.1016/j.beth.2016.11.005

Bell, C., Jordan, J., & Alexander, A. (2016). Transdiagnostic psychological treatments for anxiety and depression. *Australian and New Zealand Journal of Psychiatry, 50*(3), 201–202. https://doi-org.unr.idm.oclc.org/10.1177/0004867415614084

Benuto, L. T. (Ed.). (2013). Guide to psychological assessment with Hispanics. New York, NY: Springer.

Benuto, L. T., Gonzalez, F., Reinosa-Segovia, F., & Duckworth, M. (2019). Mental health literacy, stigma, and behavioral health service use: The case of latinx and non-latinx whites. *Journal of Racial and Ethnic Health Disparities, 6(*6), 1122-1130. https://doi.org/10.1007/s40615-019-00614-8

Benuto, L., O'Donohue, W., Bennett, N., & Casas, J. (2019). Treatment outcomes for Latinos and Non-Hispanic White victims of crime: An effectiveness study. *Hispanic Journal of the Behavioral Sciences*. https://doi.org/10.1177/0739986319860507

Black, M.C., Basile, K.C., Breiding, M.J., Smith, S.G., Walters, M.L., Merrick, M.T., Chen, J. & Stevens, M. (2011). The national intimate partner and sexual violence survey (NISVS): 2010 summary report. Atlanta, GA: National Center for Injury Prevention and Control, Centers for Disease Control and Prevention. Retrieved from http://www.cdc.gov/violenceprevention/pdf/nisvsreport2010-a.pdf

Blevins, C. A., Weathers, F. W., Davis, M. T., Witte, T. K., & Domino, J. L. (2015). The posttraumatic stress disorder checklist for DSM-5 (PCL-5): Development and initial psychometric evaluation. *Journal of Traumatic Stress, 28*(6), 489-498. doi:10.1002/jts.22059

Bond, F. W., Hayes, S. C., Baer, R. A., Carpenter, K. M., Guenole, N., Orcutt, H. K., Waltz, T., & Zettle, R. D. (2011). Preliminary psychometric properties of the acceptance and action Questionnaire–II: A revised measure of psychological inflexibility and experiential avoidance. *Behavior Therapy, 42*(4), 676-688. https://doi.org/10.1016/j.beth.2011.03.007

Bonomi, A. E., Anderson, M. L., Cannon, E. A., Slesnick, N., & Rodriguez, M. A. (2009). Intimate partner violence in latina and non-latina women. *American Journal of Preventive Medicine, 36*(1), 43-48.e1. doi:10.1016/j.amepre.2008.09.027

Breiding, M.J., Chen J., & Black, M.C. (2014). Intimate Partner Violence in the United States — 2010. Atlanta, GA: National Center for Injury Prevention and Control, Centers for Disease Control and Prevention. Retrieved from: https://www.cdc.gov/violenceprevention/pdf/cdc_nisvs_ipv_report_2013_v17_single_a.pdf

Caplan, S. (2019). Intersection of cultural and religious beliefs about mental health: Latinos in the faith-based setting. *Hispanic Health Care International, 17*(1), 4-10.

Castro, F. G., Barrera Jr, M., & Holleran Steiker, L. K. (2010). Issues and challenges in the design of culturally adapted evidence-based interventions. *Annual review of clinical psychology, 6*(1)*,* 213-239. doi:10.1146/annurev-clinpsy-033109-132032

Centers for Disease Control and Prevention. (2003). Costs of Intimate Partner Violence Against Women in the United States. Atlanta, GA: National Center for Injury Prevention and Control. Retrieved from https://www.cdc.gov/violenceprevention/pdf/IPVBook-a.pdf

Centers for Disease Control and Prevention. (2020). *Intimate Partner Violence*. National Center for Injury Prevention and Control, Division of Violence Prevention. Retrieved from http://www.cdc.gov/violenceprevention/intimatepartnerviolence/index.html

Chapman, A. L. (2006). Dialectical behavior therapy: Current indications and unique elements. *Psychiatry, 3*(9), 62–68.

