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An Intervention Program for Adult Female Survivors of Childhood Sexual Abuse

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by

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

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ABSTRACT OF THE DOCTORAL PROJECT

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by

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Doctor of Marital and Family Therapy,
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Childhood Sexual Abuse (CSA) has been linked to adverse impacts within the biological, psychological, social, and spiritual (BPSS) domains of adult female survivors' lives (Fergusson et al., 2013). The impact of CSA within each of these domains may contribute to long-term trauma symptoms that impact multiple areas of life including symptoms of Post-Traumatic Stress Disorder (PTSD) that underlie dysfunction within intrapersonal and interpersonal functioning. Programs that have been designed to holistically treat this population lack interventions that target each of the BPSS domains with a structured, cohesive approach that assess the survivor's readiness based on level of current trauma symptoms. This project seeks to address this gap in treatment.

This intensive outpatient intervention program is designed to meet the needs of the adverse impact of CSA within each of the BPSS domains through a phased approach partially guided by the survivor's current level of functioning as measured by the Clinician Administered PTSD Scale (CAPS). During phase one, the survivor will begin the individual therapies of Eye Movement Desensitization and Reprocessing (EMDR), and Narrative Therapy. Within phase two, the survivor will continue the therapies from phase one, and begin Trauma Center Trauma Sensitive Yoga (TCTSY). During phase

three, the survivor will continue the therapies in phases one and two, as well as begin Emotionally Focused Couple's Therapy (EFT).

CHAPTER ONE

EXECUTIVE SUMMARY AND PROJECT PURPOSE

Executive Summary

The trauma of CSA holds the potential to pervasively impact the brain and body of adult female survivors, the biological, psychological, social, and spiritual functioning of survivors may suffer from long-term symptoms that contribute to overall decreased quality of life (Fergusson et al., 2013). As the impact of CSA may differ from one survivor to the next, this program is designed to address each of the domains within the BPSS model that are tailored to the needs of the unique survivor's trauma symptoms may be beneficial. This intensive outpatient program seeks to provide treatment to adult survivors of CSA through an integrated approach of individual therapies (EMDR, Narrative Therapy), group intervention (TCTSY) and Couple's Therapy (EFT) to address the root of trauma symptoms contributing to decreased quality of life.

Chapter Two: Literature Review

In the United States alone, 26.6% of adult females report having experienced CSA that has been linked to poor outcomes in each of the BPSS domains (Finkelhor et al., 2014). Within the biological domain, survivors experience structural changes to the brain that contribute to the suppression of memories and malfunctioning of the autonomic nervous system (De Beliis et al., 2011; Shrivastava et al., 2017). These changes to the brain structure have been correlated with increased responsiveness to stress and dysregulation of a range of emotional experiences (Shrivastava et al., 2017; Edwards,

2018). Survivors of CSA are 2.5 times more likely to experience mental health issues as compared to non-abused individuals including depression, suicidal ideation and attempts, anxiety, substance abuse, lower self-esteem, and others (Fergusson et al., 2013). As spirituality includes a sense of connection to self, others, and the world, CSA may contribute to spiritual impairments as survivors may experience dissociation, pervasive experiences of shame, lack of trust, safety, and connection to their bodies (Duros & Crowley, 2014; MacGinley et al. (2019); Daphna-Tekoah, 2019). Socially, survivors of CSA have been found to experience the most significant deficits in intimate partner relational functioning due to disrupted attachment, self-criticism contributing to relational distress, difficulty regulating emotions, and sexual dysfunction (MacIntosh & Johnson, 2008; Lassrie et al., 2018; De Beliis et al., 2011; Nelson & Wampler, 2002).

Multiple programs have been developed in attempt to holistically address the impact of CSA through integrating therapeutic interventions. These programs are innovative in nature as they seek to address the pervasive impact of the trauma of CSA. However, they overarchingly lack the ability to address each of the BPSS domains through an approach that is tailored to the severity of trauma symptoms present in the survivor's life. This proposed intensive outpatient intervention program seeks to address this gap in treatment in order to benefit this population of adult female survivors of CSA, the field of mental health, and more specifically the field of Marriage and Family Therapy.

Chapter Three: Conceptual Framework

BPSS

Engel (1980), developer of BPSS theory, discusses how the biological, psychological, social, and spiritual domains of a person are each components of larger systems, and each system functions as both a whole and a part. Each of these domains interact with and influences one another, and each require being considered in order to understand a person's functioning. Adaptive Information Processing (AIP) Theory, Social Constructionism, Attachment Theory, Neuroscience, and Trauma Theory will be applied to domains within the BPSS model to provide the foundation of chosen interventions to address the impact of CSA.

Biological

Adaptive Information Processing (AIP) theory understands that that individuals make sense of new experiences through a framework of memories of past events that have occurred in their lives. However, traumatic events may not be fully processed or integrated into these pre-existing networks, leaving the memory to remain tied to physical sensations, emotions, perceptions and beliefs that were present in the original event. This theory was developed to explain the effectiveness of EMDR discovered by Shapiro at significantly reducing trauma symptoms (Shapiro & Laliotis, 2011).

Psychological

Social Constructionism understands that psychological functioning may be impacted through dominant discourses within an individual's life that oppress other more adaptive narratives. Narrative therapy, rooted in the theory of social constructionism, posits that an effective way to create change within lives is to deconstruct the narrative in which problems have developed, externalize the problem to be separate from the individual, identify unique outcomes where the problem was not a problem in the life of the individual that reflect preferred narratives (Bitter, 2014; Nicholson, 1995). Within a narrative therapy framework, CSA survivors begin to deconstruct the dominant discourse surrounding sexual abuse and the impact of larger social structures as well as uncover preferred realities and narratives that have been subjugated in the survivor's life.

Spiritual

Emerson and Hopper (2011) describes how TCTSY is founded in the theories of neuroscience (described in AIP theory), attachment theory, and trauma theory that describes how life-threatening events can alter cognitions, emotion, and behavior. Price et al. (2017) discuss how yoga in the context of the treatment of trauma allows the survivor to increase her ability to regulate emotions and mood that have been impacted by trauma's impact on the biological functioning of the amygdala and limbic system.

Social

Within the context of couples where the female partner has survived CSA, the ability to securely attach to intimate partners may be impaired. Dalton et al. (2013)

discuss how individual trauma symptoms including dissociation, hypervigilance, a chronic sense of danger within the body, flashbacks and emotional reactivity may impact the survivor's ability to securely attach to her intimate partner.

Chapter Four: Methodology.

AIP theory is the theoretical foundation to the intervention of EMDR, which will be used in this program to target specific memories through EMDR for the purpose of integrating these memories into pre-existing memory frameworks in order to reduce trauma symptoms (van der Kolk et al., 2007). Narrative Therapy will be implemented to address the psychological impact of CSA including guilt, shame, self-blame, self-hate and stigma that is common for many survivors. The intention underlying the incorporation of this therapy into the program is to enhance narratives of resilience and the power of their voice and choice as they move into the future of their lives. TCTSY will be implemented to enhance the spiritual functioning of the survivor by increasing connection to the body, decrease dissociation, enhance emotional regulation and self-soothing strategies. Finally, EFT will be used to develop secure attachment between partners, support the healing of the relational wound of CSA, and increase relational satisfaction.

The Clinician Administered PTSD Scale (CAPS) will be used to determine readiness of survivors to progress through the phases of treatment. Additionally, the Scale of Body Connection (SBC) will be used to measure changes in bodily dissociation and awareness before and after TCTSY. Finally, the Dyadic Adjustment Scale (DAS) will be used before and after the intervention of EFT to determine changes to relational

satisfaction. This program will include three phases, where each phase builds upon the previous phase's intervention. Phase one will implement EMDR and Narrative Therapy. Phase Two will include TCTSY. Phase three will include EFT. Goals at the end of the program include reduction of trauma symptoms to absent on the CAPS, increase to positive dyadic adjustment on the DAS, and an increase in bodily awareness and decrease in bodily dissociation on the SBC.

Project Purpose

The trauma of Childhood Sexual Abuse (CSA) holds the potential to significantly impact multiple areas of life for adult women. The trauma of CSA holds the potential to reach deep into the brain and body of female survivors, impacting their biological, psychological, social, and spiritual domains of life (Fergusson et al., 2013). Each of these domains may contribute to and maintain the long-lasting symptoms of having experienced the CSA. Symptoms of trauma may continue to arise if each domain is attended to in a cohesive, integrated program, symptoms of the trauma may continue to arise throughout the adult female survivor's life.

The biological impact of CSA includes the neurological changes including structure of the brain and neural connections (De Bellis et al., 2011). These underlying biological changes contribute to chronic physical and psychosomatic conditions and complaints, as well as psychological functioning. The psychological impact of CSA includes co-occurring disorders that may be rooted in trauma, shame, guilt, anxiety, and signs and symptoms of Post-Traumatic Stress Disorder (PTSD) among others (Fergusson et al., 2013). These symptoms contribute and maintain problems within the social domain

of connecting and relating to others. CSA has been linked to difficulty in maintaining intimate partner relationships due to the nature of CSA being an attachment trauma (Nielsen et al., 2018). Finally, CSA also holds the potential to impact an adult female survivor's spiritual functioning as she may struggle with connecting to both self and others as well as struggle to find meaning within her life (Saha et al., 2011).

As the biopsychosocial-spiritual impact of CSA are associated with the severity of CSA, duration of the events, the relationship to those who perpetrated the events, developing treatment programs that are tailored to the individual needs of each survivor may be beneficial in supporting the health and wellbeing of each unique individual. The development of a program that develops treatment plans based on the assessment for the symptom severity of each survivor may lead to effective outcomes in reducing trauma symptoms. This program seeks to attend to biopsychosocial-spiritual domain, in addition to determining appropriate readiness to move forward within the treatment program based on the survivor's trauma symptom severity and/or stability.

Based on the potential pervasive and severe impact of CSA on adult female survivor's functioning, this intensive outpatient program is designed to attend to the biological, psychological, social, and spiritual functioning of the individual in order to support improved wellbeing and quality of life. In order to attend to each domain, this program integrates individual therapy (EMDR and Narrative therapy), group intervention (TCTSY), and couples' therapy (EFT) to address the root of the trauma symptoms. Historically, trauma treatment has either focused on the individual or the couple system, rather than an integrated approach that may holistically care for both the individual and the couple, as well as offer healing resources to both units of treatment (MacIntosh &

Johnson, 2008). Addressing each domain through integrating the individual therapies of EMDR, Narrative Therapy, TCTSY as a group intervention, and EFT for couples may work to increase adult female survivors of CSA' quality of life through addressing each contributing factor to maintaining trauma symptoms.

Developing a treatment program that attends to the Biopsychosocial-spiritual needs of CSA survivors may improve the field of mental health therapy at large by decreasing long-term and pervasive symptoms of trauma that contribute to decreased wellbeing throughout the lifetime. Additionally, this intensive outpatient program seeks to enhance the overarching field of Marriage and Family Therapy (MFT) by addressing the long-term impact of CSA on adult female survivors' functioning through a relational lens and by addressing each system of influence. Rather than multiple courses of therapy that disjointedly address each domain of influence, the creation of a cohesive, structured program to integrate interventions designed to address each domain demonstrates an applied systemic approach to treatment.

Key Terms

Childhood Sexual Abuse (CSA): Any sexual act (attempted or completed), perpetrated by an individual who had sexual contact with the child prior to the child turning 18.

Adult Female Survivors of CSA: Female, age 18 or above, who has survived CSA.

Biopsychosocial-spiritual (BPSS): Biological, psychological, social, and spiritual domains of an individual's life.

Biological includes structure and function of the brain and body.

Psychological includes all mental health symptoms, cognitions, and emotions.

Social includes an individual's ability to maintain intimate partner relationships.

Spiritual includes one's connection to self, others, and the world.

Spirituality: An individual's sense of awareness and connection to oneself, others, and the world.

CHAPTER TWO

LITERATURE REVIEW

Problem Statement

Within the United States, an alarming 26.6% of adult females report having experienced CSA (Finkelhor et al., 2014). CSA has been found to be linked to negative biological, psychological, social, and spiritual impact throughout an adult female survivor's life. The adverse impact of CSA may depend on what stage of development the female was in when the abuse occurred, which protective and risk factors were present in the female's life, and the severity and duration of the abuse. As Duros and Crowley (2014) discuss, trauma holds the ability to reach deep into the brain and body of the survivor, potentially impacting each of the survivor's biological, psychological, social, and spiritual domains.

This project seeks to identify the pervasive impact of CSA on each domain, and develop a comprehensive program designed to holistically treat the impact of trauma within each domain in order to promote healing, address the root of trauma symptoms, and increase quality of life for adult female survivors. This proposed intensive outpatient program (IOP) is based on a systemic approach as adult female survivors are understood to exist in multiple systems within the BPSS domain. Additionally, trauma symptoms are conceptualized as being maintained within the couple system and therefore the survivor's partner is involved in the program throughout the duration of treatment to support second order, long-lasting change. As the survivor functions within the larger social system, narratives of trauma and resilience within each system will be assessed and addressed. In

order to address each impact of CSA and the maintaining factors of trauma symptoms, this novel (IOP) integrates individual therapies and couple's therapy. Individual therapy including EMDR, Narrative Therapy, and Trauma Center Trauma Sensitive Yoga will address the biological, psychological, and spiritual domains. A psychoeducational component for the female survivor's partner to support the survivor's work in individual therapy and to prepare for couples' therapy, consisting of EFT, will be implemented to address the social domain. This IOP seeks to provide structured integration of individual and couples to meet each level of the pervasive impact of CSA.

Biopsychosocial-spiritual Impact of CSA

Biological Domain

Brain Changes

As the brain is developing throughout childhood, surviving CSA has been found to have the potential of significantly impact neurobiology of the survivor, including changes in brain structure and development. De Beliis et al. (2011) suggest sexual trauma experienced during childhood may be more detrimental than trauma experienced in adulthood due to the effects of CSA on brain development including reduction in corpus callosum volume, contributing to poor communication between the brain's two hemispheres. Long-term effects of CSA may lead to changes in the hippocampus that do not appear until adulthood due to the impact of CSA being gradual in this region of the brain. This change to the hippocampus leads to forgetting or "suppressing" memories of

the abuse (Shrivastava et al., 2017). Trauma has also been found to be linked to significant changes in the amygdala, various neural connections, and the release of chemicals responsible for emotions and the functioning of the autonomic nervous system (Duros & Crowley, 2014). Edwards (2018) describes how depending on which stage of brain development a child is in when the CSA occurs, this may determine the impact on the brain and development of chronic, long-lasting symptoms in adulthood. Childhood trauma in general can cause damage to neurons within the hippocampus, prefrontal cortex, and amygdala, which are vital to emotion and memory functions.

Stress

When trauma occurs while the brain is continuing to develop during childhood, chronic post-traumatic stress symptoms may serve as the trajectory to developing more severe psychopathology and compromised cognitive and psychosocial functioning at large. During the stressful episodes of CSA, multiple neurotransmitter and neuroendocrine systems are activated. These same systems are designed to modulate the brains response to routine, expected stimuli as well as acute and chronic stressors. Due to these multiple brain structure changes that are seen over time, CSA may lead to increased responsiveness to stress (Shrivastava et al., 2017).

Emotional Dysregulation as a Result of Brain Changes

CSA has been linked to altered amygdala and hippocampal structures within survivors' brains that are responsible for executive and cognitive functioning, emotional regulation, autonomic functions, and sleep cycles (Edwards, 2018). When CSA occurs, it

is possible for chronic symptoms within these areas of functioning to arise, as these systems are responsible for arousal, emotional, and behavioral regulation. Furthermore, when intense fear and anxiety are activated during CSA biologic changes in the fight or flight response within the brain may occur. Shrivastava et al. (2017) describe how early adverse life experiences sensitize neural circuits that are responsible for emotion regulation, leading to an increased vulnerability to experience depression, anxiety, and other mood disorder signs and symptoms. Additionally, sexual abuse results in changes in stress response that can be long-lasting and significantly increase risk of depression (Shrivastava et al., 2017).

Psychological Domain

Overall psychological health for female survivors of CSA is a significant concern, as these survivors are shown to have 2.5 times as many mental health issues than non-abused counterparts. Ensink et al. (2020) found that 70-75% of CSA survivors experience mental health problems at some point over the course of their lives. These mental health issues may range from major depression, suicidal ideation and attempts, anxiety disorders, substance use disorders, and lower self-esteem among others (Fergusson et al., 2013). Closely related to the aforementioned biological impact of CSA, adult survivors are likely to experience symptoms of post-traumatic stress including hyper-responsiveness to stressful stimuli, flashbacks, emotional flooding, physiological and psychological arousal symptoms such as panic attacks and anxiety, lack of trust, anger, depression, isolation, self-destructive behavior, and sexual dysfunction (Nelson & Wampler, 2002).

Spiritual Domain

Spirituality includes the sense of connection that humans feel to themselves, others, and the world around them. Adult female survivors of CSA are more likely to detach themselves from their own body, particularly those who have experienced incest or continuous sexual abuse (Duros & Crowley, 2014). As dissociation describes a lack of connection to one's sense of self, cognitions, memories, emotions, and/or actions, dissociation can also be conceptualized using a spiritual lens. Duros and Crowley (2014) describe how various forms of trauma hold the potential to result in a pervasive sense of danger within the body, leading to lack of trust, sense of safety, and sense of connectedness to one's own body. Daphna-Tekoah (2019) found through listening adult female survivors of CSA stories of how they experienced the self, that the ability to disconnect from the physical body during painful events of CSA is a form of survival during the event, as well as a way to avoid painful memories long-term.

Shame

As adult female survivors of CSA tend to experience low levels of self-esteem, low self-image, and a sense of unworthiness, these symptoms negatively impact and alter their core sense of self. Saha et al. (2011) further describe how these symptoms connected to sense of self and spirituality are also connected with psychiatric disorders. MacGinley et al. (2019) describe the sense of self that may be present within adult women who have survived CSA may be rooted in shame in response to the trauma event. Saha et al. (2011) found that adult female survivors' of CSA sense of self, rooted in shame, is connected to the belief there is lack of meaning to their existence and they do

not deserve basic human rights. Furthermore, these women were more likely to view themselves as underserving, insignificant, and believe others view them this way as well, impairing their connection to self, others, and the world. This sense of shame was found to be correlated with avoidance of connecting with both self and others emotionally and physically (Saha et al., 2011). Survivors have also reported avoidance as a way to not allow the time or space to reflect on the sense of self due to the pervasive experience of shame. This avoidance due to shame contributes to further isolation and disconnection from self, others, and the world (MacGinley et al., 2019; Saha et al., 2011).

Social Domain

Larger Social System Functioning (Education, Employment, Community)

Kallstrom-Fuqua et al., (2004) found that childhood sexual abuse is linked to negative outcomes in social relationships. The contributing factors to the negative impact of CSA on social functioning include survivors' feelings of powerlessness, betrayal, and stigmatization within the larger social context. Additionally, adult survivors of CSA maintain higher rates of reliance on the welfare system, have lower levels of gross income, and are more likely to not complete school or lack qualifications when they leave school (Kallstrom-Fuqua et al., 2004). Those who belong to lower socioeconomic classes may experience greater feelings of powerlessness than those who belong to higher classes due to the impact of living in poverty. Additionally, women of color may have a greater likelihood of experiencing powerlessness in the aftermath of CSA due to their experiences of racism and discrimination (Kallstrom-Fuqua et al., 2004).

Intimate Partner Relational Functioning

Overall, CSA has been linked to decreased life satisfaction, including intimate partner relationships (De Beliis et al., 2011). Callahan et al. (2003) discuss how research surrounding the long-term impacts of CSA on social functioning do not provide congruent results, as some studies have found a long-term impact of CSA to be maladaptive social functioning overall, whereas others have found no differences between groups of adult survivors of CSA and non-abused groups. Within the research studying the impact of CSA on social functioning, the most significant impairment found is maladaptive functioning within intimate partner relationships. Due to intimate partner relationship functioning being the most significantly impacted area of functioning within the larger social domain, this proposed intervention program targets intervening within the couple system in order to enhance quality of life and wellbeing for survivors.

Attachment

MacIntosh and Johnson (2008) found that adult female survivors of CSA are more likely to experience fearful and avoidant attachment styles and report negative views of both self and others. These symptoms contribute to avoidance of closeness and intimacy as well as high levels of anxiety surrounding the nature of intimate relationships. De Beliis et al. (2011) describe how the survivor's ability to form attachment relationships remains present, but this system has been traumatized and impaired due to CSA, leading to a pervasive sense of fear and distrust in relationships. Lassrie et al. (2018) describe how this disruption to secure attachment may contribute to the survivor's low levels of reaching out for support and overall distrust in close, intimate relationships.

