CASE SERIES

# Cognitive Therapy and Logotherapy Implementation: Case Series on Women Victims of Domestic Violence with Psychotic

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## ABSTRACT

**Introduction:** Women are vulnerable to domestic violence. Domestic violence triggers a decrease in self-esteem in women, which can lead to mental problems. The purpose of this case series was to describe the implementation of cognitive therapy and logotherapy to women victims of domestic violence with chronic low self-esteem. **Case Series:** There were four cases of psychotic female clients of domestic violence victims who experienced chronic low self-esteem through Meleis' transitional model approach. They received therapy for four meetings, consisting of logo therapy and cognitive therapy. Chronic low self-esteem was measured using the Rosenberg Self Esteem Scale Instrument at pre and post. After receiving therapy, the four clients experienced decreased signs and symptoms of chronic low self-esteem in cognitive, affective, physiological, behavioural, and social. This was influenced by internal factors (low level of education and the length of time the client had a mental disorder) and external factors (still living in the same house with her husband as a perpetrator of domestic violence, reasons for having children, and not having an adequate support system). **Conclusion:** Implementation of logotherapy can be a bridge in using cognitive therapy to increase self-esteem. Combining these two therapies was quite effective in eliminating cognitive distortions, lowering low self-esteem levels, and helping clients make meaning of their lives.

**Keywords:** Chronic low self-esteem, Cognitive therapy, Domestic violence, Logotherapy, Women

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## INTRODUCTION

Cases of domestic violence committed against women are still high. Demographic Health Survey (DHS) was performed in 48 countries between 1995 and 2007, showed that between 10% and 90% of women in poor countries validate domestic violence against women (1). In addition, the National Commission on Violence against Women (2) released data on the increase in domestic violence cases in 2016-2017 against housewives perpetrated by their husbands, which amounted to 259,150 to 348,446 cases (2). Domestic violence can be affected to psychology of women.

Securities-related psychological intimidation, harassment and violence, whether verbal or non-verbal, can impact mental health, such as decreased self-esteem, self-efficacy, and the onset of depression or stress. Psychological problems such as fear, anxiety, uncertainty, sleep disturbances, fragility and vulnerability are also mentioned due to traumatic experiences (3). The most impactful thing that happens in women victims of domestic violence is low self-esteem (4,5). Low self-esteem can trigger cognitive distortions (6).

The effect of low self-esteem can be overcome, one of which is by providing therapy. Based on the evidence, cognitive therapy is the most effective therapy to reduce symptoms of depression, anxiety, and trauma/post-traumatic stress disorder in victims of domestic violence with low self-esteem (7). But, cognitive therapy cannot reach the domain of interpersonal trauma experienced by clients for a long time, so it needs to be combined with logotherapy to bridge these domains. Logotherapy describes innovative techniques to restructure cognitive therapy (8). This study used the Meleis' transition model approach and Stuart's Adaptation Process to describe the assessment and experience of the client's transition comprehensively, as seen in figure 1 (9,10).

So far, no studies on domestic violence cases have discussed how to deal with women victims of domestic violence by combining cognitive therapy and

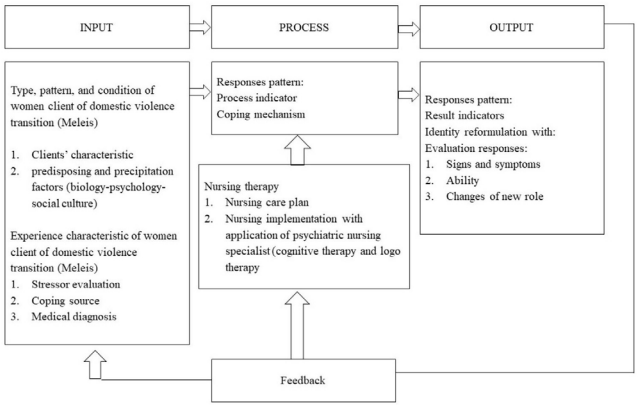


**Figure 1: Implementation of nursing care plan on women domestic violence victim with chronic low self-esteem with Meleis' transition model and Stuart's adaptation model**

logotherapy using the Meleis' transition model approach. The previous studies have focused on using only one of the existing therapies, such as using only cognitive therapy or cognitive behaviour therapy or also using a combination of therapies, but not using logo therapy. This case series aimed to describe the implementation of cognitive therapy and logotherapy to women victims of domestic violence with chronic low self-esteem.