Clark, D. A. (2009). Cognitive behavioral therapy for anxiety and depression: Possibilities and limitations of a transdiagnostic perspective. *Cognitive Behaviour Therapy*, *38*(Suppl 1), 29–34. doi:10.1080/16506070902980745

Cohen, Jacob (1988). Statistical Power Analysis for the Behavioral Sciences. Routledge. ISBN 978-1-134-74270-7.

Correa-Fernández, V., McNeel, M. M., Sandoval, J. R., Tavakoli, N., Kahambwe, J. K., & Kim, H. (2020). Acceptance and action questionnaire II: Measurement invariance and associations with distress tolerance among an ethnically diverse university sample. *Journal of Contextual Behavioral Science, 17,* 1-9. https://doi.org/10.1016/j.jcbs.2020.04.002

Cuevas, C. A., Sabina, C., & Picard, E. (2010). Interpersonal victimization patterns and psychopathology among Latino women: Results from the SALAS study. *Psychological Trauma: Theory, Research, Practice, and Policy, 2*(4), 296–306. doi:10.1037/a0020099

Danielson, K. K., Moffitt, T. E., Caspi, A., & Silva, P. A. (1998). Comorbidity between abuse of an adult and DSM-III-R mental disorders: Evidence from an epidemiological study. *American Journal of Psychiatry, 155*(1), 131-133. https://doi.org/10.1176/ajp.155.1.131

Derr, A. S. (2016). Mental health service use among immigrants in the United States: A systematic review. *Psychiatric Services*, *67*(3), 265–274. https://doi.org/10.1176/appi.ps.201500004

Edelson, M.G., Hokoda, A., & Ramos-Lira, L. (2007). Differences in effects of domestic violence between Latina and non-Latina women. *Journal of Family Violence*, *22*(1), 1–10. doi:10.1007/s10896-006-9051-1

Ernst, A. A., Weiss, S. J., Hall, J., Clark, R., Coffman, B., Goldstein, L., Hobley, K., Dettmer, T., Lehrman, C., Merhege, M., Corum, B., Rihani, T., & Valdez, M. (2009). Adult intimate partner violence perpetrators are significantly more likely to have witnessed intimate partner violence as a child than nonperpetrators. *American Journal of Emergency Medicine*, *27*(6), 641-650. doi:10.1016/j.ajem.2008.05.003

Ertl, A., Sheats, K.J., Petrosky, E., Betz, C.J., Yuan, K., & Fowler, K.A. (2019). Surveillance for violent deaths — national violent death reporting system, 32 states, 2016. MMWR. *Surveillance Summaries*, *68*(9), 1-36. Retrieved from https://www.cdc.gov/mmwr/volumes/68/ss/ss6809a1.htm. https://doi.org/10.15585/mmwr.ss.6809a1

Escovar, E. L., Craske, M., Roy-Byrne, P., Stein, M. B., Sullivan, G., Sherbourne, C. D., Bystritsky, A., & Chavira, D. A. (2018). Cultural influences on mental health symptoms in a primary care sample of latinx patients. *Journal of Anxiety Disorders, 55*, 39-47. https://doi.org/10.1016/j.janxdis.2018.03.005

Farchione, T. J., Fairholme, C. P., Ellard, K. K., Boisseau, C. L., Thompson-Hollands, J., Carl, J. R., Gallagher, M. W., & Barlow, D. H. (2012). Unified protocol for transdiagnostic treatment of emotional disorders: A randomized controlled trial. *Behavior Therapy, 43(*3), 666-678. https://doi.org/10.1016/j.beth.2012.01.001

Feigenbaum, J. (2007). Dialectical behaviour therapy: An increasing evidence base. *Journal of Mental Health, 16*(1), 51-68. https://doi.org/10.1080/09638230601182094

Fischer, E. H., & Farina, A. (1995). Attitudes toward seeking professional psychological help: A shortened form and considerations for research. *Journal of College Student Development, 36*(4), 368.

Foiles Sifuentes, A. M., Robledo Cornejo, M., Li, N. C., Castaneda-Avila, M. A., Tjia, J., & Lapane, K. L. (2020). The role of limited english proficiency and access to health insurance and health care in the affordable care act era. *Health Equity, 4*(1), 59-517. https://doi.org/10.1089/heq.2020.0057

Fruzzetti, A.E., Crook, W., Erikson, K., Lee, J., & Worrall, J. M. (2009). Emotion regulation. In W. T. O'Donohue & J. E. Fisher (Eds.), General principles and empirically supported techniques of cognitive behavior therapy (pp. 272-284). Hoboken, NJ: Wiley.