Self-Criticism Contributing to Decreased Relational Satisfaction

As survivors of CSA are more likely to maintain higher levels of self-criticism and relationship dissatisfaction, survivors may attempt to cope with their experiences through seeking autonomy, dismissing and suppressing negative emotions, and being less likely to reach out for social support. These attempts at coping maintain the experience of lower levels of trust in relationships (De Beliis et al., 2011; Lassrie et al., 2018). The pervasive nature of self-criticism that adult female survivors of CSA experience may be due to the survivors attempt to direct shame, blame, and criticism inward as this internalized blame may be more manageable or provide a sense of control for the traumatized individual. These self-critical beliefs may also contribute to impaired communication and negative interaction cycles within the couple system, furthering dissatisfaction in the relationships (Nelson & Wampler, 2002).

Emotionality

Adult female survivors of CSA present with difficulty in regulating emotional responses, including experiencing emotions in “all-or-nothing” ways, impacting their ability to maintain intimate partner relationships (De Beliis et al., 2011). This difficulty in regulating emotional responses may include emotional flooding, numbing or dismissing emotions and avoidance of negative affect (Lassrie et al., 2018). As survivors may struggle with with the belief that others cannot be trusted, they may strive for autonomy and achievement in order to avoid negative emotional experiences of reliance on their intimate partner.

Sexual Dysfunction

Correlated with disrupted attachment and the PTSD symptom of avoidance of stimuli, sexual dysfunction may also arise as the survivor may avoid sexual interactions (Neslon & Wampler, 2002; MacIntosh & Johnson, 2008). Due to the nature of CSA involving sexual contact, adult female survivors may experience distress surrounding sexuality in general, fear of intimacy, and fear or avoidance of intimate touch as these interactions may trigger flashbacks of the traumatic event (Nelson & Wampler, 2002). As Duros and Crowley (2014) discuss, a survivor may experience a chronic sense of danger within her body after surviving CSA, contributing to sexual interactions prompting a sense of danger within the survivor's brain and body. Nelson and Wampler (2002) summarize how sexual dysfunction as related to surviving CSA contributes to overall relational dissatisfaction.

Impact on Intimate Partners

Hunt-Amos et al. (2004) describe how little within the literature is devoted to understanding the impact of CSA on adult female survivor's intimate partners, who often experience vicarious trauma. Partners may experience self-blame for not being able to save their partners from the experience of CSA itself or fix the impact of the trauma on their functioning. Partners may also distance themselves from their wives, experience frustration due to the lengthy healing process, anger in response to the news and impact of CSA, contemplate divorce, struggle with balancing meeting their own needs in addition to their partners, feel rejected, confused, and hurt by their wives distancing and/or sexual and emotional dysfunction (Hunt-Amos et al., 2004). In order to further

support the female survivor through individual therapy and to prepare for EFT, each adult female survivor's partner will be involved in the treatment program.

Conclusion

CSA holds the potential to pervasively impact an adult female survivor's BPSS functioning (Finkelhor et al., 2014). Each of these impacted domains may influence one another and maintain trauma symptoms the adult female struggles with daily. The biological system may suffer from chronic changes in structure and function of the brain and body (De Bellis et al., 2011). The psychological system may suffer from the chronic symptoms of mental health disorders including PTSD, other comorbid disorders, feelings of worthlessness, and shame among others (Lassrie et al., 2018). The social system may be impacted by the dysfunction of the adult female survivor's ability to maintain satisfying intimate partner relationships and negative impact to attachment (Nielsen et al., 2018). The spiritual system may be adversely impacted by the lack of ability to connect to oneself, others, and the world (Saha et al., 2011). The field of mental health would benefit from a program designed to assess and intervene within each domain, depending on the nature and severity of the adult female survivor's impact on functioning, through integrating modalities that target each area of impact. There are several programs designed to attempt to address each domain of the BPSS model. These programs will be analyzed for review to support the development of this project.

Programs

Dare to Flourish

"Dare to Flourish" is an outpatient pilot treatment program in the United States that seeks to support young adult female survivors of CSA. This outpatient program understands that CSA may pervasively impact young adult female's psychological, social, physical, and spiritual domains. Rooted in adaptive information processing theory (AIP), Cognitive Model, and Theory of Meaning, this program is structured to include five modules. The first module is group-based and focused on building rapport with the survivors and to provide education about the program. The second module is focused on enhancing strengths of the self and to "accept" past experiences. Within the second, third, fourth, and fifth module, group sessions are conducted as well as individual sessions where the survivor engages in Eye Movement Desensitization and Reprocessing (EMDR) and installing positive cognitions and emotions. The third module is focused on improving interpersonal skills. The fourth module is focused on positive coping, empowering choice, increasing appreciation of life. The final module is focused on renewing spirituality and developing a sense of purpose in life. Altogether, there are 15 sessions within the Dare to Flourish program. The outcomes of this program were studied by enrolling eight young adult females in a study to determine outcomes after receiving the intervention. Results showed a new sense of meaning and purpose in life, improved relationship to self and others, enhanced awareness of strengths, and increased positive coping skills (George & Bance, 2019).

Critique

One strength of the program "Dare to Flourish" is it conceptualizes the nature of CSA as impacting the biological, psychological, social, and spiritual domains of adult females and tailors interventions to support improved functioning in each of the domains. One limitation of the program is the interventions within each of the domains may not address the underlying factors that contribute to the trauma symptoms. For example, although CSA has been shown to significantly impact a survivor's ability to sustain intimate partner relationships, there are not interventions designed to address relational issues outside of teaching interpersonal skills within a psycho-education format. As CSA has been shown to impact survivors attachment relationship with significant others, MacIntosh and Johnson (2008) describe the importance of integrating significant others into the treatment of adult female survivors of CSA in order to restructure the attachment relationship. Another critique of this program is that there are no indicators described of readiness to move forward into additional phases. As the experience of CSA may be drastically different from survivor to survivor, it may be important to acknowledge the severity of symptoms between survivors will differ significantly, contributing to the need for various durations within each stage of treatment depending on the unique presentation of each survivor. Another limitation of the Dare to Flourish program is the efficacy of the program may not be generalizable to the entire population of adult female survivors of CSA due to the small sample size of eight female participants. The eight participants were selected for the study due to being in Shelter Homes within India, which may have contributed to the results of the study. Research into the treatment efficacy of this program would be more beneficial if it consisted of a randomized control trial.

The Health Model

Connor and Higgins (2008) describe "The Health Model," which is inpatient treatment for adult survivors of CSA. This program consisted of three months of treatment where adult survivors engage in three phases of treatment. The first phase includes treatment reduction and stabilization. The second phase is focused on treating traumatic memories. Finally, the third stage is focused on integrating personality and increasing social function. Treatment consists of a multidisciplinary team of social workers, pastors, art and occupational therapists, nurses, psychiatrists, and psychologists. The theoretical framework of this model includes psychodynamic theories, cognitive and behavioral approaches, group therapy, and individual therapy. Multiple measures designed to assess for psychiatric symptoms, depression, trauma symptoms, and interpersonal problems were used at evaluation, admission, discharge, and at one year follow up. Improvements were seen most significantly within interpersonal functioning. Symptoms of PTSD significantly decreased at time of discharge, to then increase again at one year follow up that impaired daily functioning.

Critique

One of the strengths of this model is the strong focus on interpersonal issues. Not only does this program include groups that teach interpersonal skills and effectiveness, but there are group therapy components designed to increase connection to others within the survivor's social system at large. However, there were no measures used to assess intimate partner relational functioning, but rather, interpersonal functioning in general.

One limitation of this model includes that treatment was not tailored to the individual. Noted by Connor and Higgins (2008) a significant limitation of the program is the lack of treatment tailored to each individual's particular presentation. This program fails to assess for the nature and severity of trauma symptoms of each unique patient and tailor duration of treatment as well as specific interventions and treatment planning accordingly. Additionally, it is described how traumatic memories and symptoms are "targeted" within this model, but the interventions used to target these memories are not clearly identified (Connor & Higgins, 2008).

Wellness Program

The Wellness Program is an outpatient program designed to holistically treat the impact of CSA on adult females by integrating the unity of the mind, body, and soul into treatment (Sigurdardottir et al., 2016). The program's duration is ten weeks, within two-hour time frames, five days per week. In providing holistic treatment, the Wellness Program offers individual therapy consisting of psychosomatic therapy, relaxation, and massage therapy. Group therapy is offered within this program that includes mindfulness groups led by psychologists and various groups led by nurses. In effort to support the survivor's body's needs, each woman enrolled in the program receives consultation services regarding diet and nutrition. The women who were enrolled in the study of the efficacy of this program experienced symptoms that impaired their ability to work or attend school, experienced health problems, and social isolation. Results of the program have shown to include increase in mental, physical, and social wellbeing. Women reported experiencing increased self-confidence, peace, ability to trust others, and

demonstrated increased levels of ability to manage symptoms, reach out for support, and receive support from others within their environment. Furthermore, the majority of women returned to work or school after receiving treatment within the Wellness Program (Sigurdardottir et al., 2016).

Critique

One strength of this program is the attentiveness to the various impacts of CSA, including the biological, psychological, and social domains of the BPSS model, and it incorporates multiple modalities in order to address each domain. Additionally, the Wellness Program has a strong focus on how trauma is stored within the body and integrates interventions to address the mind-body connection. However, one limitation of the program is the lack of integration between the modalities, including lack of description of the theories used to develop the interventions and explanation of how each area of treatment (mind, body, and soul) interact with one another. Another limitation of this program is the lack of evaluation tools used to determine the symptom severity of CSA survivors. Without a tool used to measure the symptom severity, there may be lack of ability for mental health professionals to determine readiness of the participants to enter into the various interventions.

Conclusion

Each of these programs are innovative in nature as they integrate multiple modalities to address the impacts of trauma in multiple areas of the lives of adult female survivors of CSA. The Wellness Program poses the limitation of not addressing the

spiritual domain within the BPSS model. Although the Dare to Flourish program seeks to address elements of the BPSS model through integrating individual therapies and psycho-educational approaches to support interpersonal functioning, it lacks addressing potential underlying attachment wounds that may be contributing to the survivor's maintained trauma symptoms. This proposed intervention program will draw upon these innovative programs in order to integrate modalities that address each of the BPSS domain.

This proposed intervention program also seeks to address the limitations of these aforementioned programs. The Wellness Program, Health Model, and Dare to Flourish programs lack an individualized treatment approach that allow survivors to progress through treatment dependent on the nature and severity of trauma symptoms. The field of mental health treatment would benefit from an intervention program that integrates modalities to address each domain within the BPSS model that the literature shows to be impacted by surviving CSA. Additionally, the field of MFT in particular would benefit from a program that provides treatment to survivors of CSA from a system's approach that integrates couples therapy to work toward long-term alleviation of trauma symptoms.

CHAPTER THREE

CONCEPTUAL FRAMEWORK

Conceptualization of Treatment for Adult Female Survivors of Childhood Sexual Abuse and Their Partners

The aim of this project is to develop a program that integrates individual therapies (EMDR, Narrative Therapy, and TCTSY) and couple's trauma therapy (EFT) for adult female survivors of childhood sexual abuse (CSA). The purpose of this program is to provide cohesive, integrated care that attends to the pervasive impacts of trauma within the biological, psychological, social, and spiritual domains of the BPSS model. This proposed intervention program is founded on Adaptive Information Processing Theory (AIP), Social Constructionism, Yoga, and Attachment Theory as the foundational theories in understanding the pervasive impact of CSA on each of the BPSS domains. Each of these overarching theories offer models of interventions to be integrated in order holistically treat the trauma survivor's BPSS needs.

The impact of CSA contributes to an array of individual symptoms including dissociation, emotional reactivity, a chronic sense of danger in the body and flashbacks among others (Duros & Crowley, 2014). In addition to these individual symptoms that impact biological and psychological functioning of the survivor, the survivor's intimate partner relationship may also be adversely impacted due to the survivor's potential impairment in ability to attach to her partner, avoidance intimacy, fear of closeness, maintaining a reduced capacity to trust, and experiencing shame and guilt. These relational symptoms may contribute to dysfunction within the couple system and overall

decreased relationship satisfaction (Dalton, Greenman, Classen & Johnson, 2013). As this program seeks to integrate individual therapies (EMDR, Narrative therapy, TCTSY) and couple's therapy (EFT) for adult female survivors of CSA, (AIP) theory, Social Constructionism, Yoga, and Attachment Theory are required to understand the broad, pervasive impact of trauma as well as lay the framework for implementing key interventions to attend to all of the needs present within the survivor's life. The relevant concepts and implications of each of these theories will be discussed as well as how these theories complement one another and work effectively in integration to provide holistic treatment for this population.

Biopsychosocial-Spiritual Theory

Biopsychosocial-spiritual theory provides a framework that understands individuals have multiple levels of functioning. Furthermore, to understand the whole person, the biological, psychological, sociological, and spiritual domains require being assessed in order to gain understanding of present functioning and symptomology. Suls and Rothman (2004) discuss how biological, psychological, social, and spiritual processes interact with one another and shape an individual's physical and psychological health. Engel (1980), developer of BPSS theory, also describes how the biological, psychological, social, and spiritual domains of a person are each components of larger systems, and each system functions as both a whole and a part. Each of these domains interact with and influences one another and require being assessed in order to understand a person's functioning. The biological domain includes what is happening at the cellular level within a person's brain and body. The psychological domain includes thoughts,

emotions and behavioral drives of an individual. The sociological domain includes the relationships and larger social structures that an individual lives within. Finally, the spiritual domain includes the survivor's sense of awareness and connection to oneself, others, and the world. The BPSS model serves as a foundational theory in conceptualizing the pervasive impact of CSA within each domain of a survivor's life. In order to propose a comprehensive intervention program, additional frameworks will be applied to each domain that provide a foundation for specific interventions to target the impacts of CSA. Adaptive Information Processing Theory, Social Constructionism, Yoga, and Attachment Theory will be applied to their respective domains within the BPSS model to provide the foundation of chosen interventions to address the impact of CSA.

Biological Domain

Adaptive Information Processing Theory

Adaptive Information Processing (AIP) Theory poses that individuals make sense of new experiences through a framework of memories of past events that have occurred in their lives. Shapiro and Laliotis (2011) describe how these memory frameworks guide an individual's functioning in the future. When events occur in an individual's life, the memory is either integrated into these networks to inform future behavior, or the memory is discarded if it is not useful. When events occur that may be distressing to an individual, the brain works to integrate the memory into these pre-existing frameworks in order to bring the individual's level of disturbance down so that the individual is able to move

forward with minimal distress in his or her life. However, there may be traumatic events that occur within a person's life that are not fully processed or integrated into these pre-existing networks, leaving the memory to remain tied to physical sensations, emotions, perceptions and beliefs that were present in the original event. As this event is left unprocessed and unintegrated, when new events occur that may have similar aspects of experience, this unprocessed memory is triggered, which quickly floods the new experience with the physical sensations, emotions, perceptions and beliefs of the unprocessed memory.

Adaptive Information Processing Theory was developed to explain the effectiveness of Eye Movement Desensitization and Reprocessing (EMDR) discovered by Shapiro to significantly reduce trauma symptoms (Shapiro & Laliotis, 2011). AIP Theory has been applied to the population of adult female survivors of sexual abuse in understanding how present dysfunction in their lives may be explained through understanding the trauma event(s) of CSA to be unprocessed within the individual's mind leading to current trauma symptoms of emotional reactivity, hypervigilance, flashbacks and dissociation among others. Edmond et al. (1999) were some of the first researchers to apply AIP theory to understanding the long-term symptoms of female CSA survivors. Traumatic symptoms within this population were conceptualized through the events of CSA being unprocessed within the survivor's mind, coloring current experiences with the emotions, body sensations, perceptions and beliefs to resemble the actual traumatic events. Edmond and Rubin (2004) understand that adult female CSA survivors experience traumatic symptoms rooted in these traumatic memories.

Psychological Domain

Social Constructionism

One of the main tenets of social constructionism is that dominant discourses within society marginalize and oppress other narratives within individuals' lives. A dominant discourse is a particular way that a subject is discussed throughout culture, or expectations about what "should be" within a cultural group that become spoken or unspoken guidelines. These dominant discourses are often times unchallenged, accepted way of viewing the self or the world (Bitter, 2014). Social Constructionism understands that problems may develop in individual's lives when the dominant discourse no longer meets the needs of the individual or when the dominant discourse becomes oppressive in nature to the individual. Narrative therapy, rooted in Social Constructionism, posits that an effective way to create change within lives is to deconstruct the narrative in which problems have developed, externalize the problem to be separate from the individual, identify unique outcomes where the problem was not a problem that reflect preferred narratives. The individual then works to find historical evidence of this preferred narrative in her life, as well as construct this preferred reality for the future (Bitter, 2014). Nicholson (1995) describes how this preferred narrative for the future becomes thickened through story-telling, letter writing and including others into the therapeutic process.

Miller et al. (2006) use the concepts of narrative therapy to understand the issue of childhood sexual abuse as an expression of oppression within a patriarchal, heterosexist society that are unaddressed within the larger culture. These dominant discourses and expressions of oppression through sexual abuse of women create struggles

within women's lives including self-blame, guilt, shame, self-hate and cognitive distortions around trust, safety, self-esteem, power, and intimacy. Within a narrative therapy framework, CSA survivors begin to deconstruct the dominant discourse surrounding sexual abuse, and the impact of larger social structures, as well as uncover preferred realities and narratives that have been subjugated in the survivor's life. Through this exploration, the survivor begins to re-author her story, separate the problem of CSA from herself and move toward living out these preferred, previously marginalized stories of her life.

Spiritual Domain

Trauma Center Trauma Sensitive Yoga

Emerson and Hopper (2011) describes how Trauma Center Trauma Sensitive Yoga (TCTSY) is founded in the theories of neuroscience (described in AIP theory), attachment theory, and trauma theory that describe how life-threatening events can alter cognitions, emotion, and behavior. Price et al. (2017) discuss how yoga, in the context of trauma treatment, allows survivors to increase their ability to regulate emotions and mood that have been impacted by trauma's impact on the biological functioning of the amygdala and limbic system. As CSA may contribute to chronic dissociation and disconnection from self, others, and the world, the spiritual domain of the survivor may be negatively impacted. Women who have survived this trauma are more likely to detach themselves from their own body, particularly those who have experienced incest or continuous sexual abuse. Duros and Crowley (2014) describe how various forms of

trauma hold the potential to result in a pervasive sense of danger within the body, leading to lack of trust, sense of safety, and sense of connectedness to one's own body. As adult female survivors of CSA tend to experience low levels of self-esteem, low self-image, and a sense of unworthiness, these symptoms negatively impact and alter their core sense of self (Saha et al., 2011).

TCTSY was specifically developed to treat trauma survivors with their needs in mind. As opposed to more traditional styles of yoga that direct individuals to engage in specific movements with language that is driven by commands, TCTSY uses invitational language to emphasize a survivor's power of choice in moving their bodies through stretches guided by breath (Nguyen-Feng et al., 2020). Additionally, TCTSY encourages introspection that guides participants to be curious about their body and internal experience rather than being focused on their physical form. The goal of TCTSY is to bring higher levels of bodily awareness, reclaiming the body, and befriending the body. Additionally, modifications are encouraged and allow for individuals of all abilities to participate (Nguyen-Feng et al., 2020).

Social Domain

Attachment Theory

Bowlby (1998) founded attachment theory on the understanding of how throughout the lifespan, a basic component of human nature is to seek intimate emotional bonds. Initial emotional bonds begin in infancy with the caregiver, and these bonds continue throughout an individual's lifetime as they expand from caregivers, to friends,

and eventually to significant others in adulthood. Core tenets of attachment theory include there being a secure base between attachment figures. This secure base includes trust, safety and emotional closeness that are maintained so an individual is able to develop autonomy, go off and explore the world, and come back to the relationship for safety and reassurance. Johnson (2004) expanded on this theoretical framework of attachment theory in developing Emotionally Focused Couples Therapy (EFT) to describe how tenets of secure attachment and a secure base include partners being accessible, responsive and engaged within the relationship.