## CASE SERIES

### Case 1

A 22-years-old woman was admitted to the hospital complaining of being angry, hitting her mother, breaking household appliances, talking to herself, being suspicious. Biological: sick since seven months ago, the client revealed that she was often beaten by her husband. Medical diagnose were paranoid schizophrenia and mild mental retardation. Psychological assessment of the unpleasant experience of being tortured by her husband for two years being beaten, snatched, abandoned by her husband. If the client complained to her in-laws, she got the same treatment as her husband did. Sociocultural: Junior high school education and jobless. Mental nursing diagnosis: Chronic low self-esteem, hallucinations and risk of violent behaviour. After receiving therapy, there was an improvement in client's self-esteem scale from seven to 23 based on Rosenberg Self Esteem Scale.

### Case 2

A 27-years-old woman, was admitted to the hospital with the main complaint of being angry, banging her head, even shaving her hair with scissors until she was bald and sleeping in the shop yard was found by people with mental disorders' volunteers. Biological: the client had been mentally ill since 2003, stopped treatment, had a hereditary history (her aunt), a history of head trauma when she fell from a motorbike several years ago. The client was currently pregnant with her 2nd child (G2A0P1). The pregnancy was estimated at 12 weeks. A few days ago client tried to commit suicide by trying to drown herself in the river. Two days later had tried to bang her head against the wall because the client felt kicked out by her family. Medical diagnosed paranoid schizophrenia. Psychological: father died in 2017, the husband was rude to clients, often beat clients and even slapped and hit clients using buckles, did not go to grade in elementary school. Sociocultural: Low education, jobless and no friends, fear of divorce from husband. Clients expressed feelings of worthlessness, failure and hopelessness. Psychiatric nursing diagnosis: chronic low self-esteem, hallucinations and Suicide Risk. After receiving therapy, there was an improvement in client's self-esteem scale from five to 15 based on Rosenberg Self Esteem Scale.

### Case 3

A 25-years-old woman, in a week, the client was at home showing symptoms of being angry, talking to herself, playing with water, being suspicious, breaking household appliances, constantly crying for no reason, sleeplessness, aggressive towards men, often naked. Biological predisposition: stopped taking medication a year ago, had a history of previous mental disorders, hereditary (the client's uncle and twin brother), had attempted suicide by stabbing her stomach with a knife. The medical diagnose was paranoid schizophrenia. Psychological: the client had been beaten by her ex-husband because she was caught hitting her child. The client felt inferior because she did not feel beautiful anymore after giving birth to three children. The client wanted to reconcile with her ex-husband so that he could gather with her children. Sociocultural: High school, Sundanese, not working. She thought that the reason her ex-husband divorced her was that she was no longer beautiful. Psychiatric nursing diagnoses: chronic low self-esteem, hallucinations and risk of violent behaviour. After receiving therapy, there was an improvement in client's self-esteem scale from five to 19 based on Rosenberg Self Esteem Scale.

### Case 4

A 40-years-old woman, was brought to the hospital because of feeling anxious, suicidal, depressed, unable to sleep for about three months, so that she often got angry, cried. Biological precipitation: injuring herself by slashing the wrist. The medical diagnose was paranoid schizophrenia. Psychological: been married two times, was in debt with money lenders due to her second husband not providing her enough. The client divorced from her first husband because he was verbally abusive and often beat dragged, and spat on the client and decided to divorce in 2005, then the second husband also often verbally abused the client and rarely provided for her, so she decided to divorce in 2012 Sociocultural: Undergraduate education, active in mass organizations. The client felt ashamed of failing to be a mother and wife. Psychiatric nursing diagnoses: chronic low self-esteem, Hallucinations, risk of suicide and violent behaviour. After receiving therapy, there was an improvement in client's self-esteem scale from nine to 25 based on

Rosenberg Self Esteem Scale.