Fruzzetti, A. E., & Iverson, K. M. (2006). Intervening with couples and families to treat emotion dysregulation and psychopathology. In D. K. Snyder, J. A. Simpson, & J. N. Hughes (Eds.), Emotion regulation in families: Pathways to dysfunction and health (pp. 249–267). Washington, DC: American Psychological Association.

Fruzzetti A.E., Worrall J.M. (2010). Accurate expression validation: A transactional model for understanding individual relationship distress. Oxford University Press, Oxford.

Germán, M., Smith, H. L., Rivera-Morales, C., González, G., Haliczer, L. A., Haaz, C., & Miller, A. L. (2015). Dialectical behavior therapy for suicidal latina adolescents: Supplemental dialectical corollaries and treatment targets. *American Journal of Psychotherapy, 69*(2), 179-197. https://doi.org/10.1176/appi.psychotherapy.2015.69.2.179

Gilbert, L., El-Bassel, N., Manuel, J., Wu, E., Go, H., Golder, S., Seewald, R., & Sanders, G. (2006). An integrated relapse prevention and relationship safety intervention for women on methadone: Testing short-term effects on intimate partner violence and substance use. *Violence and Victims, 21*(5), 657-672. https://doi.org/10.1891/0886-6708.21.5.657

Golding, J. M. (1999). Intimate partner violence as a risk factor for mental disorders: A meta-analysis. *Journal of Family Violence, 14*, 99–132. https://doi.org/10.1023/A:1022079418229

Gómez-Simón, I., Penelo, E., & de la Osa, N. (2014). Factor structure and measurement invariance of the difficulties emotion regulation scale (DERS) in spanish adolescents. *Psicothema, 26*(3), 401-408. https://doi.org/10.7334/psicothema2013.324

Gonzalez, F. R., Benuto, L. T., & Casas, J. B. (2018). Prevalence of interpersonal violence among latinas: A systematic review. *Trauma, Violence, & Abuse 21*(5), 977-990. doi:10.1177/1524838018806507

Gonzalez-Guarda, R.M., Cummings, A.M., Becerra, M., Fernandez, M.C., & Mesa I. (2013). Needs and preferences for prevention of intimate partner violence among

Hispanics: A community's perspective. *The Journal of Primary Prevention*, *34*(4):221–35. doi:10.1007/s10935-013-0312-5

Grasso, D. J., Stover, C., & Whitaker, D. (2019). Call for papers: Prospectus for special issue of child maltreatment: "The intersection of intimate partner violence and child maltreatment". *Child Maltreatment, 24*(4), 469-470. doi:10.1177/1077559519875252

Gu, J., Strauss, C., Crane, C., Barnhofer, T., Karl, A., Cavanagh, K., & Kuyken, W. (2016). Examining the factor structure of the 39-item and 15-item versions of the five facet mindfulness questionnaire before and after mindfulness-based cognitive therapy for people with recurrent depression. *Psychological Assessment, 28*(7), 791-802. https://doi.org/10.1037/pas0000263

Harned M.S., Korslund K.E., & Linehan M.M. (2014). A pilot randomized controlled trial of dialectical behavior therapy with and without the dialectical behavior therapy prolonged exposure protocol for suicidal and self-injuring women with borderline personality disorder and PTSD. *Behaviour Research and Therapy, 55*, 7-17. https://doi.org/10.1016/j.brat.2014.01.008

Hegarty, K., Tarzia, L., Hooker, L., & Taft, A. (2016). Interventions to support recovery after domestic and sexual violence in primary care. *International Review of Psychiatry, 28*(5), 519-532. doi:10.1080/09540261.2016.1210103

Iverson, K. M., Shenk, C., & Fruzzetti, A. E. (2009). Dialectical behavior therapy for women victims of domestic abuse: a pilot study. *Professional Psychology: Research and Practice, 40*(3), 242. doi:10.1037/a0013476