Within the context of couples where the female partner has survived CSA, the ability to securely attach to intimate partners may be impaired (MacIntosh & Johnson, 2008). Dalton et al (2013) discuss how individual trauma symptoms including dissociation, hypervigilance, a chronic sense of danger within the body, flashbacks and emotional reactivity may impact the survivor's ability to securely attach to her intimate partner and relational symptoms and dissatisfaction may develop. Female survivors of CSA may experience impaired attachment including avoidance of intimacy, fear of closeness and vulnerability, decreased ability to trust, and experience shame and guilt that hold the potential to disrupt the couple system and create relational dissatisfaction (Goff et al., 2007). MacIntosh and Johnson (2008) further discuss how within attachment theory, the conceptualization of the impact of CSA on a couple system includes how survivors may develop an inability to remain accessible, responsive and engaged within the relationship. MacIntosh and Johnson (2008) have developed a protocol for utilizing EFT to develop secure attachment and heal from the wounds of trauma for couples where

one partner has survived CSA that has shown to be effective in increasing relational satisfaction and intimate partner functioning.

Conclusion

This proposed intervention program is founded on the theoretical frameworks of BPSS theory, AIP theory, Social Constructionism, Yoga, and Attachment Theory. These frameworks work in unison and complement one another to attend to the interconnected needs present in the aftermath of surviving CSA. The interventions of this proposed program will include a phased approach where female survivors will first begin EMDR to address biological impact and narrative therapy to address the psychological and spiritual impact of CSA. Within the second phase, the survivor will continue EMDR and narrative therapy and begin TCTSY to further address the biological and spiritual domains. At the onset of the third phase, the survivor will continue the aforementioned therapies and begin EFT for couples.

CHAPTER FOUR

METHODOLOGY

Program Design Description

This program is designed to integrate individual therapies (EMDR, Narrative Therapy, TCTSY and couples' therapy (EFT) to treat adult female survivors of CSA The impact of CSA may have a profound impact on BPSS domains of the female's life. Duros and Crowley (2014) discuss how the impact of trauma has the potential to reach deep into the brain and body of the survivor, impacting multiple brain structures that lead to chronic post-traumatic symptoms of dissociation, hypervigilance, emotional reactivity, a pervasive, chronic sense of danger within the body and flashbacks among others. In addition to these individual symptoms, Dalton et al., (2013) discuss how relational symptoms may also become present, particularly in the context of intimate partner relationships. Female survivors of CSA may experience impaired attachment including fear of closeness and vulnerability, avoidance of intimacy, reduced capacity to trust, shame, and guilt. These relational symptoms in addition to the individual symptoms that impact the female's ability to relate to others hold the potential to disrupt the couple system and create relational dissatisfaction (Goff et al., 2007).

MacIntosh and Johnson (2008) describe how the survivor may experience an inability to maintain secure attachment within the context of intimate adult relationships that creates a negative interaction cycle of pursue and withdraw in the couple relationship that maintain the couple's distress. Not only may the couple relationship present with its own unique challenges in response to the trauma, the couple relationship also holds

healing potential for the survivor. As securely attached intimate partner relationships offer a secure base and safe haven, the female survivor of CSA may experience increased ability to heal from the trauma in the context of the relationship. This proposed intervention program integrates individual therapy (EMDR, narrative therapy, and TCTSY) and couples' therapy (EFT) to address the impact of the trauma of CSA in each of the BPSS domains of a female survivor's life.

Theory of Change

Biological Domain

AIP theory is the theoretical foundation supporting the intervention of EMDR. As Shapiro (2011) found bilateral eye movements to significantly reduce traumatic symptoms, AIP was developed to explain the theoretical underpinnings of the effectiveness of EMDR (Shapiro & Laliotis, 2011). The implications of AIP theory include targeting specific memories of trauma events through EMDR in order to integrate these memories into pre-existing memory frameworks in effort to reduce trauma symptoms. EMDR has been shown to be significantly more effective at maintaining a decrease in trauma symptoms and to improve scores in standardized measures over time as compared to other validated trauma therapies. At long-term follow-up, patients who received EMDR maintained all therapeutic gains and increased functioning on all measures (van der Kolk et al., 2007).

Edmond et al. (1999) found that EMDR in the context of trauma treatment for adult female survivors of CSA is linked to significant reductions in posttraumatic stress

symptoms, depression, negative self-beliefs, anxiety, and depression. Edmond and Rubin (2004) found that the therapeutic gains that were demonstrated within Edmond et al., (1999) study were not only maintained, but most participants improved on every standardized measure at 18 months follow up. These findings indicate that survivors of CSA find better resolution to their trauma symptoms than control groups at long-term follow up, supporting the integration of EMDR into this proposed IOP. Edmond et al. (2004) found that adult female survivors of CSA who received EMDR treatment as opposed to other forms of talk therapy reported experiencing changes on a deeper level where they discussed eradication of issues, whereas those who receive other treatments discuss learned ways to cope with trauma symptoms.

As EMDR has been shown to be significantly effective at treating traumatic symptoms, EMDR will be included in the first phase of this program. EMDR's eight phase approach, consisting of the clinician obtaining a history of the client, preparation, assessment, desensitization, installation, body scan, closure and reevaluation will be implemented. van der Kolk et al. (2007) describes how survivors of CSA may require a longer duration of EMDR treatment as compared to other types of trauma that occurred during adulthood. Therefore, this proposed intervention program will incorporate EMDR beginning in the first phase until completion of the program.

Psychological Domain

Narrative therapy will be used to the issues of oppression that these women have faced in their trauma. Through Narrative Therapy, survivors will explore the dominant discourses that have contributed to the development and maintenance of problems within

their lives. Issues of oppression will be explored as well as the impact of larger social structures and the pervasive impact of trauma. Through these discussions, the individual will be separated from the problem of CSA. The survivor and therapist will begin to identify unique outcomes where the problem was not dominant within her life and work to thicken the plot of this story, moving toward preferred narratives of living that defy the oppressive nature and traumatic impact of CSA. Narrative Therapy will be used to address issues of oppression and the internalized impact of CSA including guilt, shame, self-blame, self-hate and stigma that is common for many survivors, and to replace these narratives with narratives of resilience and the power of their voice and choice as they move into the future of their lives.

Spiritual Domain

Trauma Center Trauma Sensitive Yoga (TCTSY), an individual therapeutic intervention, will be included to address the biological and spiritual domains of the survivor. Price et al. (2017) discuss how yoga in the context of the treatment of trauma allows the survivor to increase her ability to regulate emotions and mood that have been impacted by trauma's impact on the biological functioning of the amygdala and limbic system. With the intervention of TCTSY enhancing the survivor's connection with her body, research supports that this may improve the survivor's symptoms of PTSD including decreased dissociation, decreased emotional reactivity and increased ability to self-soothe and cope (Price et al., 2017). Furthermore, the chronic sense of danger within the body may decrease through the use of yoga leading to improved outcomes. TCTSY

has been shown to be effective in reducing PTSD symptoms for adult female survivors of interpersonal trauma (Nguyen-Feng et al., 2020).

Social Domain

As CSA has been linked with negative outcomes in adult intimate partner relationships, incorporating a model of therapy that works to create secure attachment between partners and the development of a secure base to heal from the wounds of trauma is of vital importance to the holistic treatment of CSA within this program. This program will incorporate EFT for couples that has been modified for partners where trauma has occurred. This will include a minimum of 15 EFT sessions that include de-escalating the negative interaction cycle that may be present within the relationship of pursue and withdraw, accessing the underlying emotions of each interactional position, identifying the unmet attachment needs including the violated attachment needs stemming from the CSA event(s), reprocessing of these emotional experiences between partners where the survivor is able to reprocess the trauma, allowing for the creation of a safe haven of reassurance, comfort and a place to heal from the trauma of CSA (Johnson & Williams-keeler, 1998).

In order to prepare the female survivor's intimate partner's for beginning EFT, during phase two of the program, the female's partner will engage in a psychoeducational group with the other partners. These psychoeducational groups will occur twcie and the duration will be one hour. Topics to be covered will include psychoeducation on the impact of CSA on the BPSS domains of the survivor, common impacts of CSA on the

intimate partners, and information for how to support themselves and their partners through this journey.

Within the first stage of EFT, an alliance will be built between therapist and the couple and the negative interaction cycle of pursue and withdraw are identified. Within the second stage, each partner accesses unacknowledged emotions that underlie the interactional positions and the unmet attachment needs that are present. The couple then begins to reprocess these emotions and unmet attachment needs that redefine the attachment relationship. Within the process of EFT, the trauma survivor is able to express fears within the attachment relationship that allow for reprocessing of the trauma and the creation of a safe haven of comfort, reassurance and healing from the trauma (Johnson & Williams-Keeler, 1998).

Program Design

This proposed intervention program includes a phased approach where adult female survivors of CSA will receive individual therapy (EMDR, narrative therapy, and TCTSY) and couple's therapy (EFT) to attend to the impact of CSA on the BPSS domains of the survivor's life. The phased approach to treatment includes beginning with EMDR and Narrative therapy within phase one. During phase two, the CSA survivor continues EMDR and Narrative therapy with the addition of TCTSY. Within the second phase, the survivor's intimate partner will engage in a psychoeducational group with other partners of the survivor to learn about the impact of CSA on the survivor, the survivor's partner, the couple system, how to support the survivor in the treatment process, and what to potentially expect in EFT. In phase three, the survivor continues to

the aforementioned therapies and begins EFT with her partner. The Clinician Administered PTSD Scale (CAPS) is the evaluation tool that will determine readiness for the survivor's progression of phases in addition with the survivor's self-assessment. Altogether, this IOP will take approximately one year for couples to complete.

Program Implementation

Inclusion Criteria

To qualify for enrollment in this program, an individual must be an adult female, age 18 and above, who has survived the trauma of CSA. CSA is considered any sexual act, attempted or completed, through use of coercion, force, manipulation, or exploitation, perpetrated by an individual who had contact with the child prior to the child turning 18. The purpose of this definition is to be inclusive of the vast experiences of CSA that may be present for survivors. Adult female survivors must score between "mild/subthreshold" and "severe/markedly elevated" to qualify for the program. Additionally, the female survivor must also be in a heterosexual intimate partner relationship that both partners report a commitment to. As there may be various ideas regarding what commitment means, there is no set criteria for how long a couple has been together in order to qualify for the program or a legal union such as marriage.

Exclusion criteria

Male survivors of CSA will be excluded from this program as this program has been specifically designed for female survivors. Adult female survivors of CSA who are

not in a committed intimate partner relationship will be excluded. Couples will be excluded if there has ever been a history of domestic violence in the couple system. Any survivor of CSA who is under the age of 18 will also be excluded from this program. Additionally, prior to beginning the program, survivors will be informed that if at any point throughout the phased program, she a endorses “extreme/incapacitating” symptoms on the CAPS, she will be referred to a higher level of care due to this intervention program not being adequate to support her needs. If a survivor endorses extreme/incapacitating symptoms on the CAPS, the assessing clinician will support the participant in scheduling an assessment with a program that provides a higher level of care for trauma treatment.

Evaluation Plan and Methodology

In evaluating the effectiveness of the program, a combination of standardized and non-standardized measures will be used. The CAPS will be used throughout the program’s phases to determine readiness for the survivor to transition into subsequent phases and whether the program is decreasing trauma symptoms and increasing interpersonal functioning. Other evaluation tools that will be implemented included the Scale of Body Connection (SBC) to assess symptoms of dissociation, and the Dyadic Adjustment Scale (DAS) to assess couple satisfaction. Finally, attendance data will be used to assess how many survivors and their respective partners complete the program. Although this proposed IOP is in part based on an attachment theory conceptualization, an attachment disorder evaluation tool will be excluded as this program is not designed to treat attachment disorders. Additionally, adult female survivors may struggle to maintain

secure attachment relationships due to the trauma of CSA as the primary underlying factor as opposed to an attachment disorder. The difficulty in maintaining secure attachment relationships may be better explained by post-traumatic stress as opposed to an attachment disorder, and therefore attachment disorder evaluations will not be included as treating attachment disorder is outside of the scope and purpose of this program.

Biopsychosocial-Spiritual Assessment

A BPSS assessment will be the first administered assessment within the assessment phase. This will serve as a tool to obtain general background information on the client, as well as and any pertinent past or current information within each of the biological, psychological, social, and spiritual domains. This includes developmental/childhood, family, substance use, risk, trauma, social support, and spiritual support history. As this IOP seeks to treat each domain of impact within the BPSS model, this BPSS assessment will provide foundational information to use in the client's treatment.

Clinician Administered PTSD Scale (CAPS)

The Clinician Administered PTSD Scale (CAPS) will be administered during the Intake Assessment component of the program, and then on a weekly basis as the survivor moves through the program. The CAPS is an interview-style questionnaire that is utilized with survivors to assess the severity of trauma symptoms that are occurring in the individual's life within each criterion of the PTSD diagnosis (Blake et al., 1995;

Weathers et al., 2013). Internal consistency of the CAPS has been show to be high, with a range of $\alpha = .73 - .85$ (Blake et al., 2001). The CAPS will be administered on a weekly basis in order to inform the program of the readiness of survivors to move into the next phases of the program as well as to determine if the survivor is experiencing an increase, decrease, or maintenance of trauma symptoms. See Appendix A.

In phase one, the survivor will begin EMDR and Narrative Therapy. When the CAPS indicates "moderate/threshold," participants will be provided the opportunity to transition into phase two where they will continue EMDR and Narrative Therapy with the addition of TCTSY. When the survivor reaches "mild/subthreshold" symptoms on the CAPS, she will be provided the opportunity to begin EFT for couples with her partner. MacIntosh and Johnson (2008) discuss how although it may be challenging to engage in an experiential therapy such as EFT where attachment is addressed within the context of CSA, it may be important to engage in couple's therapy while trauma symptoms remain active as the work of EFT may be deeply restorative. The purpose of waiting until the CAPS indicates mild/subthreshold symptoms of trauma is to ensure that the survivor has reached stability in their trauma symptoms and ability to use adaptive coping skills if and when triggered during intimate partner attachment work. If the survivor was experiencing elevated symptoms of trauma including dissociation and flashbacks that impact her ability to remain present in the room, she may not be prepared to enter into attachment therapy. At the conclusion of the survivor's time in the program, the goal is for the survivor to continue to endorse "mild/subthreshold" symptoms on the CAPS. If a participant transitions into a proceeding phase and thereafter her trauma symptoms increase past the marker that demonstrated readiness to transition into the next phase of

the program for two consecutive weeks, she will be offered the opportunity to return back to the previous phase to support her in managing her increased trauma symptoms.

Self-Assessment

In addition to scores endorsed on the CAPS demonstrating readiness to proceed into the next phases of the program, the survivor will also complete a self-assessment. Within this self-assessment, she will reflect on the work she has completed within the respective phase and determine if she believes it is appropriate to proceed into the next phase. The addition of this self-assessment tool allows for reinforcement of personal agency over the survivor's treatment process. If she determines she is not ready to transition into the proceeding phase, she will identify a list of goals she would like to continue to work on in the current phase. If she determines she is ready to transition into the proceeding phase, she will reflect on what progress supports her readiness for the transition and what goals she would like to work on in the proceeding phase. See Appendix B.

Scale of Body Connection (SBC)

The Scale of Body Connection (SBC) is a survey questionnaire that asks for participants to rate on a scale from 0-4 if they identify with the statements not at all (0), a little bit (1), some of the time (2), most of the time (3) or all of the time (4). Carvalheira et al. (2017) discuss how the SBC is used to assess dissociation from the body as well as awareness of inner body sensations. The SBC's items that measure bodily awareness have been shown to have good internal consistency with α ranging from .72 - .86. For

items on the SBC measuring bodily dissociation, α ranged from .63 - .81 (Price et al., 2017). This evaluation tool will be used to determine if the program is effective at treating the dissociation and sensations of danger within the body that may present after surviving CSA (Duros & Crowley, 2014). This measurement tool will be administered during intake assessment and prior to beginning phase two of the program where participants will begin TCTSY. This will inform the program if using TCTSY is effective at treating dissociation and disconnection from the body. The SBC will also provide valuable information of whether there may be correlations between increased connection to the body and lower levels of trauma symptoms as indicated on the CAPS (see Appendix C).

Dyadic Adjustment Scale (DAS)

As the final phase of the program incorporates EFT for couples, the DAS will be utilized to measure the couple's overall level of functioning. Spanier and Dispenza (2015) discuss how the purpose of the DAS is to assess an overall level of functioning within a couple system including the couple's consensus, satisfaction, expression of affect, and cohesion. The DAS has been shown to have good internal consistency with α = .85 (Graham et al., 2006). The DAS will be administered during the intake assessments as well as at the beginning and end of phase three where couples will receive the EFT intervention. The DAS measures couple's dyadic adjustment within the four areas of couple consensus, satisfaction, expression of affect, and couple cohesion are at satisfactory levels for the couple. The therapist who is working with the couple will be responsible for administering the DAS pre and post couple's treatment (see Appendix D).

Transgenerational Trauma and Resilience Genogram

Goodman (2013) discusses how trauma narratives may be passed from one generation to the next within a family system, and across communities. A Transgenerational Trauma and Resilience Genogram (TTRG) is a visual tool that captures a comprehensive assessment of how an individual has experienced trauma within the family system and the larger community system. This tool will be used within the intake portion of the program to understand intersectionality between the trauma of CSA with other narratives of trauma in the family, community, and larger ecological system. Additionally, the TTRG captures narratives of resilience within the systems of the survivor's life that have also been transmitted across generations. This assessment will provide valuable information for the work that the adult female survivor will engage in during narrative therapy, where she will deconstruct narratives of trauma that have been reinforced or interact with larger systems, and work to create new narratives such as resilience.

Attendance Data

Participants within the program will be tracked as they move through each phase. A tracking tool in the form of a spreadsheet will be used to indicate how many participants move through each phase. On a quarterly basis, this spreadsheet will be reviewed to see if the program is meeting the process goals as indicated in the Logic Model Chart.

Conclusion

The CAPS will be used on a weekly basis throughout the program to determine the readiness of the survivor to progress from one phase to the next. Additionally, each of the evaluation tools will be used to determine the program's effectiveness at decreasing trauma symptoms in the survivor's life, increasing bodily awareness and decreasing bodily dissociation, and increasing relational satisfaction and functioning within the couple system. Additionally, the results of the CAPS, SBC, DAS, and attendance data will be input into a spreadsheet that will be reviewed on a quarterly basis by program staff. The results of this data will inform the program if the interventions utilized are meeting the process and outcome goals. If these are not being met, changes will be made as necessary to the implemented interventions.

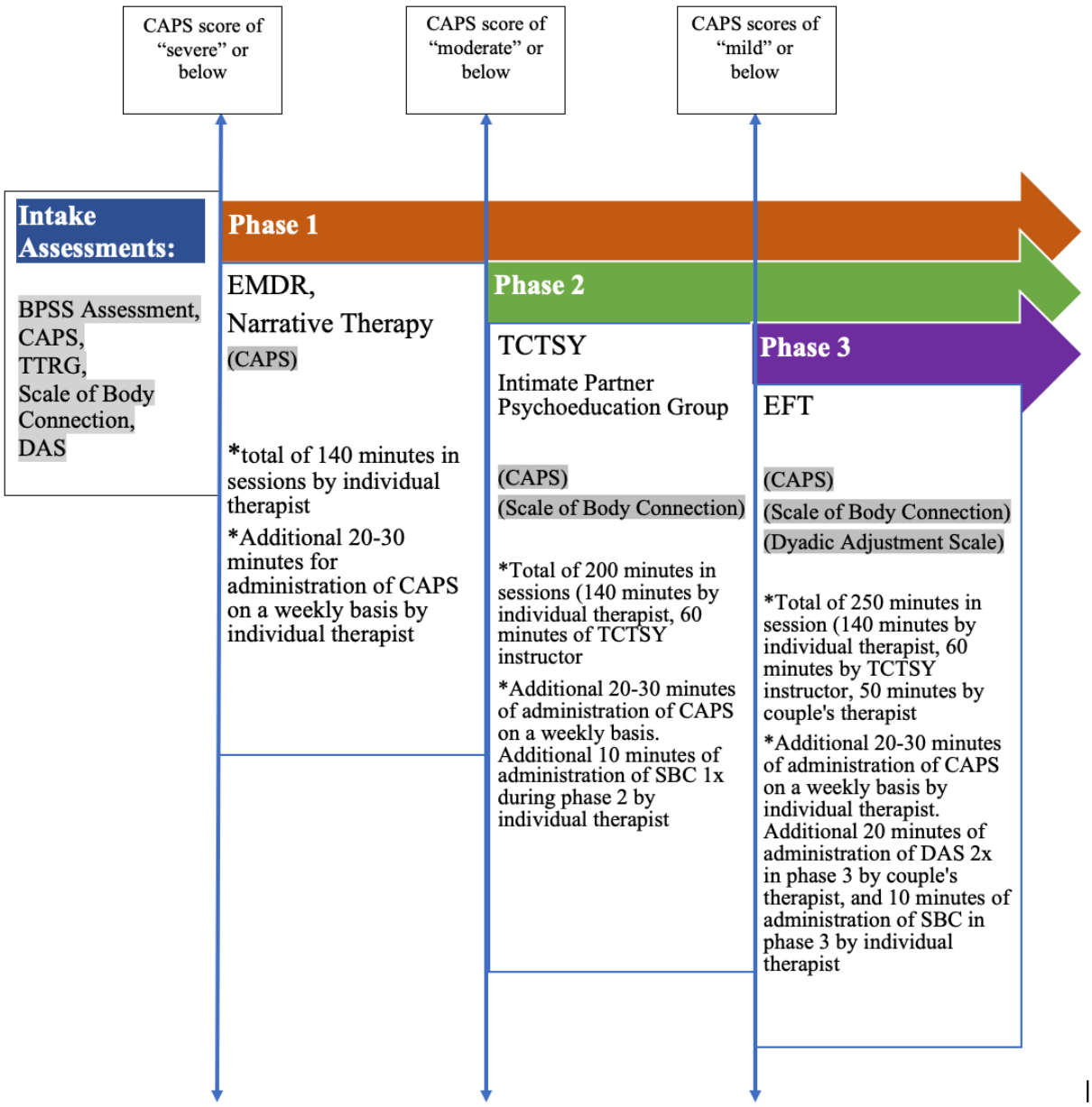

Figure 1. Program Flow Chart.