The summarize of Rosenberg Self Esteem Scale change can be seen in figure 2. The list of client's signs and symptoms can be seen in Table I and II.

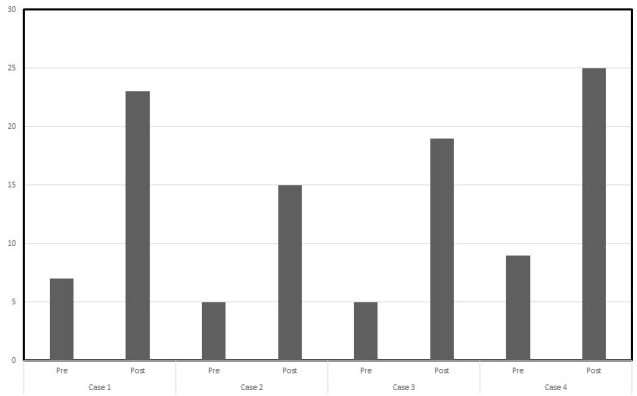


**Figure 2: Rosenberg Self Esteem Scale Assessment Results**

## DISCUSSION

This case series discussed four cases of mental disorders that occurred in women who are victims of domestic violence. The same nursing problem was found chronic low self-esteem. Thomas et al. (2010) presented the impact of domestic violence on female victims about 56% of women experienced mental disorders due to emotional or mental violence (11). Violent behaviour committed by a husband against his wife can change the victim's view of himself and his world.

The biological assessment found three out of four clients managed to have a history of mental disorders and hereditary factors. Mental health problems were already capable of affecting vulnerability to domestic violence. A serious mental illness affected being in insecure environments and relationships and increased the vulnerability of victims of violence (12). The assessment of psychological showed an unpleasant experience, and

**Table I: Changes in signs and symptoms in female clients victims of domestic violence with chronic low self-esteem**

| Sign and Symptoms | Case 1 | | Case 2 | | Case 3 | | Case 4 | |
|---|---|---|---|---|---|---|---|---|
| | Pre | Post | Pre | Post | Pre | Post | Pre | Post |
| **Cognitive** | | | | | | | | |
| Assess yourself as useless | 0 | 0 | 1 | 0 | 0 | 0 | 1 | 0 |
| A feeling of not having positive abilities | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Feeling unable to do anything | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Lack of concentration | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Overly proud | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Self-assessment is negative | 1 | 0 | 1 | 1 | 1 | 0 | 1 | 0 |
| **Affective** | | | | | | | | |
| Feeling embarrassed | 1 | 0 | 1 | 1 | 1 | 0 | 1 | 0 |
| Feeling sad | 1 | 0 | 1 | 1 | 0 | 0 | 1 | 1 |
| Mood | 1 | 0 | 1 | 1 | 0 | 0 | 1 | 0 |
| Feeling useless | 0 | 0 | 1 | 1 | 0 | 0 | 1 | 0 |
| Annoyed | 0 | 0 | 0 | 0 | 1 | 1 | 1 | 0 |
| Anger | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 0 |
| Feeling a failure | 0 | 0 | 1 | 1 | 0 | 0 | 1 | 0 |
| Feeling insignificant | 1 | 0 | 1 | 1 | 0 | 0 | 1 | 0 |
| **Physiological** | | | | | | | | |
| Decreased/increased appetite | 1 | 0 | 0 | 0 | 1 | 0 | 0 | 0 |
| Difficulty sleeping | 1 | 0 | 1 | 1 | 0 | 0 | 0 | 0 |
| Weakness | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Headache, dizziness | 0 | 0 | 1 | 0 | 0 | 0 | 1 | 0 |
| Nausea | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Slouching posture | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 |
| **Behaviour** | | | | | | | | |
| Avoiding others | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 |
| Looking down | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 0 |
| Moving slowly | 0 | 0 | 0 | 0 | 1 | 0 | 1 | 0 |
| Speaks slowly | 1 | 0 | 1 | 1 | 1 | 1 | 0 | 0 |
| Decreased eye contact | 0 | 0 | 1 | 0 | 1 | 0 | 0 | 0 |
| Decreased activity | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 |
| Self-destructive | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Unassertive behaviour | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Passive | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Criticizing others | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Lack of attention to appearance / excessive appearance | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| **Social** | | | | | | | | |
| Prefers to be alone | 1 | 0 | 0 | 0 | 0 | 0 | 1 | 1 |
| Limits interaction with others | 1 | 0 | 1 | 0 | 0 | 0 | 0 | 0 |
| More silent | 1 | 0 | 0 | 0 | 1 | 0 | 1 | 0 |
| **TOTAL** | 12 | 0 | 13 | 9 | 10 | 2 | 16 | 2 |