Iverson, K. M., Litwack, S. D., Pineles, S. L., Suvak, M. K., Vaughn, R. A., & Resick, P. A. (2013). Predictors of intimate partner violence revictimization: The relative impact of distinct PTSD symptoms, dissociation, and coping strategies. *Journal of Traumatic Stress, 26*(1), 102-110. https://doi.org/10.1002/jts.21781

Jack, S. P. D., Petrosky, E., Lyons, B. H., Blair, J. M., Ertl, A. M., Sheats, K. J., & Betz, C. J. (2018). Surveillance for violent deaths - national violent death reporting system, 27 states, 2015. MMWR. *Surveillance Summaries, 67*(11), 1-32. https://doi.org/10.15585/mmwr.ss6711a1

Jacobson, N. S., & Truax, P. (1991). Clinical significance: A statistical approach to defining meaningful change in psychotherapy research. *Journal of Consulting and Clinical Psychology, 59*(1), 12–19. https://doi-org.unr.idm.oclc.org/10.1037/0022-006X.59.1.12

Kasturirangan, A., & Williams, E.N. (2003). Counseling Latina battered women: A qualitative study of the Latina perspective. *Journal of Multicultural Counseling and Development, 31*(3), 162–78. https://doi.org/10.1002/j.2161-1912.2003.tb00541.x

Kaufman, E. A., Xia, M., Fosco, G., Yaptangco, M., Skidmore, C. R., & Crowell, S. E. (2016). The difficulties in emotion regulation scale short form (DERS-SF): Validation and replication in adolescent and adult samples. *Journal of Psychopathology and Behavioral Assessment, 38*(3), 443-455. https://doi.org/10.1007/s10862-015-9529-3

Kroenke, K., Spitzer, R. L., & Williams, J. B. W. (2001). The PHQ-9: Validity of a brief depression severity inventory. *Journal of General Internal Medicine, 16,* 606 – 613. doi:10.1046/j.1525-1497.2001.016009606.x

Kroenke, K., Spitzer, R. L., Williams, J. B., Monahan, P. O., & Löwe, B. (2007). Anxiety disorders in primary care: prevalence, impairment, comorbidity, and detection. *Annals of internal medicine, 146*(5), 317–325. https://doi.org/10.7326/0003-4819-146-5-200703060-00004

Labrador, F. J., & Alonso, E. (2007). Eficacia a corto plazo de un programa de intervención para el trastorno de estrés postraumático en mujeres mexicanas víctimas de violencia doméstica/Efficacy of a short-term intervention program for PTSD in Mexican women victims of domestic violence. *Revista de Psicopatología y Psicología Clınica, 12*, 117–130.

Lee, J., & Fruzzetti, A. E. (2017). Evaluating a brief group program for women victims of intimate partner abuse. *Journal of Trauma Stress Disorder Treatment. 6*(3), 2. doi:10.4172/2324-8947.1000174

Levis, B., Benedetti, A., & Thombs, B. D. (2019). Accuracy of Patient Health Questionnaire-9 (PHQ-9) for screening to detect major depression: Individual participant data meta-analysis. BMJ: *British Medical Journal,* 365, l1476-l1476. https://doi.org/10.1136/bmj.l1476

Linehan, M. M. (1993). Cognitive-behavioral treatment of borderline personality disorder. New York, NY: Guilford Press.

Linehan, M. M., Armstrong, H. E., Suarez, A., Allmon, D., & Heard, H. L. (1991). Cognitive-behavioral treatment of chronically parasuicidal borderline patients. *Archive of General Psychiatry, 48*(12)*,* 1060–1064. https://doi.org/10.1001/archpsyc.1991.01810360024003

Linehan, M. M., & Wilks, C. R. (2015). The course and evolution of dialectical behavior therapy. *American Journal of Psychotherapy, 69*(2), 97-110. https://doi.org/10.1176/appi.psychotherapy.2015.69.2.97

Marín Tejeda, M., Robles García, R., Andrade Palos, P., & González-Forteza, C. (2012). P-307 - psychometric properties of the "difficulties in emotion regulation scale" in spanish (DERS-E) in mexican adolescents. *European Psychiatry, 27*, 1-1. https://doi.org/10.1016/S0924-9338(12)74474-7

Mercado, A., & Hinojosa, Y. (2017). Culturally adapted dialectical behavior therapy in an underserved community mental health setting: A latina adult case study. P*ractice Innovations*, *2*(2), 80-93. https://doi.org/10.1037/pri0000045

Muñoz-Navarro, R., Cano-Vindel, A., Moriana, J. A., Adrián Medrano, L., Ruíz-Rodríguez, P., Agüero, L., Rodríguez-Enríquez, M., Pizà, M. R., & Ramírez-Manent, I. (2017). Screening for generalized anxiety disorder in spanish primary care centers with the GAD-7. *Psychiatry Research, 256*, 312-317.