Program Phase System and Key Interventions

Intake Assessments

At intake, a mental health therapist will administer a biopsychosocial-spiritual assessment to gain understanding of functioning within each domain as well as obtain relevant childhood, developmental, familial, educational/occupational, medical, abuse, and risk information. The therapist will also assess the current trauma symptoms of the female survivor of CSA by administering the Clinician Administered PTSD Scale (CAPS). If an individual endorses a score of "extreme/incapacitating" on the CAPS, she will be referred to a higher level of care due to this proposed program not adequately meeting her needs. During the intake phase, the participant will complete a TTRG. Additionally, the SBC will be administered to the adult female survivor in order to quantify her experience of connection to and awareness of her body. Finally, the DAS will be administered to assess relationship satisfaction within the interpersonal system. The scores endorsed on the SBC and DAS will not be used as inclusion/exclusion criteria but will assess symptomatology and level of functioning prior to admitting to the program. At the end of the program, these measures will be administered again to provide information about the program's effectiveness.

Phase One

During phase one, the survivor will begin EMDR with the goal to decrease the intrusive symptoms of trauma she may be experiencing. Narrative therapy will also begin within phase one, with the goal to deconstruct the impact of the trauma of CSA on the

survivor's life, externalize the previously discussed psychological impacts of surviving CSA, and to identify and live out new, preferred narratives. During phase one, the survivor will receive one 90-minute session of EMDR per week, and one separate, 50-minute session of narrative therapy, reaching a total of 140 minutes in session. Both sessions will be conducted by the same mental health therapist who is EMDR certified and trained in Narrative Therapy. Every week the CAPS will be administered to the survivor, directly prior to the Narrative Therapy session that week, which will take approximately 20 to 30 minutes. When the CAPS score indicates "moderate" symptoms, she will transition into phase two. The process goal within phase one is for 85% of survivors enrolled in the program to reach readiness as indicated on the CAPS to progress to phase two.

Phase Two

During phase two, the survivor will continue EMDR and Narrative Therapy and will also begin Trauma Center Trauma Sensitive Yoga (TCTSY) in order to increase a sense of connection and safety within the self to address the pervasive sense of danger within the body and dissociation from the body that trauma may contribute to. This component will consist of 20 weeks of TCTSY. Within the 20 weeks of TCTSY, the women involved in the program will engage in one hour group yoga practice live with the facilitator. The total amount of time in Narrative Therapy, EMDR, and TCTSY sessions each week during phase two will reach 200 minutes. The CAPS will continue to be administered every week prior to the Narrative Therapy session, and when the survivor symptoms endorse "mild/subthreshold," she will transition into phase three. The SBC

will be administered at the onset and completion of phase two, with the goal of increasing the average score to 3, indicating moderate increase in bodily awareness and decrease in bodily dissociation. The administration of the SBC will be administered during the intake session, again directly prior to the first session of TCTSY, and again after the final session of TCTSY. The process goal within phase two is for 80% of survivors who transitioned into phase two of the program to demonstrate readiness as indicated on the CAPS to progress to phase three.

Within phase two of the program, the intimate partners of the survivor will begin the intimate partner psychoeducation group to receive psychoeducation regarding what CSA entails, the potential impact of CSA on adult female survivor's functioning, and what the partner might be able to anticipate in EFT. The goal of the first session will be to define CSA and describe the ways in which this can be perpetrated against a child. Additionally, the first session will describe the biological, psychological, social, relational, and spiritual impacts of trauma. The second session will include education on the nature of vicarious trauma and how the partner may have been impacted, or how they are continuing to be impacted in the present moment. The second session will also focus on increasing the partner's awareness of what to expect in EFT, including how he and his partner may respond. Each psychoeducation group will be one hour long.

Phase Three

During phase three, the survivor will continue the aforementioned therapies and begin EFT for couples. Phase three is designed to have couples complete a minimum of 15 EFT sessions, as 15-sessions has been linked to positive outcomes within this

population (Johnson & Williams-Keeler, 1998). The weekly EFT session will be 50-minutes in duration. During phase three, the survivor will be in sessions for 250 minutes as she continues Narrative Therapy, EMDR, TCTSY, and now the addition of EFT. The CAPS will continue to be administered weekly prior to the narrative therapy session, with the goal at the end of phase three for the survivor to endorse a maximum of mild/subthreshold symptoms on the CAPS. Additionally, the couple will be administered the DAS at the onset and completion of EFT, with the goal score on the DAS being 107, indicating non-distressed partners. The DAS will be administered directly prior to beginning the EFT session, and again directly after the final EFT session. The process goal within phase three is for 70% of couples that begin EFT to complete at least 15 sessions.

Logic Model

Problem Description	Contributing Factors	Resources/Inputs	Program Activities →	Process Goals →	Short-Term Outcome Goals →	Intermediate Outcome Goals →	Long-Term Outcome Goals
Adult Female Survivors of Childhood Sexual Abuse presenting with individual trauma symptoms and intimate partner distress	Impact of trauma across BPSS domains	Assessment Phase	Administration of assessments; BPSS assess., CAPS, SBC, DAS, Self-Assessment, TTRG	All clients participate in assessment phase	Identification of level of trauma symptoms, relational satisfaction, and trauma/resiliency across generations	Overall decrease in problematic symptoms throughout proceeding phases	Long-term alleviation of problematic symptoms and restoration of health
	Biological Impact	Therapists trained in: EMDR	Phase 1: EMDR,	85% of females reach phase 2	Decrease to moderate symptoms on CAPS	Decrease to mild symptoms on CAPS	Trauma symptoms maintained at mild or lower on CAPS
	Psychological Impact	Narrative Therapy	Narrative Therapy				
	Spiritual Impact	Trauma Center Trauma Sensitive Yoga (TCTSY)	**Phase 2:** EMDR, Narrative Therapy, TCTSY Intimate Partner Psychoed Group	80% of females in phase 2 reach stability to begin EFT	Decrease to mild symptoms on CAPS, Increase to average of 2 on the SBC	Trauma symptoms maintained at mild on CAPS Maintained average of 2 on SBC	Trauma symptoms maintained at mild or lower on CAPS Increase to average of 3 on SBC
	Social Impact	Emotionally Focused Therapy (EFT) Intimate Partner Psychoeducation Group	**Phase 3:** EMDR, TCTSY, EFT	70% of couples complete a minimum of 15 EFT sessions	Maintained decrease to mild symptoms on CAPS, Average score of 2 on SBC Minimum score of 107 on DAS	Maintained decrease to mild symptoms on CAPS, Maintained average score of 2 on SBC. Minimum score of 107 on DAS	Trauma symptoms maintained at mild or lower on CAPS Average of 3 on SBC Minimum of 107 on DAS

Figure 2. Logic Model Chart.

This logic model chart provides a visual representation of how each phase of the program addresses each of the BPSS domains in the wake of CSA. In phase one of the program, the survivor's biological and psychological symptoms will be attended to through the use of EMDR and Narrative Therapy. In phase two, the survivor's biological and spiritual will also be attended to through the use of TCTSY. Within phase three, the survivor's social domain addressed through the implementation of EFT.

Outcome Goals and Evaluation

To determine if trauma symptoms have decreased across PTSD symptoms, the CAPS will be utilized on a weekly basis throughout the survivor's treatment. The outcome goal for the program is for survivor's trauma symptoms to reach "minimal/subthreshold" as indicated on the CAPS. The goal within the couple system is for the DAS to indicate positive dyadic adjustment throughout the measure. The Scale of Body Connection (SBC) will also be administered to evaluate the survivor's mind/body connection to evaluate if the goal of reaching an average score of 3 on the SBC has been met, indicating decrease bodily dissociation and increased bodily awareness. These are the overall outcome goals for the program to determine if integrating individual therapies (EMDR, Narrative Therapy, TCTSY) and couple's therapy (EFT) is effective treating the impact of CSA on the BPSS domains of survivors' lives.

CHAPTER FIVE

PROJECT OUTCOME

FLOURISH

An Intensive Outpatient Program (IOP) for adult female survivors of childhood sexual abuse and their partners

By Camille Sauder

LOMA LINDA UNIVERSITY
School of Behavioral Health
in conjunction with the
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A Project submitted in partial satisfaction of
the requirements for the degree
Doctor of Marital and Family Therapy

Flourish: Program Description

Client Population

This intensive outpatient program (IOP), called “Flourish” seeks to treat adult survivors of childhood sexual abuse (CSA) and integrates their intimate partners into treatment. The trauma of CSA is not a rare occurrence, as approximately one in five women report they have survived CSA (National Center for Victims of Crime, 2020). The impact of surviving CSA can contribute to chronic symptoms within a survivor’s biological, psychological, social, and spiritual domains of life (Duros & Crowley, 2014). To holistically treat survivors of CSA, Flourish integrates various modalities and interventions to treat each domain of impact.

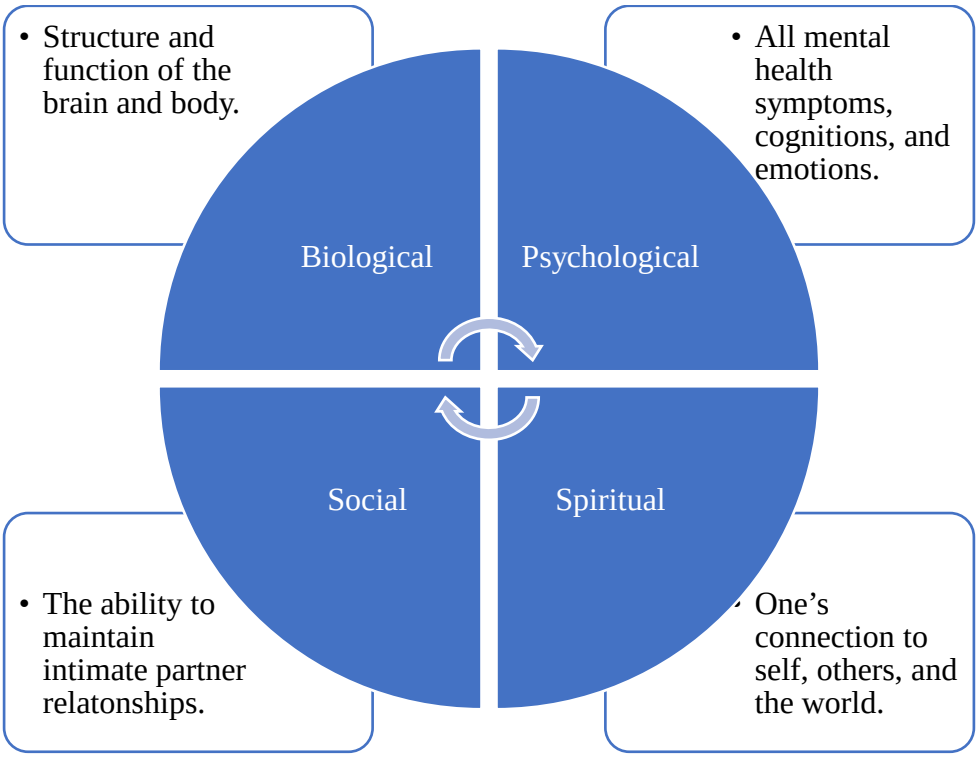


Figure 3. BPSS model.

Mission Statement

To provide integrative, effective, and compassionate treatment for adult survivors of childhood sexual abuse that meets the needs of the survivor's individual and relational functioning to promote healing and healthy living.

Vision Statement

Strengthening the journey toward healing of the body, soul, mind, and relationships for survivors.

Program Values

•**Wholeness**: supporting individuals in creating wellness in all areas of life and purpose within communities

•**Justice:** Creating a space of inclusion, equity, equality, consent, and empowering personal power of the survivor

•**Respect:** Honoring and empowering the voices and choices of each unique individual to support autonomy

•**Integrative:** Integrating multiple treatments to tend to the biological, psychological, social, and spiritual aspects of life.

•**Research-Based:** Providing exceptional care based on effective interventions shown to meet the needs of adult survivors of CSA

•**Community Care:** We believe healing and growth happens in the context of healthy relationships with others and we work to support the development of healing relationships.

Inclusion and Exclusion Criteria

Inclusion Criteria

- Females
- 18 years of age and older
- Must be a survivor of CSA, defined as any sexual act, attempted or completed, through use of coercion, force, manipulation, or exploitation, perpetrated by an individual who had contact with the child prior to the child turning 18
- Must identify as currently being in a committed, heterosexual relationship
- Must not exceed “severe/markedly elevated” symptoms on the CAPS (must score three or below)

Exclusion Criteria

- Males
- Anyone under 18 years old
- Those who are not survivors of CSA
- Those who are not currently in a committed, heterosexual relationship
- Anyone who reaches “extreme/incapacitating” trauma symptoms (score of four) on the CAPS

Review of Other Programs

Although intervention programs have been developed to treat this population of adult female survivors of CSA from a BPSS perspective. Although these programs are strong due to treating CSA from a BPSS perspective, the approach of these programs may be further strengthened by incorporating specific interventions that address each domain of impact. Programs such as the Health Model, Wellness Program, and Dare to Flourish integrate multiple treatments in effort to care for and treat the whole person from a BPSS perspective. However, these programs either lack attention to one or more domains of the BPSS model and lack addressing attachment wounds that may significantly impact a survivor's ability to maintain an intimate partner relationship. Therefore, this IOP seeks to fill the gaps in treatment models offered by providing a program that integrates individual, groups, and couple's therapies that intentionally address each domain of impact within the BPSS model that has been outlined in the literature.

Impact of CSA on the Biological, Psychological, Social, and Spiritual Domains of Functioning

Impact of CSA on the Biological Domain:

The trauma of CSA holds the potential to chronically alter the biological domain of a survivor's functioning. Shrivastava et al. (2017) discuss how this impact may include reduced ability for the two hemispheres of the brain to communicate, changes to the hippocampus that contribute to forgetting or suppressing memories, changes to the amygdala that contribute to emotional functioning, prefrontal cortex that is involved with decision making, and changes to the autonomic nervous system that contribute to a survivor's response to perceived danger, safety and stress, including fight, flight, and freeze responses associated with trauma (Shrivastava et al., 2017). The individual therapies of Eye Movement Desensitization and Reprocessing (EMDR) will be the intervention to treat the impact of CSA on the biological domain.

Impact of CSA on the Psychological Domain:

The impacts of CSA on a survivor's psychological domain range in severity and can include a range of associated mental health disorders including depression, anxiety, substance abuse, low self-esteem, and post-traumatic stress disorder (PTSD) (Fergusson et al., 2013). In addition to potential comorbid mental health disorders in adult life, survivors of CSA often suffer from PTSD symptoms including flashbacks, emotional flooding, panic attacks, lack of trust, anger, isolation, suicide attempts, and other self-destructive behavior (Nelson & Wampler, 2002). Many of the previously mentioned biological changes to the survivor's brain and body can contribute to chronic psychological impacts, including struggles with emotional regulation and stress (Shrivastava et al., 2017). Narrative Therapy is the intervention that will treat the impact of CSA on a survivor's psychological domain.

Impact of CSA on the Social Domain:

Impairments in a survivor's social functioning can be rooted in feelings of betrayal, powerlessness, and stigmatization (Kallstrom-Fuqua et al., 2004). The most significant finding regarding social impairments in adult female survivors of CSA is impairment in intimate adult relationships (Callahan et al., 2003). MacIntosh and Johnson (2008) describe how adult survivors of CSA are more likely to have fearful and avoidant attachment styles, avoid closeness and intimacy, and have anxiety surrounding intimate relationships. Additionally, De Beliis et al., (2011) describes how the survivor's ability to maintain secure attachment relationships has been impaired, and the survivor may experience fear and distrust in intimate relationships overall. Survivors may cope with their symptoms through seeking autonomy, dismissing, or suppressing negative emotions,

and direct shame, blame, and criticism inward, contributing to negative interaction cycles within the couple relationship (Lassrie et al., 2018; Nelson & Wampler, 2002). Survivors may also struggle to regulate their emotional responses in relationships (De Beliis et al., 2011). As the nature of CSA is sexual, adult female survivors may also experience sexual impairment as they may fear and avoid intimate touch due to sexual interactions potentially being triggering (Nelson & Wampler, 2002; MacIntosh & Johnson, 2008). Within this IOP, survivors and their intimate partners will participate in Emotionally Focused Couple's Therapy (EFT) to treat the impact of CSA on the survivor's social domain.

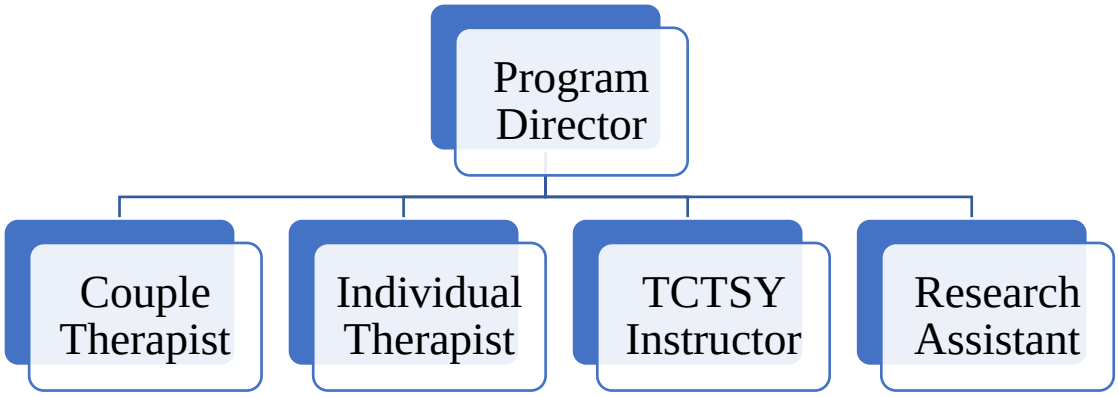
Impact on Adult Female Survivor's Partners:

The intimate partners of the CSA survivor may experience vicarious trauma, where they experience personal impacts of the trauma although they did not survive it themselves. Partners may experience self-blame, attempt to "save" the survivor, distance themselves from their wives, experience frustration, anger, rejection, confusion, and hurt feelings in response to their partners distress (Hunt-Amos et al., 2004). These responses on behalf of the intimate partner may contribute to overall relationship dissatisfaction and turmoil that may be present for adult female survivors of CSA. In order to address the impact of CSA on adult female survivors' partners, the intimate partners will not only participate in EFT, but will participate in a psychoeducation group with other partners prior to beginning EFT.

Impact of CSA on the Spiritual Domain:

Spirituality includes connection that humans feel with themselves, others, and the world around them. As survivors of CSA may struggle with detaching themselves from their physical body, this can be conceptualized as a spiritual issue (Duros & Crowley, 2014). Dissociation can be a chronic symptom for survivors of CSA, and is a phenomenon that includes detachment from one's self, cognitions, memories, emotions, and actions. This disconnection from the self may have developed as a survival tactic to disconnect from the self during the actual occurrence(s) of the CSA event(s), and may become a chronic symptom used to avoid painful memories. Duros and Crowley (2014) also describe how the trauma of CSA can contribute a pervasive sense of danger and lack of trust in one's own body, contributing to further dissociation symptoms. Survivors may also experience a negative, altered core sense of self and struggle with low self-esteem, low self-worth, negative beliefs that she is not deserving of basic human rights, and perceive the self as insignificant and underserving, contributing to a deep sense of shame (Saha et al., 2011). Trauma Center Trauma Sensitive Yoga (TCTSY) and Narrative Therapy are the interventions survivors will participate in to address CSA's impact on the survivors' spiritual domains.