**Table II: Evaluation of capabilities in female clients of domestic violence victims with chronic low self-esteem**

| Client's Ability | Case 1 | | Case 2 | | Case 3 | | Case 4 | |
|---|---|---|---|---|---|---|---|---|
| | Pre | Post | Pre | Post | Pre | Post | Pre | Post |
| Able to identify abilities and positive aspects that they still have | 0 | 1 | 0 | 1 | 1 | 1 | 0 | 1 |
| Able to assess the ability that can be used | 0 | 1 | 0 | 1 | 1 | 1 | 0 | 1 |
| Able to determine the ability to be trained | 0 | 1 | 0 | 1 | 0 | 1 | 0 | 1 |
| Able to train the selected ability | 0 | 1 | 0 | 1 | 0 | 1 | 0 | 1 |
| Able to identify experiences that are unpleasant and against one automatic negative thought | 0 | 1 | 0 | 1 | 0 | 1 | 0 | 1 |
| Able to counter second negative automatic thought | 0 | 1 | 0 | 1 | 0 | 1 | 0 | 1 |
| Able to utilize a support system | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 1 |
| Able to evaluate benefits against negative thought | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 1 |
| Able to identify problems, causes and expectations. | 0 | 1 | 0 | 1 | 0 | 1 | 0 | 1 |
| Able to convey reasons for hope and the meaning of these reasons | 0 | 1 | 0 | 0 | 0 | 1 | 0 | 1 |
| Able to practice meaningful activities | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 1 |
| Able to evaluate benefits | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 1 |
| Total Ability | 0 | 12 | 0 | 7 | 2 | 8 | 0 | 12 |

personality closed a cause of low self-esteem in clients such as physical violence, violence, psychologically, sexually abuse, and behaviour overprotective like stalking (13), then sociocultural factors found poverty and low socioeconomic status was reasons for domestic violence (14).

Assessments to stressors on all clients' cognitive responses considered a negative, feelings of failure and not functional as mother or wife (10). Childress (2013) explained that women who experienced domestic violence thought that the violence they experienced could destroy their identity and self-esteem. The experiences related to domestic violence and the decreased self-esteem were manifested in feelings of sadness, social isolation, life degradation and hopelessness (5). Physiological response of sleeplessnesses, such as headache, loss of appetite, digestive problems, sleep disturbances, menstrual pain and digestive problems resulting from injury or physical injuries from maltreatment. Behavioural responses appeared in clients who experienced chronic low self-esteem, such as decreased activity and productivity. While social responses prefer to be solitude, harboured the problems they experienced, difficulty to make decisions, the emergence of distrust of themselves in carrying out their activities, feeling guilty because it was said that the client's actions provoked the perpetrator to commit acts of violence, rationalized the perpetrator's actions, experienced confusion, considered violence as karma, underestimated the severity of domestic violence, was not allowed to develop, tolerated incidents and lack of family support (losing family figures as protectors) (10,15).