National Coalition Against Domestic Violence (2020). Domestic violence. Retrieved from https://assets.speakcdn.com/assets/2497/domestic_violence-2020080709350855.pdf?1596811079991

Neacsiu, A. D., Rizvi, S. L., & Linehan, M. M. (2010). Dialectical behavior therapy skills use as a mediator and outcome of treatment for borderline personality disorder. *Behaviour research and therapy, 48*(9), 832-839. doi:10.1016/j.brat.2010.05.017

Nelson, A., Ayers, E., Sun, F., & Zhang, A. (2020). Culturally adapted psychotherapeutic interventions for latino depression and anxiety: A meta-analysis. *Research on Social Work Practice*, *30*(4), 368-381. doi:10.1177/1049731519899991

Newlands, R. T., & Benuto, L. T. (2021). Enhancing mental health services for survivors of intimate partner violence: A stage one pilot. *Community Mental Health Journal,* https://doi.org/10.1007/s10597-021-00782-0

Noe-Bustamante, L., Lopez, M. H., & Krogstad, J. M. (2020, July 07). U.S. Hispanic population surpassed 60 million in 2019, but growth has slowed. *Pew Research Center*. Retrieved from https://www.pewresearch.org/fact-tank/2020/07/07/u-s-hispanic-population-surpassed-60-million-in-2019-but-growth-has-slowed/

Osma, J., Castellano, C., Crespo, E., & García-Palacios, A. (2015). The unified protocol for transdiagnostic treatment of emotional disorders in group format in a Spanish public mental health setting. *Behavioral Psychology, 23*(3), 447–466.

Plummer, F., Manea, L., Trepel, D., & McMillan, D. (2016). Screening for anxiety disorders with the GAD-7 and GAD-2: A systematic review and diagnostic metaanalysis. *General Hospital Psychiatry, 39*, 24-31. https://doi.org/10.1016/j.genhosppsych.2015.11.005

Reivan-Ortiz, G. G., Ortiz Rodas, P. E., & Reivan Ortiz, P. N. (2020). A brief version of the difficulties in emotion regulation scale (DERS): Validity evidence in ecuadorian population. *International Journal of Psychological Research, 13*(2), 14-24. https://doi.org/10.21500/20112084.4325

Rizo, C. F., Reynolds, A., Macy, R. J., & Ermentrout, D. M. (2016). Parenting and safety program for system-involved female survivors of intimate partner violence: A qualitative follow-up study. *Journal of Family Violence, 31*(7), 833-848. doi:10.1007/s10896-016-9833-z

Sandín, B., Simons, J. S., Valiente, R. M., Simons, R. M., & Chorot, P. (2017). Psychometric properties of the spanish version of the distress tolerance scale and its relationship with personality and psychopathological symptoms. *Psicothema, 29*(3), 421-428. https://doi.org/10.7334/psicothema2016.239

Simons, J. S., & Gaher, R. M. (2005). The distress tolerance scale: Development and validation of a self-report measure. *Motivation and Emotion, 29*(2), 83-102. https://doi.org/10.1007/s11031-005-7955-3

Smith, S. G., Zhang, X., Basile, K.C., Merrick, M.T., Wang, J., Kresnow, M., & Chen, J. (2018). *The national intimate partner and sexual violence survey (NISVS): 2015 data brief—updated release*. Atlanta, GA: National Center for Injury Prevention and Control, Centers for Disease Control and Prevention. Retrieved from https://www.cdc.gov/violenceprevention/pdf/2015data-brief508.pdf

Spitzer, R. L., Kroenke, K., Williams, J. B. W., & Löwe, B. (2006). A brief measure for assessing generalized anxiety disorder: The GAD-7. *Archives of Internal Medicine*, 166(10), 1092–1097. https://doi-org.unr.idm.oclc.org/10.1001/archinte.166.10.1092

Sugg, N. (2015). Intimate partner violence: Prevalence, health consequences, and intervention. *The Medical Clinics of North America, 99*(3), 629-649. https://doi.org/10.1016/j.mcna.2015.01.012

Swatt, M., & Sabina, C. (2013). Summary report: Latino intimate partner homicide (Grant No. 2013-IJ-CX-0037). Washington, DC: National Institute of Justice.