Flourish Flow Chart for Clinical Staff



This chart represents how each program staff report directly to and are supervised by the program director. Additionally, this represents who will be serving clients enrolled in this program.

Services Offered

Problem Description	Contributing Factors	Resources/Inputs	Program Activities →	Process Goals →	Short-Term Outcome Goals →	Intermediate Outcome Goals →	Long-Term Outcome Goals
Adult Female Survivors of Childhood Sexual Abuse presenting with individual trauma symptoms and intimate partner distress	Impact of trauma across BPSS domains	Assessment Phase	Administration of assessments; CAPS, SBC, DAS, Self-Assessment, TTRG	All clients participate in assessment phase	Identification of level of trauma symptoms, relational satisfaction, and trauma/resiliency across generations	Overall decrease in problematic symptoms throughout proceeding phases	Long-term alleviation of problematic symptoms and restoration of health
	Biological Impact	Therapists trained in: EMDR	Phase 1: EMDR,	85% of females reach phase 2	Decrease to moderate symptoms on CAPS	Decrease to mild symptoms on CAPS	Trauma symptoms maintained at mild or lower on CAPS
	Psychological Impact	Narrative Therapy	Narrative Therapy				
	Spiritual Impact	Trauma Center Trauma Sensitive Yoga (TCTSY)	**Phase 2:** EMDR, Narrative Therapy, TCTSY Intimate Partner Psychoed Group	80% of females in phase 2 reach stability to begin EFT	Decrease to mild symptoms on CAPS, Increase to average of 2 on the SBC	Trauma symptoms maintained at mild on CAPS Maintained average of 2 on SBC	Trauma symptoms maintained at mild or lower on CAPS Increase to average of 3 on SBC
	Social Impact	Emotionally Focused Therapy (EFT) Intimate Partner Psychoeducation Group	**Phase 3:** EMDR, TCTSY, EFT	70% of couples complete a minimum of 15 EFT sessions	Maintained decrease to mild symptoms on CAPS, Average score of 2 on SBC Minimum score of 107 on DAS	Maintained decrease to mild symptoms on CAPS, Maintained average score of 2 on SBC. Minimum score of 107 on DAS	Trauma symptoms maintained at mild or lower on CAPS Average of 3 on SBC Minimum of 107 on DAS

Figure 4. Logic Model Chart: Assessment Phase

Assessment Phase

The assessment phase will support the program in determining the level of trauma symptoms the individual is surviving with and the level intimate partner couple functioning. Additionally, this assessment phase will provide valuable information regarding whether this IOP is an appropriate level of care for the individual. If the survivor presents with severe or incapacitating trauma symptoms, he or she will be referred to a higher level of care to receive appropriate services. Additional considerations for the client proceeding into the next phases of the program can be found after each phase's description.

The research assistant will be responsible for scoring of each assessment throughout the program and will provide a synopsis of any significant changes or pertinent information to the treatment team on a weekly basis.

Biopsychosocial-Spiritual Assessment

- Obtain relevant developmental, medical, family of origin, substance use/abuse, risk, legal, educational, occupational, social history to inform the client's treatment plan.
- The BPSS assessment will be administered during the initial intake session.

Clinician Administered PTSD Scale (CAPS)

- The CAPS measures PTSD symptoms as described in the DSM-V.
- The CAPS will be the assessment that determines readiness to proceed into the next phases of the program, with the goal to stabilize and reduce trauma symptoms prior to entering proceeding treatments.
- The CAPS will be administered during the initial intake session as well as on a weekly basis directly prior to engaging in the Narrative Therapy session of that week.

Scale of Body Connection (SBC)

- The SBC measures level of connection to the body, as well as symptoms of dissociation from the body that can be present for many survivors of CSA (Duros & Crowley, 2014).
- The SBC will be administered during the initial intake session, again directly prior to the first TCTSY session, and again after the final TCTSY session.

Dyadic Adjustment Scale (DAS)

- The DAS will be administered to the survivor as well as their partner
- This will provide a baseline for couple functioning prior to and post the interventions of Emotionally Focused Therapy (EFT) and the intimate partner psychoeducation group
- The DAS will be administered during the initial intake session, directly prior to the first EFT session, and again after the final EFT session.

Self-Assessment

- During the assessment phase, the self-assessment will allow for survivors to identify their motivation for treatment, what their goals are for therapy, what their strengths are, and what things they would like to improve or enhance about themselves.
- During transition phases, another version of the self-assessment will be used to assess if the survivor perceives herself as ready to proceed into the additional phases of treatment, identify why or why not, as well as set SMART goals for herself.
- The Self-Assessment will be administered during the intake session and during the session where the therapist and client are discussing potential transition into the next phase of treatment.

Transgenerational Trauma and Resilience Genogram

- A visual tool that captures a comprehensive assessment of how an individual has experienced trauma within the family system and the larger community system
- Will provide information for the work that the adult female survivor may engage in during narrative therapy, where she will deconstruct narratives of trauma that

have been reinforced or interact with larger systems, and work to create new narratives such as resilience.

- The Transgenerational Trauma and Resilience Genogram will be administered one time during the initial intake assessment.

Phase One

Problem Description	Contributing Factors	Resources/Inputs	Program Activities →	Process Goals →	Short-Term Outcome Goals →	Intermediate Outcome Goals →	Long-Term Outcome Goals
Adult Female Survivors of Childhood Sexual Abuse presenting with individual trauma symptoms and intimate partner distress	Impact of trauma across BPSS domains	Assessment Phase	Administration of assessments; BPSS assess., CAPS, SBC, DAS, Self-Assessment, TTRG	All clients participate in assessment phase	Identification of level of trauma symptoms, relational satisfaction, and trauma/resiliency across generations	Overall decrease in problematic symptoms throughout proceeding phases	Long-term alleviation of problematic symptoms and restoration of health
	Biological Impact	Therapists trained in: EMDR	Phase 1: EMDR,	85% of females reach phase 2	Decrease to moderate symptoms on CAPS	Decrease to mild symptoms on CAPS	Trauma symptoms maintained at mild or lower on CAPS
	Psychological Impact	Narrative Therapy	Narrative Therapy				
	Spiritual Impact	Trauma Center Trauma Sensitive Yoga (TCTSY)	**Phase 2:** EMDR, Narrative Therapy, TCTSY Intimate Partner Psychoed Group	80% of females in phase 2 reach stability to begin EFT	Decrease to mild symptoms on CAPS, Increase to average of 2 on the SBC	Trauma symptoms maintained at mild on CAPS Maintained average of 2 on SBC	Trauma symptoms maintained at mild or lower on CAPS Increase to average of 3 on SBC
	Social Impact	Emotionally Focused Therapy (EFT) Intimate Partner Psychoeducation Group	**Phase 3:** EMDR, TCTSY, EFT	70% of couples complete a minimum of 15 EFT sessions	Maintained decrease to mild symptoms on CAPS, Average score of 2 on SBC Minimum score of 107 on DAS	Maintained decrease to mild symptoms on CAPS, Maintained average score of 2 on SBC. Minimum score of 107 on DAS	Trauma symptoms maintained at mild or lower on CAPS Average of 3 on SBC Minimum of 107 on DAS

Figure 5. Logic model chart: Phase one

Phase One: Narrative Therapy and EMDR

Aims of Phase One:

1. The survivor will deconstruct the impact of the trauma of CSA on her life, externalize these impacts, and identify new, more preferred and functional narratives of living
2. The survivor's most distressing memories that contribute to trauma symptoms will be targeted, with the aim of EMDR being to integrate and process traumatic memories to reduce and alleviate trauma symptoms

Outcome Goal(s) of Phase One:

1. The survivor will reach a score of "moderate/threshold" or below on the CAPS (score of two or below).
2. Readiness to transition into phase two of the program.

Description:

Narrative Therapy: The first phase will be the onset of therapeutic intervention and will include Narrative Therapy and EMDR with the CSA survivor. Narrative Therapy will be a targeted intervention to treat the impact of CSA on both the psychological and spiritual domains of the BPSS model. Narrative therapy will be used to address the issues of oppression and loss that survivors have faced, as well as separate their identities from the problem of CSA, moving toward preferred narratives of living (Bitter, 2014). Each narrative therapy session will occur one time per week for a duration of 50 minutes.

Eye Movement Desensitization and Reprocessing: EMDR will target the biological domain by working to integrate traumatic memories of CSA into the neural frameworks of the survivor. The goal of using EMDR is to treat the biological symptoms of trauma including flashbacks, emotional reactivity, hypervigilance, and dissociation among others (Shapiro & Laliotis, 2011). When traumatic events occur, the memory may not be integrated into pre-existing neural frameworks, leaving this memory to be connected to physical sensations, emotions, and perceptions that can be triggered by external and internal stimuli, contributing to pervasive trauma symptoms. Each EMDR session will occur one time per week for a duration of 90 minutes.

Assessments:

On a weekly basis, the CAPS will be administered directly prior to the Narrative Therapy session to monitor trauma symptoms.

Transitioning from Phase One into Phase Two

- When the client reaches a CAPS score of “moderate/threshold” (score of two) or below.

- It is recommended that at least four weeks be spent within the first phase of the program to become acclimated to the types of therapies being used, to provide space for trauma symptoms to potentially increase throughout the first phase of therapy.

- Due to the severity and duration of trauma symptoms having the potential to vary significantly from survivor to survivor, there is no set time frame that a client must transition into the next phase by. It may be possible for a survivor to spend up to six months in phase one prior to trauma symptoms reaching “moderate/threshold” on the CAPS or below. Each client’s case will be discussed in weekly treatment team meetings with the oversight of the clinical director to identify if treatment plan changes are necessary and how to best support each client.

- The discussion and consideration of transitioning into the next phase of treatment must always include the discussion of the client herself. If the client reaches a score of “moderate” or below on the CAPS, the assessing clinician will also engage the client in a non-formal discussion on if she perceives herself as ready to transition into the next phase of treatment, or not, and why. Additionally, the client will complete the self-assessment form for transitioning from one phase to the next. Perhaps the client has additional goals that she would like to work on in phase one of the program prior to transition to phase two. These goals should be discussed and incorporated into the client’s treatment plan as appropriate. Additionally, if it is appropriate to keep the client in phase one until they perceive they are ready to transition into the second phase, the therapist and program should work to honor this request. However, there may occasionally be a client that has unreasonable fears or expectations about what the next phase(s) will include, and this may stop or block her from desiring to transition into the next phase. These concerns should be discussed with the client, and these concerns might also present additional work that could be addressed within EMDR and narrative therapy.

- The research assistant will bring the results of the CAPS and any follow up discussion to the program’s next treatment team meeting in order to discuss and develop a plan of action under the guidance of the program director and consultation of the other program therapists.

How to Address Potential Challenges in Phase One

- If a survivor's CAPS score meets or exceeds "extreme/incapacitating" (score of four), she will be referred to a higher level of care:

  If this occurs, the individual therapist will engage the client in a discussion that outlines how the survivor's trauma symptoms have increased to a level where she may benefit from more support than what Flourish is able to provide. This conversation should aim to be supportive in that it focuses on how the program is lacking in resources to adequately support her, rather than something being "wrong" with the client. The individual therapist will engage the survivor in a discussion about the brave and strong work the survivor has done in Flourish so far, and outline recommendations to a higher level of care. The therapist will discuss specific referral sources and will support the client with securing another provider prior to the client being discharged from Flourish's program.

- If a survivor does not want to proceed into phase two:

  Although the survivor may reach a score of "moderate/threshold" (score of 2) or below on the CAPS, she may report she does not yet want to proceed into phase two of the program. When this occurs, the clinician should engage the survivor in a conversation about why she does not perceive she is ready to transition into the next phase and why. If appropriate, the clinician will then incorporate additional goals into the client's treatment plan to address what the survivor's concerns are. If the concerns are not appropriate or reasonable, the clinician should address these concerns in individual therapy. This could potentially include further education about what to expect in each phase of the treatment process.

Phase Two

Problem Description	Contributing Factors	Resources/Inputs	Program Activities	Process Goals	Short-Term Outcome Goals	Intermediate Outcome Goals	Long-Term Outcome Goals
Adult Female Survivors of Childhood Sexual Abuse presenting with individual trauma symptoms and intimate partner distress	Impact of trauma across BPSS domains	Assessment Phase	Administration of assessments; BPSS assess., CAPS, SBC, DAS, Self-Assessment, TTRG	All clients participate in assessment phase	Identification of level of trauma symptoms, relational satisfaction, and trauma/resiliency across generations	Overall decrease in problematic symptoms throughout proceeding phases	Long-term alleviation of problematic symptoms and restoration of health
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	Social Impact	Emotionally Focused Therapy (EFT) Intimate Partner Psychoeducation Group	**Phase 3:** EMDR, TCTSY, EFT	70% of couples complete a minimum of 15 EFT sessions	Maintained decrease to mild symptoms on CAPS, Average score of 2 on SBC Minimum score of 107 on DAS	Maintained decrease to mild symptoms on CAPS, Maintained average score of 2 on SBC. Minimum score of 107 on DAS	Trauma symptoms maintained at mild or lower on CAPS Average of 3 on SBC Minimum of 107 on DAS

Figure 6. Logic model chart: Phase two

Phase Two: TCTSY, Narrative Therapy and EMDR

Aims of Phase Two:

1. Increase the survivor's ability to regulate her emotions, body, and bodily responses that have been impacted by the nature of the impact of CSA changing the biological functioning of the amygdala and limbic system.
2. Decrease dissociation and emotional reactivity
3. Increase the survivor's ability to self-soothe
4. Continue EMDR to continue integrating and processing traumatic memories in order to reduce and alleviate trauma symptoms
5. Continue Narrative Therapy to deconstruct the impact of the trauma of CSA on her life, externalize these impacts, and identify new, more preferred and functional narratives of living

Outcome Goal(s) of Phase Two:

1. The survivor will reach a score of "mild/subthreshold" or below on the CAPS (score of 1 or below).
2. Readiness to transition into phase three of the program.

Description:

Once the survivor reaches the score of "moderate," or below on the CAPS, he or she will begin phase three, where they will continue EMDR and Narrative Therapy, and begin group therapy with other adult survivors of CSA and Trauma Center Trauma Sensitive Yoga (TCTSY). The goal of group therapy is to address the social impact of CSA, which can include stigmatization within the larger social context, feelings of betrayal and powerlessness, and negative outcomes in social relationships (Kallstrom-Fuqua et al., 2004). TCTSY will be used to address both the biological and spiritual impact of CSA that include dissociation, disconnection from the sense of self and the survivor's physical body, and difficulty regulating emotions within the body (Edwards, 2018; Shrivastava et al., 2017; Duros & Crowley, 2014). TCTSY groups will occur one time per week for a duration of 60-minutes.

Assessments:

Prior to beginning phase two, the survivor will be administered the SBC. The first administration will be directly prior to the initial session of TCTSY. The next administration of the SBC will occur directly after the final TCTSY session during phase three. On a weekly basis, the CAPS will continue to be administered directly prior to the narrative therapy session.

Phase Two: Intimate Partner Psychoeducation Group

Aims of IPPG:

1. Provide psychoeducation regarding what CSA entails, the potential impact of CSA on adult female survivor's functioning, the partner, and the couple relationship, and what the partner might be able to anticipate in EFT

Goals of IPPG:

1. Prepare the intimate partner for EFT.
2. Increase the intimate partner's understanding of the survivor's treatment process.

Description:

The adult female survivor's intimate partner will join the IPPG that will include two groups that provide psychoeducation regarding what CSA entails, the potential impact of CSA on adult female survivor's functioning, and what the partner might be able to anticipate in EFT. The goal of the first session will be to define CSA and describe the ways in which this can be perpetrated against a child. Additionally, the first session will describe the biological, psychological, social, relational, and spiritual impacts of trauma. The second session will include education on the nature of vicarious trauma and how the partner may have been impacted, or how they are continuing to be impacted in the present moment. The second session will also focus on increasing the partner's awareness of what to expect in EFT, including how he and his partner may respond. The goal of the second session will be to equip the partner with understanding how he can take steps to support himself and his partner throughout the process of EFT. These groups will occur one time per week for two weeks, with the duration of each session being two hours.

How to Address Potential Challenges in Phase Two

- If a survivor's intimate partner does not want to engage in the Intimate Partner Psychoeducation Group:

  The couple's therapist will request a meeting with both the survivor and her intimate partner to discuss the partner's expressed disinterest in attending the IPPG. The therapist will provide the partner with the opportunity to express any concerns he may have with the group or engaging. The survivor will then be provided the opportunity to discuss her perspective, including why it may be important to her personally if her partner attends the group. The therapist will then remind the partner that this IPPG is a required part of the program in order for the couple to engage in EFT. If the partner expresses disinterest in EFT, the therapist will facilitate a conversation about the importance of engaging the couple system in therapy due to the potential impact of the trauma of CSA on the couple relationship. If there is refusal on behalf of the partner to attend, there will be no consequence for the survivor other than she will not engage in phase three of the program, but continue the therapies initiated prior.

- If a survivor's CAPS score meets or exceeds "extreme/incapacitating" (score of 4), she will be referred to a higher level of care:

  If this occurs, the individual therapist will engage the client in a discussion that outlines how the survivor's trauma symptoms have increased to a level where she may benefit from more support than what Flourish is able to provide. This conversation should aim to be supportive in that it focuses on how the program is lacking in resources to adequately support her, rather than something being "wrong" with the client. The individual therapist will engage the survivor in a discussion about the brave and strong work the survivor has done in Flourish so far, and outline recommendations to a higher level of care. The therapist will discuss specific referral sources and will support the client with securing another provider prior to the client being discharged from Flourish's program.

- If a survivor does not want to proceed into phase three:

  Although the survivor may reach a score of "moderate/threshold" (score of 2) or below on the CAPS, she may report she does not yet want to proceed into phase three of the program. When this occurs, the clinician should engage the survivor in a conversation about why she does not perceive she is ready to

transition into the next phase and why. If appropriate, the clinician will then incorporate additional goals into the client's treatment plan to address what the survivor's concerns are. If the concerns are not appropriate or reasonable, the clinician should address these concerns in individual therapy. This could potentially include further education about what to expect in each phase of the treatment process.

Transitioning From Phase Two into Phase Three

- When the client reaches a CAPS score of "mild/subthreshold" (score of one) or below.

- It is recommended that the survivor stay within phase two for at least four weeks prior to moving on to phase three. This will allow for trauma symptoms to potentially increase while the trauma is continuing to be addressed, while providing the space for these symptoms to be further treated prior to engaging in an additional therapy offered within phase three.

- Due to the severity and duration of trauma symptoms having the potential to vary significantly from survivor to survivor, there is no set time frame that a client must transition into the next phase by. It may be possible for a survivor to spend up to six months in phase two prior to trauma symptoms reaching "mild/subthreshold" on the CAPS or below. Each client's case will be discussed in weekly treatment team meetings with the oversight of the clinical director to identify if treatment plan changes are necessary and how to best support each client.

- The assessing clinician will engage the client in a non-formal discussion on if she perceives herself as ready to transition into the next phase of treatment, or not, and why. Additionally, the client will complete the self-assessment form for transitioning from one phase to the next. Perhaps the client has additional goals that she would like to work on in phase two of the program prior to transition to phase three. These goals should be discussed and incorporated into the client's treatment plan as appropriate. Additionally, if it is appropriate to keep the client in phase two until they perceive they are ready to transition into the second phase, the therapist and program should work to honor this request. However, there may occasionally be a client that has unreasonable fears or expectations about what the next phase(s) will include, and this may stop or block her from desiring to transition into the next phase. These concerns should be discussed with the client, and these concerns might also present additional work that could be addressed within individual therapy.