Coping sources such as ongoing social support from either the family or the community can be ensured that they felt safe and able to meet their basic needs (16). Social support was very important in helping clients to make decisions. Besides that, social support was also able to provide resources for clients to leave or escape from domestic violence they have experienced (16). The client's coping mechanism most expressed anger and self-injury. Two out of four clients used this mechanism as a self-defence mechanism. Displacement or displaced aggression was an attack on an object that is not the source of the frustration (17). The forms of vents carried out by victims of domestic violence such as avoiding, hurting themselves, or doing other strange and extreme things.

The results of cognitive therapy succeeded in reducing the client's chronic low self-esteem level, especially in eliminating cognitive distortions. Three out of four clients stated they were qualitatively able to fight their negative thoughts after receiving the therapy. Cognitive therapy was the most effective individual therapy to reduce depression, anxiety, and trauma in victims of domestic violence (7). In the concept of cognitive therapy, clients learned to identify, evaluated (against objective data and facts), and modified their automatic thoughts, assumptions, and core beliefs so that their thinking became more realistic and adaptive. This process was cognitive restructuring (18). However, this therapy was less effective in trauma survivors because it was difficult to access. They also considered that this therapy was not able to overcome many domains caused by interpersonal trauma experienced by the victim, such as the victims who still deal with perpetrators of domestic violence and still struggling with various distressing pressures (e.g. protecting their children, unstable financial problems and fear of dealing with the law) (19).

The results of logotherapy succeeded in reducing the client's chronic low self-esteem level, especially in interpreting their lives. Two out of four clients stated the benefits of logotherapy. Some clients said they would take on new roles such as divorce from their husbands

and decided to remain single parents to focus on taking care of their children. Logotherapy had the potential to reduce levels of depression and increase meaning in life. Logotherapy could describe innovative techniques to restructure cognitive therapy (8). Therapy began with implementing VAT logotherapy first to find the meaning of the client's life, then continued with the implementation of cognitive therapy. Logotherapy will become a bridge when the client reveals her cognitive distortion. Cognitive distortion will be countered by using the meaning of the client's life.

Evaluation, two out of four clients who lack a support system, decreased signs and symptoms, and increased ability is also not optimal. One client stated that she still wanted to be reconciled because she wanted to hang out with their children, and the next client considered themselves imperfect mothers and wives for their children and husbands. The high rate of self-blame was associated with the relationship between previous traumatic events (20) .

The journey of self-recovery for women victim's domestic violence took a long time. Victims went through trial and error. They described regaining self-esteem and health as a very scary thing. They feel that people who had never been through trauma like them may not understand the struggles. Women who leave abusive relationships understood that they have internal strengths to help them survive and move through the trauma. After they were saved, they would become aware and develop ideas about living a life free from domestic violence. At this stage, the victims of domestic violence will begin to explore aspects of their lives that have been tested (16). They decided to reframe their roles and realized they have to change. Domestic violence survivors were often marked by identity deconstruction, then identity reconstruction to rebuild self-esteem, mental well-being, self-efficacy, and, finally, to form a new identity (4). Nursing care provided by nurses must be done by creating a positive attitude. Nurses needed to reinforce to clients that acts of violence are the responsibility of the perpetrator. Nurses needed to provide correct knowledge about the reasons behind tough decisions, such as leaving the perpetrator to seek legal assistance, information or other assistance and raising awareness about the need for security.

## CONCLUSION

Cognitive therapy and logotherapy to women of domestic violence victims with chronic low self-esteem can reduce the level of signs and symptoms in each aspect and overcome cognitive distortions, increase life meaning and improve the client's ability to cope with low self-esteem. Meleis' transition model and Stuart's stress adaptation model were able to integrate the variables involved in the therapy. Further study is required to combine with family psychoeducation therapy to increase support system.

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