Tirado-Muñoz, J., Gilchrist, G., Farré, M., Hegarty, K., & Torrens, M. (2014). The efficacy of cognitive behavioural therapy and advocacy interventions for women who have experienced intimate partner violence: A systematic review and meta-analysis. *Annals of Medicine (Helsinki), 46*(8), 567.

Torres, L., Magnus, B., & Najar, N. (2020). Assessing the psychometric proprieties of the attitudes toward seeking professional psychological help Scale–Short form (ATSPPH-SF) among latino adults. *Assessment (Odessa, Fla.), 28*(1), 211-224. https://doi.org/10.1177/1073191119899470

Trabold, N., McMahon, J., Alsobrooks, S., Whitney, S., & Mittal, M. (2020). A systematic review of intimate partner violence interventions: State of the field and implications for practitioners. *Trauma, Violence, & Abuse 21*(2), 311-325. doi:10.1177/1524838018767934

US Census Bureau. (2019, December 30). *Slower Growth for Nation's Population*. Retrieved from https://www.census.gov/library/visualizations/2019/comm/slower-growth-nations-pop.html

US Census Bureau (2020, June 25). *65 and Older Population Grows Rapidly as Baby Boomers Age*. [Press release]. Retrieved from https://www.census.gov/news-room/press-releases/2020/65-older-population-grows.html

Victor, S. E., & Klonsky, E. D. (2016). Validation of a brief version of the difficulties in emotion regulation scale (DERS-18) in five samples. *Journal of Psychopathology and Behavioral Assessment, 38(*4), 582-589. https://doi.org/10.1007/s10862-016-9547-9

Vidales, G. T. (2010). Arrested justice: The multifaceted plight of immigrant Latinas who faced domestic violence. *Journal of Family Violence, 25*(6), 533–544. doi:10.1007/s10896-010-9309-5

Weathers, F. W., Bovin, M. J., Lee, D. J., Sloan, D. M., Schnurr, P. P., Kaloupek, D. G., Keane, T. M., & Marx, B. P. (2018). The clinician-administered PTSD scale for DSM-5 (CAPS-5): Development and initial psychometric evaluation in military veterans. *Psychological Assessment, 30*(3), 383-395. https://doi.org/10.1037/pas0000486

Wolz, I., Agüera, Z., Granero, R., Jiménez-Murcia, S., Gratz, K. L., Menchón, J. M., & Fernández-Aranda, F. (2015). Emotion regulation in disordered eating: Psychometric properties of the difficulties in emotion regulation scale among spanish adults

and its interrelations with personality and clinical severity. *Frontiers in Psychology, 6*, 907-907. https://doi.org/10.3389/fpsyg.2015.00907

Wood, S. L., & Sommers, M. S. (2011). Consequences of intimate partner violence on child witnesses: A systematic review of the literature. *Journal of Child and Adolescent Psychiatric Nursing, 24*(4), 223-236. doi:10.1111/j.1744-6171.2011.00302.x

World Health Organization. (2013). Responding to intimate partner violence and sexual violence against women: WHO Clinical and Policy Guidelines. *Geneva, Switzerland: WHO*.

Yeo, A. J., German, M., Wheeler, L. A., Camacho, K., Hirsch, E., & Miller, A. (2020). Self-harm and self-regulation in urban ethnic minority youth: a pilot application of dialectical behavior therapy for adolescents. *Child and Adolescent Mental Health, 25*(3), 127-134. doi:10.1111/camh.12374

Zlotnick, C., Capezza, N. M., & Parker, D. (2011). An interpersonally based intervention for low-income pregnant women with intimate partner violence: A pilot study. *Archives of Women's Mental Health, 14*(1), 55–65. doi:10.1007/s00737-010-0195-x