Phase Three

Problem Description	Contributing Factors	Resources/Inputs	Program Activities	Process Goals	Short-Term Outcome Goals	Intermediate Outcome Goals	Long-Term Outcome Goals
Adult Female Survivors of Childhood Sexual Abuse presenting with individual trauma symptoms and intimate partner distress	Impact of trauma across BPSS domains	Assessment Phase	Administration of assessments; BPSS assess., CAPS, SBC, DAS, Self-Assessment, TTRG	All clients participate in assessment phase	Identification of level of trauma symptoms, relational satisfaction, and trauma/resiliency across generations	Overall decrease in problematic symptoms throughout proceeding phases	Long-term alleviation of problematic symptoms and restoration of health
	Biological Impact	Therapists trained in: EMDR	Phase 1: EMDR,	85% of females reach phase 2	Decrease to moderate symptoms on CAPS	Decrease to mild symptoms on CAPS	Trauma symptoms maintained at mild or lower on CAPS
	Psychological Impact	Narrative Therapy	Narrative Therapy				
	Spiritual Impact	Trauma Center Trauma Sensitive Yoga (TCTSY)	**Phase 2:** EMDR, Narrative Therapy, TCTSY Intimate Partner Psychoed Group	80% of females in phase 2 reach stability to begin EFT	Decrease to mild symptoms on CAPS, Increase to average of 2 on the SBC	Trauma symptoms maintained at mild on CAPS Maintained average of 2 on SBC	Trauma symptoms maintained at mild or lower on CAPS Increase to average of 3 on SBC
	Social Impact	Emotionally Focused Therapy (EFT) Intimate Partner Psychoeducation Group	**Phase 3:** EMDR, TCTSY, EFT	70% of couples complete a minimum of 15 EFT sessions	Maintained decrease to mild symptoms on CAPS, Average score of 2 on SBC Minimum score of 107 on DAS	Maintained decrease to mild symptoms on CAPS, Maintained average score of 2 on SBC. Minimum score of 107 on DAS	Trauma symptoms maintained at mild or lower on CAPS Average of 3 on SBC Minimum of 107 on DAS

Figure 7. Logic model chart: Phase three

Phase Three: EFT in Addition to TCTSY, Narrative Therapy, and EMDR

Aims of Phase Three:

1. The couple will redefine and heal the attachment relationship between the partners to create a safe haven and space of healing from the trauma of CSA.
2. Address and reduce the negative impact that the trauma of CSA can have on a survivor's relational functioning.
3. Identify the negative interaction cycle of purse and withdraw that is present in the relationship, acknowledge emotions that underlie each of these positions and the unmet attachment needs that are present.
4. Continue aims of phase one and phase two.

Outcome Goal(s) of Phase Three:

1. Reach a minimum score of 107 on the DAS, indicating non-distress between partners.
2. Reach a score of three on the SBC, indicating that the survivor is aware of her body most of the time and can regulate difficult emotions in the body most of the time.
3. Reach a score of "mild/subthreshold" on the CAPS (score of one) or lower.

Description:

Once the survivor reaches a score of "mild" or below on the CAPS, she will begin phase three of the program where she will continue the aforementioned therapies in the previous phases and also begin EFT for couples. The intervention of EFT will be used to address the social impact of CSA on the survivor's potentially impaired ability to maintain securely attached partner relationships due to emotional reactivity, fear of closeness and intimacy, lower levels of trust in relationships, shame, and self-criticism among others (De Beliis et al., 2011; Lassrie et al., 2018).

Assessments:

The survivor will continue to be administered the CAPS on a weekly basis directly prior to the Narrative Therapy session. Prior to the first EFT session, the couple will be administered the DAS, and then again after the final EFT session. Additionally, the survivor will be administered the SBC again after the final TCTSY session to obtain outcome data.

How to Address Potential Challenges in Phase Three

- If a partner refuses to continue participating in EFT:

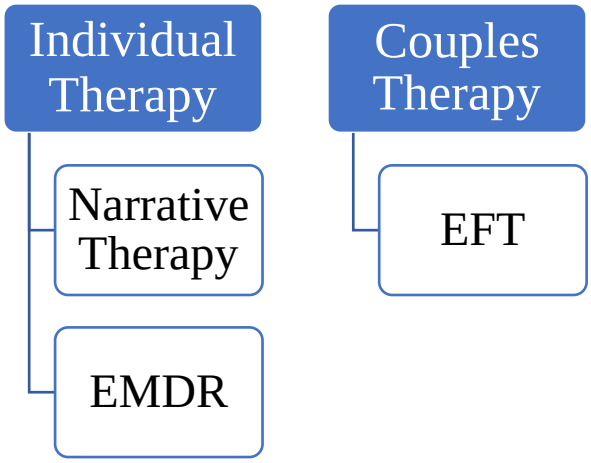
  Anyone participating in treatment of Flourish has the right to discontinue services at any time. However, if a partner voices hesitation or ambivalence with regard to continuing EFT, the therapist should engage both partners in a conversation about what their motivation for treatment is, what their concerns are, and how they would like to address these concerns in EFT. If after conversation, a partner decides he or she will no longer engage in the treatment process, EFT will end. If it is the male partner who disengages, the survivor will continue individual therapy as usual. If it is the female partner who disengages, the couple therapist should discuss in treatment team if it is appropriate for her to continue individual therapy through Flourish, discharged, or referred to another facility due to noncompliance with program recommendations.

- If a survivor's CAPS score meets or exceeds "extreme/incapacitating" (score of 4), she will be referred to a higher level of care:

  If this occurs, the individual therapist will engage the client in a discussion that outlines how the survivor's trauma symptoms have increased to a level where she may benefit from more support than what Flourish is able to provide. This conversation should aim to be supportive in that it focuses on how the program is lacking in resources to adequately support her, rather than something being "wrong" with the client. The individual therapist will engage the survivor in a discussion about the brave and strong work the survivor has done in Flourish so far, and outline recommendations to a higher level of care. The therapist will discuss specific referral sources and will support the client with securing another provider prior to the client being discharged from Flourish's program.

Program Therapist Description

Flourish's therapists must either provide:



Description:

Therapists do not require training in these modalities prior to being hired at Flourish, but they must be open to pursuing training of either an individual therapist or couple's therapist and receive appropriate training through external institutions to be qualified to provide the above outlined services. Flourish will provide payment for trainings and compensation for travel accommodations as necessary.

When onboarded, therapists will be selected for either the track of an individual therapist or couple therapist. Therapists in either track will **not** provide services to any client that are outside of their tracks. For example, an individual therapist will not provide EFT for a couple, and a couple therapist will not provide narrative therapy or EMDR to an individual client.

Individual therapists will provide one 50-minute narrative therapy session and one 90-minute EMDR session to each client on their caseload per week. Couple therapists will provide on 50-minute EFT session to each couple on their caseload per week. Therapists will participate in weekly treatment team meetings with the clinical director and TCTSY instructor to discuss pertinent information regarding individual client and couple's treatment plans.

Licensing Qualifications:

To be eligible for hire, therapists must hold a license to practice mental health therapy including LMFT, LCSW, or LPCC.

TCTSY Instructor Description

Qualifications:

Instructors must be trained in TCTSY prior to onboarding with Flourish. It is not required for TCTSY instructors to be licensed mental health therapists, but this is preferred.

Description:

TCTSY instructors will provide one TCTSY group session per week. Additionally, the instructor will participate in treatment team meetings on a weekly basis to provide and receive any pertinent information from the TCTSY sessions on any of the clients that may alter the treatment plan.

Problem Description	Contributing Factors	Resources/Inputs	Program Activities	Process Goals	Short-Term Outcome Goals	Intermediate Outcome Goals	Long-Term Outcome Goals
Adult Female Survivors of Childhood Sexual Abuse presenting with individual trauma symptoms and intimate partner distress	Impact of trauma across BPSS domains	Assessment Phase	Administration of assessments; BPSS assess., CAPS, SBC, DAS, Self-Assessment, TTRG	All clients participate in assessment phase	Identification of level of trauma symptoms, relational satisfaction, and trauma/resiliency across generations	Overall decrease in problematic symptoms throughout proceeding phases	Long-term alleviation of problematic symptoms and restoration of health
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	Spiritual Impact	Trauma Center Trauma Sensitive Yoga (TCTSY)	**Phase 2:** EMDR, Narrative Therapy, TCTSY Intimate Partner Psychoed Group	80% of females in phase 2 reach stability to begin EFT	Decrease to mild symptoms on CAPS, Increase to average of 2 on the SBC	Trauma symptoms maintained at mild on CAPS Maintained average of 2 on SBC	Trauma symptoms maintained at mild or lower on CAPS Increase to average of 3 on SBC
	Social Impact	Emotionally Focused Therapy (EFT) Intimate Partner Psychoeducation Group	**Phase 3:** EMDR, TCTSY, EFT	70% of couples complete a minimum of 15 EFT sessions	Maintained decrease to mild symptoms on CAPS, Average score of 2 on SBC Minimum score of 107 on DAS	Maintained decrease to mild symptoms on CAPS, Maintained average score of 2 on SBC. Minimum score of 107 on DAS	Trauma symptoms maintained at mild or lower on CAPS Average of 3 on SBC Minimum of 107 on DAS

Figure 8. Logic model chart: Outcome goals.

Outcome Goals

- Trauma symptoms indicate “mild/subthreshold” or below (score of one or below) by the completion of the program.

- Increase to average score of three on the Scale of Body Connection, indicating good bodily awareness and low bodily dissociation.

- Couples reach a minimum of 107 on the DAS indicating non-distress in the couple relationship.

CHAPTER SIX

PROJECT SUMMARY AND APPLICATIONS

Project Summary

Flourish is an IOP designed to intervene in adult female survivors of CSA lives to promote health and wellbeing. Flourish integrates modalities including EMDR, Narrative Therapy, TCTSY, and EFT to tend to the impact of CSA on each of the biological, psychological, social, and spiritual domains of functioning. Applications of the Flourish program could be used in cities across the United States as CSA is a rampant issue that many women face (Finkelhor et al., 2014). Additionally, as many intervention programs and clinics offer one modality or serve one unit of treatment (individuals or couples), Flourish could be used in most cities in the United States as a tool to provide more comprehensive services to female CSA survivors. This section will review the strengths, limitations, opportunities, threats, and how the program benefits the field of MFT.

Strengths

Flourish not only treats the female survivor of CSA, but also treats the couple system that may be suffering in response to the impact of CSA. Therefore, Flourish is a program that is systemic in nature, working to elicit second order change within the attachment relationship of the intimate partner relationship. In creating new cycles of attachment between partners in addition to treating the trauma of CSA in individual therapy and TCTSY, the survivor may be more equipped to sustain the positive changes created in therapy. Therefore, Flourish is a novel approach to the treatment of CSA as it

integrates various modalities and units of treatment, rather than providing one unit of treatment as many already established programs do. Flourish supports CSA survivors in healing their inner wounds caused by trauma to function in a healthy way in their lives and relationships.

Flourish Compared to Other Programs

Flourish is a novel program that stands apart from previously developed intervention programs for adult female survivors of CSA. “The Wellness Program” is strong in that it integrates multiple modalities to treat the impact of CSA on the mind, body, and soul of survivors. This program integrates individual therapy (psychosomatic therapy, relaxation, and massage therapy), in addition to group therapy and dietitian services. With these approaches, the program seeks to address the impact of CSA on the BPSS domains of functioning (Sigurdardottir et al., 2016). “The Health Model” also uses various modalities including individual and group therapy to address both interpersonal and intrapersonal problems associated with being an adult survivor of CSA (Connor & Higgins, 2008). Finally, “Dare to Flourish” also integrates individual and group therapy to address multiple areas of impact within the BPSS domain (George & Bance, 2019).

Although these programs are strong in that they integrate various modalities to treat the holistic impact of CSA, they do not incorporate the couple relationship into treatment. MacIntosh and Johnson (2008) describe the importance of integrating the couple into the treatment of adult survivors of CSA to restructure the attachment relationship. Furthermore, decrease in ability to maintain healthy intimate partner attachment relationships has been found to be the most significant adverse impact of CSA

within an adult female survivor's social functioning (Callahan et al., 2003). Flourish integrates individual and couples therapy within the same course of treatment, whereas other intervention programs do not. Flourish applies the outcomes of research into clinical practice by integrating individual and couples therapy into the same course of treatment with the goal of systemically addressing the impact of CSA in a meaningful approach that allows for the couple therapist and individual therapist to work within the same program and collaborate effectively.

Integrating Research-Based Interventions

Flourish integrates interventions from cutting edge modalities that are supported by the literature in addressing the impacts of CSA on adult functioning. Using research-based interventions is one of Flourish's values as this is an important component of providing best practice interventions to the vulnerable population of CSA survivors. EFT, EMDR, and TCTSY are modalities that continue to have research conducted to support the effectiveness of these treatments. Flourish is committed to integrating research-based interventions, and as the program further develops in years to come, is committed to making appropriate alterations to the interventions included based on what is presented in the literature.

EFT

Flourish integrates interventions from cutting edge modalities that are supported by the literature. EFT has been found to be a clinically significant intervention for couples where one partner is the survivor of CSA (MacIntosh & Johnson, 2008). In a

study conducted by MacIntosh and Johnson (2008), it was found that in couples consisting of one CSA survivor who engaged in EFT, all CSA survivors had decreased trauma symptoms as indicated on the CAPS. Therefore, this is a clinically supported intervention for the use of EFT in this population. Additionally, this finding may support the hypothesis that couples therapy is an important intervention in decreasing individual trauma symptoms. Flourish intentionally integrates EFT into the treatment protocol based on these research findings.

EMDR

In a study conducted by Edmond, Rubin, et al. (1999) it was found that EMDR as an intervention in CSA survivors reduces trauma-specific anxiety, posttraumatic stress, depression signs and symptoms, negative beliefs, and emotional disturbances. Additionally, post-treatment, there was an increase in survivors desire for positive self-beliefs within only six sessions of EMDR. Edmond and Rubin (2004) found that when using EMDR within the population of adult survivors of CSA, therapeutic gains were not only maintained by 18 months follow up but improved. Edmond and Rubin (2004) also discuss how Shapiro, who developed EMDR, advocates not for the use of EMDR only, but for EMDR to be used in addition to other interventions, and that is why Flourish also integrates Narrative Therapy within the interventions.

TCTSY

Emerson and Sharma et al. (2009) found that after eight weeks of TCTSY, survivors of trauma demonstrated improvements in all dimensions of the symptoms

associated with PTSD, increase in positive affect, and increase in attunement with their bodies. However, TCTSY requires additional studies with larger sample sizes to gain consistent research support. Overall, the findings of TCTSY appear promising in the treatment of trauma. TCTSY was chosen to integrate within Flourish because of the cutting-edge nature of this new intervention, as well as to intervene in CSA survivors struggle with dissociating from the body.

Narrative Therapy

There appears to be a gap in the literature regarding research studies measuring clinical outcomes within the use of Narrative Therapy for CSA survivors. However, Narrative Therapy was chosen to incorporate into Flourish's intervention program in addition to the previously mentioned research-based interventions due to the nature of clinical issues such as shame, loss, oppression, and other psychological symptoms that may present as a long-term outcome of CSA (Fergusson et al., 2013). Narrative Therapy may support survivors with identifying and expanding narratives of resilience and power within their lives (Miller, Cardona et al., 2006).

Limitations

CSA Survivor's Partners

One of the potential limitations to Flourish is that the intimate partners of the CSA survivor may not be willing to participate in treatment. This may in part be due to the stigma of CSA, mental health treatment, or due to the partners not identifying themselves

as requiring support. This may require Flourish program staff to engage in community outreach events as well as informational advertisements, campaigns, and other forms of raising public awareness about the benefits of this population engaging in couple's therapy.

Diversity Issues

Additionally, Flourish was designed with inclusion criteria being that a CSA survivor must be in a long-term, committed, heterosexual, intimate partner relationship. If individuals who are not in committed, long-term intimate partner relationships are excluded from the program, that may risk these individuals not obtaining proper mental health treatment. Therefore, one way to overcome this limitation in the future is to expand the program to include females who are single. As designed, Flourish also currently excludes females who are not in a heterosexual relationship, and individuals who do not identify as female. This is a diversity issue and will require expansion. Flourish should engage in additional research and consultation to expand the program to include effective interventions and support for males, LGBTQ+ populations and those who identify as non-binary.

Group Therapy

Another limitation within the program is the lack of group therapy as an intervention. Flourish currently provides individual, couple, and group TCTSY sessions, but currently there are not opportunities for survivors to connect with and support one another. Processing the impact of CSA on survivor's functioning with other survivors

may be a powerful intervention to incorporate in a program that seeks to address each impact on the social domain. This is one area of expansion that may be important for Flourish to include to expand CSA survivor's social support and decrease isolation.

Opportunities

Larger mental health organizations, grant providers, and other assistance programs within the communities where Flourish is developed may be interested in supporting Flourish with funding as Flourish provides multiple modalities of treatment within the same program. Flourish is a novel program due to the integration of multiple modalities in effort to provide comprehensive care. Since this comprehensive program offers multiple services to treat trauma survivors, other agencies and funding sources may be interested in partnering with Flourish since one potential weakness of single intervention or unit of treatment programs is lack of providing comprehensive care. With less comprehensive services offered to this population, there may be issues with multiple clinics partnering to offer these services, leading to less positive outcomes. Therefore, Flourish may attract the support of multiple funding sources.

Threats

Funding

One major threat to Flourish may be funding sources. As Flourish is an IOP that integrates couples therapy into treatment, there may be an issue with securing insurance reimbursement for the couple services. Therefore, if Flourish is structured to rely on

insurance as payment, other forms of funding through grants and donations may be required to sustain program delivery. This will require Flourish program staff to also incorporate grant writing sections and other staff designated to secure funding sources.

Potential Lack of Stakeholders

Within the community, there are likely other clinics and agencies that provide services to this population, whether that be through individual therapy, couples therapy, or group therapy. These clinics and agencies may partner together in effort to provide comprehensive care for this population. Therefore, another threat to the program may be lack of support of stakeholders within the community due to Flourish offering the services these other clinics and agencies are already providing. This could also pose an issue with individuals within the population of interest already receiving services through one of these clinics, either through engaging in individual therapy or couples therapy. This may pose a challenge to Flourish receiving referrals since Flourish would then take over both individual and couple's therapy instead of the clinic or agency that was already providing this service.

Certifications of Clinical Staff

One barrier to hiring clinical staff may be the requirement for certificates and trainings. Although Flourish will send these clinical staff to the proper trainings, mental health therapists may not desire to obtain additional training, leading to an issue with proper staffing of the program. However, receiving additional training may also be a benefit that mental health therapists will look for when identifying employment

opportunities. This will require Flourish to discuss the requirement of obtaining these additional trainings in a way that supports professional development, expansion, and growth in effort to attract mental health therapists who value these areas.

How Flourish Fills the Gap in Treatment

In both the literature and intervention program review, there appears to be a gap in programs providing interventions that address the biological, psychological, social, and spiritual domains of adult female CSA survivors. Many programs offer unilateral treatment services such as individual or couples therapy, rather than a comprehensive program that provides both to target the BPSS domains. Flourish integrates multiple modalities and units of treatment within the same program to provide comprehensive care to adult female CSA survivors. Rather than multiple courses of therapy that disjointedly address each domain of influence, the creation of a cohesive, structured program to integrate interventions designed to address each domain demonstrates an applied systemic approach to treatment.

How Flourish Contributes to the Field of MFT

Flourish contributes to the field of MFT in multiple ways as it is a systemic and relational approach to treatment. Flourish understands CSA as a trauma that impacts multiple domains, including the biological, psychological, social, and spiritual areas of functioning within a survivor's life. Rather than addressing one area of impact, Flourish seeks to address each area of impact to provide holistic, comprehensive care, which is a tenet of the field of MFT. Although CSA is a trauma that first and foremost impacts the

individual who survived the trauma, as MFTs, we understand that oftentimes, symptoms are maintained within the system of relationships. MFTs also understand that long-term change is supported by integrating the relational system into treatment and approaching treatment through a relational lens. Flourish intentionally incorporates couples into treatment to address relational issues that originate within the trauma of CSA, support long-term change within the survivor's functioning, and by understanding that the trauma of CSA is relational in nature and may benefit from treatment that is also relational in nature.

Additionally, Flourish has the opportunity to contribute to the field of research within the profession. As Flourish integrates multiple, cutting-edge treatment interventions including TCTSY, EMDR, and EFT for couples, the program has ample opportunity to conduct research projects determining the effectiveness of these modalities. Furthermore, if research findings indicate important changes to be made to the structure, nature, or modalities integrated into treatment, Flourish will make the necessary changes to remain consistent with the program's value of being a research-based program. The field of MFT will benefit from Flourish's future contributions to the field of research.

Future Directions and Possibilities

Flourish is an IOP that has the potential to expand and be implemented in various cities across the nation. After establishing a pilot program, Flourish could open new locations to serve a greater number of adult female CSA survivors and their intimate partner attachment relationships. Additionally, Flourish could partner with pre-existing

intervention programs designed to support CSA survivors and support these programs with expansion to integrate modalities and units of treatment to holistically treat adult female survivors of CSA.

An exciting opportunity Flourish may have in the future is to publish research on the outcomes of this model. Integrating individual and couple's therapy into the same course of treatment for adult CSA survivors is not a well-researched practice. Flourish has opportunity to engage in research by measuring outcomes and contributing to the larger field of mental health in order to further equip clinicians with tools, philosophies of treatment, and intentional integration that is research-based to further support this population. Additionally, Flourish has the opportunity to publish treatment protocols for this population.

Next Steps

With the intention to implement this program, one of the first next steps would be to inquire about funding sources. As discussed previously, funding through grants, donations, and other larger funding sources may be required, as this IOP integrates couple's therapy into treatment which can often not be covered by insurance companies. In effort to make this program accessible to adult female CSA survivors from every class, securing funding sources is an additional first step. This will require the program developer and potential partners to research, select, and inquire to appropriate funding sources what the process of securing funding requires.

Another initial step would be reaching out to potential program stakeholders such as mental health agencies who provide services to this population in a variety of avenues

such as government assistance, medical workers, social services, and other mental health agencies to gain support, collaborate, and develop working relationships with these key stakeholders. Meetings with these agencies of interest could take place pitching the program design in order to secure support for the development of Flourish and carry that established support into the implementation of the program.

Then, identifying a location that is most easily accessible to various socioeconomic classes and diverse populations will be important. Choosing a location that allows the largest number of individuals, and/or those with the greatest need, to access these services is an important step. After securing potential funding sources, key community stakeholders, and a location to provide services, Flourish could then begin developing the program by hiring and training clinical staff, to then providing services to this deserving population of adult female survivors. These initial steps will pave the way for establishment and growth of Flourish.

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APPENDIX A

BIOPSYCHOSOCIAL-SPIRITUAL ASSESSMENT

FLOURISH

Name of individual being assessed _____ Date _____

1. **Presenting Problem(s)**

    a. What is bringing you in for treatment now? What is your perception of the problem you are experiencing? What concerns you the most?

    b. What has been the history/duration of the problem?

    c. Any identified precipitating events? Any identified contributing factors?

    d. Have you ever received formal mental health diagnoses?

e. What current/past psychological treatment have you received? (Obtain name of providers and request release of information be signed).

2. Lifespan/Developmental History

a. Health at birth:

b. Developmental Milestones:

c. Relevant Childhood History:

d. Other Lifespan/Developmental Issues:

3. Education and Occupation

a. Are you currently attending school? If so, where and what are you studying?

b. Education history:

c. Occupation and employment history:

d. Any special training(s):

4. **Family of Origin History:**

    a. Family's current and past psychological history

    b. Family's current and past major disruptions/experienced trauma events:

    c. Family's substance abuse/use history:

5. **Client's Current and Significant Past Social, Familial, Relational, and Spiritual Supports:**

    a. Do you currently receive emotional support?

    b. Do you believe that support is enough?

6. **Any other agencies the client is currently involved with or receiving services from?**

7. **Any relevant legal history? (Arrests, conservatorships, probation status, DUI, CPS involvement, restraining orders, etc.)**

8. **Client's current substance use and intake (including caffeine, alcohol, and other drugs). Assess frequency and history of use:**

    a. History of withdrawal?

    b. What happens if/when you stop using?

    c. What is the longest period of sobriety you have had?

d. Any involvement in NA, AA, or other substance use support services or treatment?

9. Medical History

a. Any outstanding medical problems?

b. Any known allergies?

c. Any diagnosed chronic illnesses?

d. When was the date of your last physical examination?

e. Primary Care Physicians Name and Phone Number (obtain release of information)

f. Medication history (current and previous two years) including medication name, dosage, prescriber, and if taking medications as prescribed.

g. Have you ever abused your medications?

h. Any sleep problems?

10. Abuse history: Have you ever experienced any of the following? If yes, please briefly describe the nature and extent of the abuse

a. Physical Abuse

b. Emotional Abuse

c. Sexual Abuse

d. Neglect

11. Assessment of Risk

a. Are you currently experiencing thoughts or urges to hurt or kill yourself? Have you in the previous 6 months?

b. Are you currently experiencing thoughts or urges to hurt or kill someone else? Have you in the previous 6 months?

c. Do you have an established safety plan? Do you think it would be helpful to create one today?

d. Are you currently afraid of someone harming you?

e. Any difficulty having basic needs met? (Food, clothing, shelter)

12. Strengths and Areas of Growth

a. What strengths do you identify within yourself?

b. What are some areas that you would like to grow (weaknesses, limitations)?

c. What is your motivation for treatment?

13. Spirituality

a. Do you consider yourself a spiritual or religious person?

b. Do you have a set of beliefs that are important to you?

c. Do you have a source of spiritual hope/strength to use in times of stress?

d. What importance does your faith, beliefs, or spirituality play in your life?

e. Are you part of a religious or spiritual community? If yes, do you receive support from this community?

f. Is there a group of people you find important to you?

g. How would you like your treatment team to use this information about your spirituality?

Conclusions/Recommendations:

Release of Information Forms/Other Important Documents Attached:

Signature of Assessing Therapist: _____Date/Time: _____

APPENDIX B

INITIAL SELF-ASSESSMENT TOOL

1. What is your hope or motivation for treatment?

2. What concerns you the most about your current life?

3. What would you like to accomplish by the time you complete treatment? What changes would you like to see?

4. What are your goals for therapy?

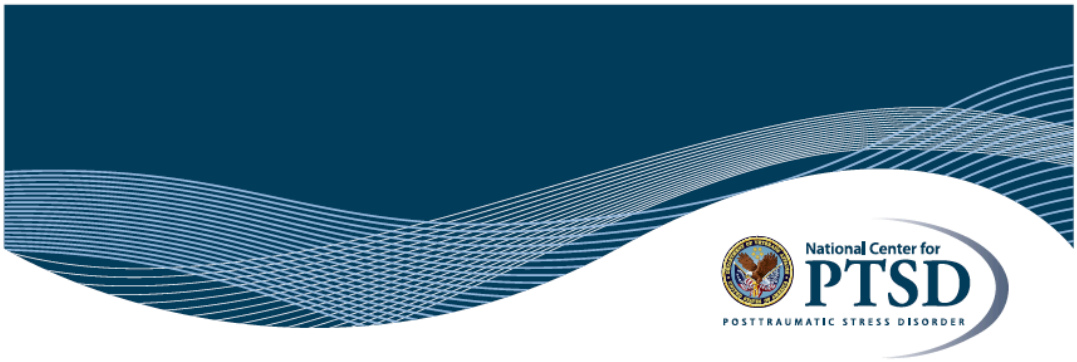
5. What strengths do you have that you believe will support you in treatment?

6. What are some areas of your life that you would like to improve or enhance?

7. What would you like for your treatment team to know about you as we begin working together?

APPENDIX C

CLINICIAN ADMINISTERED PTSD SCALE



Clinician-Administered PTSD Scale for *DSM-5* (CAPS-5)

Past Week Version

Version date: 16 April 2018

Reference: Weathers, F. W., Blake, D. D., Schnurr, P. P., Kaloupek, D. G., Marx, B. P., & Keane, T. M. (2015). *The Clinician-Administered PTSD Scale for DSM-5 (CAPS-5) – Past Week* [Measurement instrument]. Available from https://www.ptsd.va.gov/

URL: https://www.ptsd.va.gov/professional/assessment/adult-int/caps.asp

Note: This is a fillable form. You may complete it electronically.

Name: _____

Interviewer: _____

Study: _____

ID#: _____

Date: _____

CAPS-5 Past Week

The CAPS-5 Past Week instrument assesses PTSD symptoms which have occurred in the past week. This version is best used for determining whether PTSD symptoms have changed over time (e.g., in a treatment study in which you are interested in comparing a participant's PTSD symptoms at baseline versus mid-treatment). It should NOT be used to establish PTSD diagnostic status.

Instructions:

Standard administration and scoring of the CAPS-5 are essential for producing reliable and valid scores and diagnostic decisions. The CAPS-5 should be administered only by qualified interviewers who have formal training in structured clinical interviewing and differential diagnosis, a thorough understanding of the conceptual basis of PTSD and its various symptoms, and detailed knowledge of the features and conventions of the CAPS-5 itself.

Administration

1. Criterion A should already have been evaluated in a prior administration of the PAST MONTH version of the CAPS-5. Thus, for most applications of the PAST WEEK version, Criterion A does not need to be re-evaluated. However, if Criterion A has not been established, to identify an index traumatic event to serve as the basis for symptom inquiry, administer the Life Events Checklist and Criterion A inquiry provided on p. 4 , or use some other structured, evidence-based method. The index event may involve either a single incident (e.g., "the accident") or multiple, closely related incidents (e.g., "the worst parts of your combat experiences").
2. Read prompts verbatim, one at a time, and in the order presented, EXCEPT:
   a. Use the respondent's own words for labeling the index event or describing specific symptoms.
   b. Rephrase standard prompts to acknowledge previously reported information, but return to verbatim phrasing as soon as possible. For example, inquiry for item 20 might begin: "You already mentioned having problem sleeping. What kinds of problems?"
   c. If you don't have sufficient information after exhausting all standard prompts, follow up ad lib. In this situation, repeating the initial prompt often helps refocus the respondent.
   d. As needed, ask for specific examples or direct the respondent to elaborate even when such prompts are not provided explicitly.
3. In general, DO NOT suggest responses. If a respondent has pronounced difficulty understanding a prompt it may be necessary to offer a brief example to clarify and illustrate. However, this should be done rarely and only after the respondent has been given ample opportunity to answer spontaneously.
4. DO NOT read rating scale anchors to the respondent. They are intended only for you, the interviewer, because appropriate use requires clinical judgment and a thorough understanding of CAPS-5 scoring conventions.
5. Move through the interview as efficiently as possible to minimize respondent burden. Some useful strategies:
   a. Be thoroughly familiar with the CAPS-5 so that prompts flow smoothly.
   b. Ask the fewest number of prompts needed to obtain sufficient information to support a valid rating.
   c. Minimize note-taking and write while the respondent is talking to avoid long pauses.
   d. Take charge of the interview. Be respectful but firm in keeping the respondent on task, transitioning between questions, pressing for examples, or pointing out contradictions.

Scoring

1. As with previous versions of the CAPS, CAPS-5 symptom severity ratings are based on symptom frequency and intensity, except for items 8 (amnesia) and 12 (diminished interest), which are based on amount and intensity. However, CAPS-5 items are rated with a single severity score, in contrast to previous versions of the CAPS which required separate frequency and intensity scores for each item that were either summed to create a symptom severity score or combined in various scoring rules to create a dichotomous (present/absent) symptom score. Thus, on the CAPS-5 the clinician combines information about frequency and intensity before making a single severity rating. Depending on the item, frequency is rated as either the number of occurrences (how often in the past month) or percent of time (how much of the time in the past month). Intensity is rated on a four-point ordinal scale with ratings of *Minimal, Clearly Present, Pronounced*, and *Extreme*. Intensity and severity are related but distinct. Intensity refers to the strength of a typical occurrence of a symptom. Severity refers to the total symptom load over a given time period, and is a combination of intensity and frequency. This is similar to the quantity/frequency assessment approach to alcohol consumption. In general, intensity rating anchors correspond to severity scale anchors described below and should be interpreted and used in the same way, except that severity ratings require joint consideration of intensity and frequency. Thus, before taking frequency into account, an intensity rating of *Minimal* corresponds to a severity rating of *Mild / subthreshold*, Clearly Present corresponds with *Moderate / threshold*, Pronounced corresponds with *Severe / markedly elevated*, and Extreme corresponds with *Extreme / incapacitating*.

2. The five-point CAPS-5 symptom severity rating scale is used for all symptoms. Rating scale anchors should be interpreted and used as follows:

   0 ***Absent*** The respondent denied the problem or the respondent's report doesn't fit the *DSM-5* symptom criterion.

   1 ***Mild / subthreshold*** The respondent described a problem that is consistent with the symptom criterion but isn't severe enough to be considered clinically significant. The problem doesn't satisfy the *DSM-5* symptom criterion and thus doesn't count toward a PTSD diagnosis.

   2 ***Moderate / threshold*** The respondent described a clinically significant problem. The problem satisfies the *DSM-5* symptom criterion and thus counts toward a PTSD diagnosis. The problem would be a target for intervention. This rating requires a minimum frequency of *2 X month* or *some of the time (20-30%)* PLUS a minimum intensity of *Clearly Present*.

   3 ***Severe / markedly elevated*** The respondent described a problem that is well above threshold. The problem is difficult to manage and at times overwhelming, and would be a prominent target for intervention. This rating requires a minimum frequency of *2 X week* or *much of the time (50-60%)* PLUS a minimum intensity of *Pronounced*.

   4 ***Extreme / incapacitating*** The respondent described a dramatic symptom, far above threshold. The problem is pervasive, unmanageable, and overwhelming, and would be a high-priority target for intervention.

3. Use the scoring grid on the next page to determine the appropriate severity score for each CAPS-5 item. Start on the left side of the grid with the row corresponding to your intensity rating. Then follow the row that corresponds to the reported frequency to determine the severity score. For example, if your intensity rating is *Pronounced*, and the reported frequent is 2 x week, the corresponding severity score would be *Severe / markedly elevated*. However, if your intensity rating is *Pronounced*, but the reported frequency is 10%, then the corresponding severity score would be *Moderate / threshold*.

CAPS-5 Past Week Scoring Rules			
INTENSITY	***FREQUENCY (# of times or %)***		***SEVERITY***
Minimal	*1x/week or more*	*1-100%*	*1 = Mild / subthreshold*
Clearly Present		*1-19%*	*1 = Mild / subthreshold*
	1x/week or more[a]	*20-100%*	*2 = Moderate / threshold*
Pronounced	*1x/week only*[a]	*1-49%*	*2 = Moderate / threshold*
	2x/week or more[b]	*50-100%*	*3 = Severe / markedly elevated*
Extreme	*1x/week only*[a]	*1-19%*	*2 = Moderate / threshold*
	At least 2x/week but not daily/almost every day[b]	*20-79%*	*3 = Severe / markedly elevated*
	Daily/almost every day[c]	*80-100%*	*4 = Extreme / incapacitating*

[a]*For D1: 1-2 important parts* [b]*For D1: several important parts* [c]*For D1: most/all important parts*

4. You need to establish that a symptom not only meets the *DSM-5* criterion phenomenologically, but is also functionally related to the index traumatic event, i.e., started or got worse as a result of the event. CAPS-5 items 1-8 and 10 (reexperiencing, effortful avoidance, amnesia, and blame) are inherently linked to the event. Evaluate the remaining items for trauma-relatedness (TR) using the TR inquiry and rating scale. The three TR ratings are:

   a. ***Definite*** = the symptom can clearly be attributed to the index trauma, because (1) there is an obvious change from the pre-trauma level of functioning and/or (2) the respondent makes the attribution to the index trauma with confidence.

   b. ***Probable*** = the symptom is likely related to the index trauma, but an unequivocal connection can't be made. Situations in which this rating would be given include the following: (1) there seems to be a change from the pre-trauma level of functioning, but it isn't as clear and explicit as it would be for a *Definite*; (2) the respondent attributes a causal link between the symptom and the index trauma, but with less confidence than for a rating of *Definite*; (3) there appears to be a functional relationship between the symptom and inherently trauma-linked symptoms such as reexperiencing symptoms (e.g., numbing or withdrawal increases when reexperiencing increases).

   c. ***Unlikely*** = the symptom can be attributed to a cause other than the index trauma because (1) there is an obvious functional link with this other cause and/or (2) the respondent makes a confident attribution to this other cause and denies a link to the index trauma. Because it can be difficult to rule out a functional link between a symptom and the index trauma, a rating of *Unlikely* should be used only when the available evidence strongly points to a cause other than the index trauma. NOTE: Symptoms with a TR rating of *Unlikely* should not be counted toward a PTSD diagnosis or included in the total CAPS-5 symptom severity score.

5. **CAPS-5 total symptom severity score** is calculated by summing severity scores for items 1-20. NOTE: Severity scores for the two dissociation items (29 and 30) should NOT be included in the calculation of the total CAPS-5 severity score.

6. **CAPS-5 symptom cluster severity scores** are calculated by summing the individual item severity scores for symptoms contained in a given *DSM-5* cluster. Thus, the Criterion B (reexperiencing) severity score is the sum of the individual severity scores for items 1-5; the Criterion C (avoidance) severity score is the sum of items 6 and 7; the Criterion D (negative alterations in cognitions and mood) severity score is the sum of items 8-14; and the Criterion E (hyperarousal) severity score is the sum of items 15-20. A symptom cluster score may also be calculated for dissociation by summing items 29 and 30.

7. **PTSD diagnostic status** should be evaluated with the PAST MONTH version of the CAPS-5. This PAST WEEK version of the CAPS-5 should be used only to evaluate PTSD symptom severity over the past week.

NOTE: This is the PAST WEEK version of the CAPS-5, which should be used only to evaluate PTSD symptom severity over the past week. PTSD diagnostic status should be evaluated with the PAST MONTH version of the CAPS-5.

Criterion A:

Exposure to actual or threatened death, serious injury, or sexual violence in one (or more) of the following ways:

1. Directly experiencing the traumatic event(s).
2. Witnessing, in person, the event(s) as it occurred to others.
3. Learning that the traumatic event(s) occurred to a close family member or close friend. In cases of actual or threatened death of a family member or friend, the event(s) must have been violent or accidental.
4. Experiencing repeated or extreme exposure to aversive details of the traumatic event(s) (e.g., first responders collecting human remains; police officers repeatedly exposed to details of child abuse). Note: Criterion A4 does not apply to exposure through electronic media, television, movies, or pictures, unless this exposure is work related.

NOTE: Criterion A should already have been evaluated in a prior administration of the PAST MONTH version of the CAPS-5. Thus, for most applications of the PAST WEEK version, Criterion A does not need to be re-evaluated.

[Administer Life Events Checklist or other structured trauma screen]

I'm going to ask you about the stressful experiences questionnaire you filled out. First I'll ask you to tell me a little bit about the event you said was the worst for you. Then I'll ask how that event may have affected you over the past week. In general I don't need a lot of information – just enough so I can understand any problems you may have had. Please let me know if you find yourself becoming upset as we go through the questions so we can slow down and talk about it. Also, let me know if you have any questions or don't understand something. Do you have any questions before we start?

The event you said was the worst was (EVENT). What I'd like for you to do is briefly describe what happened.

Index event (specify): _____

What happened? (*How old were you? How were you involved? Who else was involved? Was anyone seriously injured or killed? Was anyone's life in danger? How many times did this happen?*)

Exposure type:

____ Experienced
____ Witnessed
____ Learned about
____ Exposed to aversive details

Life threat?
(NO) (YES) (self ___ other ___)

Serious injury?
(NO) (YES) (self ___ other ___)

Sexual violence?
(NO) (YES) (self ___ other ___)

Criterion A met?
(NO) (PROBABLE) (YES)

For the rest of the interview, I want you to keep (EVENT) in mind as I ask you about different problems it may have caused you. You may have had some of these problems before, but for this interview we're going to focus just on the past week. For each problem I'll ask if you've had it in the past week, and if so, how often and how much it bothered you.

Criterion B:

Presence of one (or more) of the following intrusion symptoms associated with the traumatic event(s), beginning after the traumatic event(s) occurred:

Item 1 (B1): Recurrent, involuntary, and intrusive distressing memories of the traumatic event(s). Note: In children older than 6 years, repetitive play may occur in which themes or aspects of the traumatic event(s) are expressed.

In the past week, have you had any unwanted memories of (EVENT) while you were awake, so not counting dreams? (Rate 0=Absent if only during dreams)

How does it happen that you start remembering (EVENT)?

[If not clear:] (***Are these unwanted memories, or are you thinking about (EVENT) on purpose?***) (Rate 0=Absent unless perceived as involuntary and intrusive)

How much do these memories bother you?

Are you able to put them out of your mind and think about something else?

[If not clear:] (***Overall, how much of a problem is this for you? How so?***)

Circle: Distress = ○ *Minimal* ○ *Clearly Present* ○ *Pronounced* ○ *Extreme*

How often have you had these memories in the past week?
# of times _____

0 Absent
1 *Mild / subthreshold*
2 *Moderate / threshold*
3 *Severe / markedly elevated*
4 *Extreme / incapacitating*

Key rating dimensions = frequency / intensity of distress

Moderate = at least 1 X week / distress clearly present, some difficulty dismissing memories

Severe = at least 2 X week / pronounced distress, considerable difficulty dismissing memories

Item 2 (B2): Recurrent distressing dreams in which the content and/or affect of the dream are related to the event(s). Note: In children, there may be frightening dreams without recognizable content.

In the past week, have you had any unpleasant dreams about (EVENT)?

Describe a typical dream. (*What happens?*)

[If not clear:] (***Do they wake you up?***)

[If yes:] (***What do you experience when you wake up? How long does it take you to get back to sleep?***)

[If reports not returning to sleep:] (***How much sleep do you lose?***)

How much do these dreams bother you?

Circle: Distress = ○ *Minimal* ○ *Clearly Present* ○ *Pronounced* ○ *Extreme*

How often have you had these dreams in the past week? # of times _____

⓪ *Absent*

① *Mild / subthreshold*

② *Moderate / threshold*

③ *Severe / markedly elevated*

④ *Extreme / incapacitating*

Key rating dimensions = frequency / intensity of distress

Moderate = at least 1 X week / distress clearly present, less than 1 hour sleep loss

Severe = at least 2 X week / pronounced distress, more than 1 hour sleep loss

Item 3 (B3): Dissociative reactions (e.g., flashbacks) in which the individual feels or acts as if the traumatic event(s) were recurring. (Such reactions may occur on a continuum, with the most extreme expression being a complete loss of awareness of present surroundings.) Note: In children, trauma-specific reenactment may occur in play.

In the past week, have there been times when you suddenly acted or felt as if (EVENT) were actually happening again?

[If not clear:] (***This is different than thinking about it or dreaming about it – now I'm asking about flashbacks, when you feel like you're actually back at the time of (EVENT), actually reliving it.***)

How much does it seem as if (EVENT) were happening again? (*Are you confused about where you actually are?*)

What do you do while this is happening? (*Do other people notice your behavior? What do they say?*)

How long does it last?

Circle: Dissociation = ○ *Minimal* ○ *Clearly Present* ○ *Pronounced* ○ *Extreme*

How often has this happened in the past week? # of times _____

⓪ *Absent*

① *Mild / subthreshold*

② *Moderate / threshold*

③ *Severe / markedly elevated*

④ *Extreme / incapacitating*

Key rating dimensions = frequency / intensity of dissociation

Moderate = at least 1 X week / dissociative quality clearly present, may retain some awareness of surroundings but relives event in a manner clearly distinct from thoughts and memories

Severe = at least 2 X week / pronounced dissociative quality, reports vivid reliving, e.g., with images, sounds, smells

Item 4 (B4): Intense or prolonged psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event(s).

In the past week, have you gotten <u>emotionally upset</u> when <u>something reminded you</u> of (EVENT)?

What kinds of reminders make you upset?

How much do these reminders bother you?

Are you able to calm yourself down when this happens? (*How long does it take?*)

[If not clear:] (***Overall, how much of a problem is this for you? How so?***)

<u>Circle:</u> Distress = ○ *Minimal* ○ *Clearly Present* ○ *Pronounced* ○ *Extreme*

How often has this happened in the past week? # of times _____

0 *Absent*

1 *Mild / subthreshold*

2 *Moderate / threshold*

3 *Severe / markedly elevated*

4 *Extreme / incapacitating*

Key rating dimensions = frequency / intensity of distress

Moderate = at least 1 X week / distress clearly present, some difficulty recovering

Severe = at least 2 X week / pronounced distress, considerable difficulty recovering

Item 5 (B5): Marked physiological reactions to internal or external cues that symbolize or resemble an aspect of the traumatic event(s).

In the past week, have you had any <u>physical reactions</u> when <u>something reminded you</u> of (EVENT)?

Can you give me some examples? (*Does your heart race or your breathing change? What about sweating or feeling really tense or shaky?*)

What kinds of reminders trigger these reactions?

How long does it take you to recover?

<u>Circle:</u> Physiological reactivity = ○ *Minimal* ○ *Clearly Present* ○ *Pronounced* ○ *Extreme*

How often has this happened in the past week? # of times _____

0 *Absent*

1 *Mild / subthreshold*

2 *Moderate / threshold*

3 *Severe / markedly elevated*

4 *Extreme / incapacitating*

Key rating dimensions = frequency / intensity of physiological arousal

Moderate = at least 1 X week/ reactivity clearly present, some difficulty recovering

Severe = at least 2 X week / pronounced reactivity, sustained arousal, considerable difficulty recovering

Criterion C:

Persistent avoidance of stimuli associated with the traumatic event(s), beginning after the traumatic event(s) occurred, as evidenced by one or both of the following:

Item 6 (C1): Avoidance of or efforts to avoid distressing memories, thoughts, or feelings about or closely associated with the traumatic event(s).

In the past week, have you tried to avoid thoughts or feelings about (EVENT)?

What kinds of thoughts or feelings do you avoid?

How hard do you try to avoid these thoughts or feelings? (*What kinds of things do you do?*)

[If not clear:] (***Overall, how much of a problem is this for you? How would things be different if you didn't have to avoid these thoughts or feelings?***)

Circle: Avoidance = ○ *Minimal* ○ *Clearly Present* ○ *Pronounced* ○ *Extreme*

How often in the past week? # of times _____

⓪ *Absent*
① *Mild / subthreshold*
② *Moderate / threshold*
③ *Severe / markedly elevated*
④ *Extreme / incapacitating*

Key rating dimensions = frequency / intensity of avoidance

Moderate = at least 1 X week / avoidance clearly present

Severe = at least 2 X week / pronounced avoidance

Item 7 (C2): Avoidance of or efforts to avoid external reminders (people, places, conversations, activities, objects, situations) that arouse distressing memories, thoughts, or feelings about or closely associated with the traumatic event(s).

In the past week, have you tried to avoid things that remind you of (EVENT), like certain people, places, or situations?

What kinds of things do you avoid?

How much effort do you make to avoid these reminders? (*Do you have to make a plan or change your activities to avoid them?*)

[If not clear:] (***Overall, how much of a problem is this for you? How would things be different if you didn't have to avoid these reminders?***)

Circle: Avoidance = ○ *Minimal* ○ *Clearly Present* ○ *Pronounced* ○ *Extreme*

How often in the past week? # of times _____

⓪ *Absent*
① *Mild / subthreshold*
② *Moderate / threshold*
③ *Severe / markedly elevated*
④ *Extreme / incapacitating*

Key rating dimensions = frequency / intensity of avoidance

Moderate = at least 1 X week / avoidance clearly present

Severe = at least 2 X week / pronounced avoidance

Criterion D:

Negative alterations in cognitions and mood associated with the traumatic event(s), beginning or worsening after the traumatic event(s) occurred, as evidenced by two (or more) of the following:

Item 8 (D1): Inability to remember an important aspect of the traumatic event(s) (typically due to dissociative amnesia and not to other factors such as head injury, alcohol, or drugs).

In the past week, have you had difficulty remembering some important parts of (EVENT)? (*Do you feel there are gaps in your memory of (EVENT)?*)

What parts have you had difficulty remembering?

Do you feel you should be able to remember these things?

[If not clear:] (***Why do you think you can't? Did you have a head injury during (EVENT)? Were you knocked unconscious? Were you intoxicated from alcohol or drugs?***) (Rate 0=Absent if due to head injury or loss of consciousness or intoxication during event)

[If still not clear:] (***Is this just normal forgetting? Or do you think you may have blocked it out because it would be too painful to remember?***) (Rate 0=Absent if due only to normal forgetting)

Circle: Difficulty remembering = ○ *Minimal* ○ *Clearly Present* ○ *Pronounced* ○ *Extreme*

In the past week, how many of the important parts of (EVENT) have you had difficu y remembering? (*What parts do you still remember?*)

# of important aspects _____

Would you be able to recall these things if you tried?

⓪ *Absent*

① *Mild / subthreshold*

② *Moderate / threshold*

③ *Severe / markedly elevated*

④ *Extreme / incapacitating*

Key rating dimensions = amount of event not recalled / intensity of inability to recall

Moderate = at least one important aspect / difficulty remembering clearly present, some recall possible with effort

Severe = several important aspects / pronounced difficulty remembering, little recall even with effort

Item 9 (D2): Persistent and exaggerated negative beliefs or expectations about oneself, others, or the world (e.g., "I am bad," "No one can be trusted," "The world is completely dangerous," "My whole nervous system is permanently ruined").

In the past week, have you had strong negative beliefs about yourself, other people, or the world?

Can you give me some examples? (*What about believing things like "I am bad," "there is something seriously wrong with me," "no one can be trusted," "the world is completely dangerous"?*)

How strong are these beliefs? (*How convinced are you that these beliefs are actually true? Can you see other ways of thinking about it?*)

Circle: Conviction = ○ *Minimal* ○ *Clearly Present* ○ *Pronounced* ○ *Extreme*

How much of the time in the past week have you felt that way, as a percentage? % of time _____

Did these beliefs start or get worse after (EVENT)? (*Do you think they're related to (EVENT)? How so?*) Circle: Trauma-relatedness = ○ *Definite* ○ *Probable* ○ *Unlikely*

⓪ *Absent*

① *Mild / subthreshold*

② *Moderate / threshold*

③ *Severe / markedly elevated*

④ *Extreme / incapacitating*

Key rating dimensions = frequency / intensity of beliefs

Moderate = some of the time (20-30%) / exaggerated negative expectations clearly present, some difficulty considering more realistic beliefs

Severe = much of the time (50-60%) / pronounced exaggerated negative expectations, considerable difficulty considering more realistic beliefs

Item 10 (D3): Persistent, distorted cognitions about the cause or consequences of the traumatic event(s) that lead the individual to blame himself/herself or others.

In the past week, have you blamed yourself for (EVENT) or what happened as a result of it? Tell me more about that. (*In what sense do you see yourself as having caused (EVENT)? Is it because of something you did? Or something you think you should have done but didn't? Is it because of something about you in general?*)

What about blaming someone else for (EVENT) or what happened as a result of it? Tell me more about that. (*In what sense do you see (OTHERS) as having caused (EVENT)? Is it because of something they did? Or something you think they should have done but didn't?*)

How much do you blame (YOURSELF OR OTHERS)?

How convinced are you that (YOU OR OTHERS) are truly to blame for what happened? (*Do other people agree with you? Can you see other ways of thinking about it?*)

(Rate 0=Absent if only blames perpetrator, i.e., someone who deliberately caused the event and intended harm)

Circle: Conviction = ○ *Minimal* ○ *Clearly Present* ○ *Pronounced* ○ *Extreme*

How much of the time in the past week have you felt that way, as a percentage? % of time _____

⓪ *Absent*

① *Mild / subthreshold*

② *Moderate / threshold*

③ *Severe / markedly elevated*

④ *Extreme / incapacitating*

Key rating dimensions = frequency / intensity of blame

Moderate = some of the time (20-30%) / distorted blame clearly present, some difficulty considering more realistic beliefs

Severe = much of the time (50-60%) / pronounced distorted blame, considerable difficulty considering more realistic beliefs

Item 11 (D4): Persistent negative emotional state (e.g., fear, horror, anger, guilt, or shame).

In the past week, have you had any strong negative feelings such as fear, horror, anger, guilt, or shame?

Can you give me some examples? (*What negative feelings do you experience?*)

How strong are these negative feelings?

How well are you able to manage them?

[If not clear:] (***Overall, how much of a problem is this for you? How so?***)

Circle: Negative emotions = ◯ *Minimal* ◯ *Clearly Present* ◯ *Pronounced* ◯ *Extreme*

How much of the time in the past week have you felt that way, as a percentage? % of time _____

Did these negative feelings start or get worse after (EVENT)? (*Do you think they're related to (EVENT)? How so?*)

Circle: Trauma-relatedness = ○ *Definite* ○ *Probable* ○ *Unlikely*

⓪ *Absent*

① *Mild / subthreshold*

② *Moderate / threshold*

③ *Severe / markedly elevated*

④ *Extreme / incapacitating*

Key rating dimensions = frequency / intensity of negative emotions

Moderate = some of the time (20-30%) / negative emotions clearly present, some difficulty managing

Severe = much of the time (50-60%) / pronounced negative emotions, considerable difficulty managing

Item 12 (D5): Markedly diminished interest or participation in significant activities.

In the past week, have you been less interested in activities that you used to enjoy?

What kinds of things have you lost interest in or don't do as much as you used to? (*Anything else?*)

Why is that? (Rate 0=Absent if diminished participation is due to lack of opportunity, physical inability, or developmentally appropriate change in preferred activities)

How strong is your loss of interest? (*Would you still enjoy (ACTIVITIES) once you got started?*)

Circle: Loss of interest = ◯ *Minimal* ◯ *Clearly Present* ◯ *Pronounced* ◯ *Extreme*

Overall, in the past week, how many of your usual activities have you been less interested in, as a percentage? % of activities _____

What kinds of things do you still enjoy doing?

Did this loss of interest start or get worse after (EVENT)? (*Do you think it's related to (EVENT)? How so?*)

Circle: Trauma-relatedness = ○ *Definite* ○ *Probable* ○ *Unlikely*

⓪ *Absent*

① *Mild / subthreshold*

② *Moderate / threshold*

③ *Severe / markedly elevated*

④ *Extreme / incapacitating*

Key rating dimensions = percent of activities affected / intensity of loss of interest

Moderate = some activities (20-30%) / loss of interest clearly present but still has some enjoyment of activities

Severe = many activities (50-60%) / pronounced loss of interest, little interest or participation in activities

Item 13 (D6): Feelings of detachment or estrangement from others.

In the past week, have you felt distant or cut off from other people?

Tell me more about that.

How strong are your feelings of being distant or cut off from others? (*Who do you feel closest to? How many people do you feel comfortable talking with about personal things?*)

Circle: Detachment or estrangement =
○ *Minimal* ○ *Clearly Present* ○ *Pronounced* ○ *Extreme*

How much of the time in the past week have you felt that way, as a percentage? % of time _____

Did this feeling of being distant or cut off start or get worse after (EVENT)? (*Do you think it's related to (EVENT)? How so?*)
Circle: Trauma-relatedness = ○ *Definite* ○ *Probable* ○ *Unlikely*

⓪ *Absent*
① *Mild / subthreshold*
② *Moderate / threshold*
③ *Severe / markedly elevated*
④ *Extreme / incapacitating*

Key rating dimensions = frequency / intensity of detachment or estrangement

Moderate = some of the time (20-30%) / feelings of detachment clearly present but still feels some interpersonal connection

Severe = much of the time (50-60%) / pronounced feelings of detachment or estrangement from most people, may feel close to only one or two people

Item 14 (D7): Persistent inability to experience positive emotions (e.g., inability to experience happiness, satisfaction, or loving feelings).

In the past week, have there been times when you had difficulty experiencing positive feelings like love or happiness?

Tell me more about that. (*What feelings are difficult to experience?*)

How much difficulty do you have experiencing positive feelings? (*Are you still able to experience any positive feelings?*)

Circle: Reduction of positive emotions =
○ *Minimal* ○ *Clearly Present* ○ *Pronounced* ○ *Extreme*

How much of the time in the past week have you felt that way, as a percentage? % of time _____

Did this trouble experiencing positive feelings start or get worse after (EVENT)? (*Do you think it's related to (EVENT)? How so?*)
Circle: Trauma-relatedness = ○ *Definite* ○ *Probable* ○ *Unlikely*

⓪ *Absent*
① *Mild / subthreshold*
② *Moderate / threshold*
③ *Severe / markedly elevated*
④ *Extreme / incapacitating*

Key rating dimensions = frequency / intensity of reduction in positive emotions

Moderate = some of the time (20-30%) / reduction of positive emotional experience clearly present but still able to experience some positive emotions

Severe = much of the time (50-60%) / pronounced reduction of experience across range of positive emotions

Criterion E:

Marked alterations in arousal and reactivity associated with the traumatic event(s), beginning or worsening after the traumatic event(s) occurred, as evidenced by two (or more) of the following:

Item 15 (E1): Irritable behavior and angry outbursts (with little or no provocation) typically expressed as verbal or physical aggression toward people or objects.

In the past week, have there been times when you felt especially irritable or angry and showed it in your behavior?

Can you give me some examples? (*How do you show it? Do you raise your voice or yell? Throw or hit things? Push or hit other people?*)

Circle: Aggression = ○ *Minimal* ○ *Clearly Present* ○ *Pronounced* ○ *Extreme*

How often in the past week? # of times _____

Did this behavior start or get worse after (EVENT)? (*Do you think it's related to (EVENT)? How so?*) Circle: Trauma-relatedness = ○ *Definite* ○ *Probable* ○ *Unlikely*

⓪ *Absent*
① *Mild / subthreshold*
② *Moderate / threshold*
③ *Severe / markedly elevated*
④ *Extreme / incapacitating*

Key rating dimensions = frequency / intensity of aggressive behavior

Moderate = at least 1 X week / aggression clearly present, primarily verbal

Severe = at least 2 X week / pronounced aggression, at least some physical aggression

Item 16 (E2): Reckless or self-destructive behavior.

In the past week, have there been times when you were taking more risks or doing things that might have caused you harm?

Can you give me some examples?

How much of a risk do you take? (*How dangerous are these behaviors? Were you injured or harmed in some way?*)

Circle: Risk = ○ *Minimal* ○ *Clearly Present* ○ *Pronounced* ○ *Extreme*

How often have you taken these kinds of risks in the past week?
# of times _____

Did this behavior start or get worse after (EVENT)? (Do you think it's related to (EVENT)? How so?) Circle: Trauma-relatedness = ○ *Definite* ○ *Probable* ○ *Unlikely*

⓪ *Absent*
① *Mild / subthreshold*
② *Moderate / threshold*
③ *Severe / markedly elevated*
④ *Extreme / incapacitating*

Key rating dimensions = frequency / degree of risk

Moderate = at least 1 X week / risk clearly present, may have been harmed

Severe = at least 2 X week / pronounced risk, actual harm or high probability of harm

Item 17 (E3): Hypervigilance.

In the past week, have you been especially alert or watchful, even when there was no specific threat or danger? (*Have you felt as if you had to be on guard?*)

Can you give me some examples? (*What kinds of things do you do when you're alert or watchful?*)

[If not clear:] (***What causes you to react this way? Do you feel like you're in danger or threatened in some way? Do you feel that way more than most people would in the same situation?***)

Circle: Hypervigilance = ○ *Minimal* ○ *Clearly Present* ○ *Pronounced* ○ *Extreme*

How much of the time in the past week have you felt that way, as a percentage? % of time _____

Did being especially alert or watchful start or get worse after (EVENT)? (*Do you think it's related to (EVENT)? How so?*)
Circle: Trauma-relatedness = ○ *Definite* ○ *Probable* ○ *Unlikely*

⓪ *Absent*
① *Mild / subthreshold*
② *Moderate / threshold*
③ *Severe / markedly elevated*
④ *Extreme / incapacitating*

Key rating dimensions = frequency / intensity of hypervigilance

Moderate = some of the time (20-30%) / hypervigilance clearly present, e.g., watchful in public, heightened awareness of threat

Severe = much of the time (50-60%) / pronounced hypervigilance, e.g., scans environment for danger, may have safety rituals, exaggerated concern for safety of self/family/home

Item 18 (E4): Exaggerated startle response.

In the past week, have you had any strong startle reactions?

What kinds of things made you startle?

How strong are these startle reactions? (*How strong are they compared to how most people would respond? Do you do anything other people would notice?*)

How long does it take you to recover?

Circle: Startle = ○ *Minimal* ○ *Clearly Present* ○ *Pronounced* ○ *Extreme*

How often has this happened in the past week? # of times _____

Did these startle reactions start or get worse after (EVENT)? (*Do you think it's related to (EVENT)? How so?*)
Circle: Trauma-relatedness = ○ *Definite* ○ *Probable* ○ *Unlikely*

⓪ *Absent*
① *Mild / subthreshold*
② *Moderate / threshold*
③ *Severe / markedly elevated*
④ *Extreme / incapacitating*

Key rating dimensions = frequency / intensity of startle

Moderate = at least 1 X week / startle clearly present, some difficulty recovering

Severe = at least 2 X week / pronounced startle, sustained arousal, considerable difficulty recovering

Item 19 (E5): Problems with concentration.

In the past week, have you had any problems with concentration?

Can you give me some examples?

Are you able to concentrate if you really try?

[If not clear:] **(*Overall, how much of a problem is this for you? How would things be different if you didn't have problems with concentration?*)**

Circle: Problem concentrating = ○ *Minimal* ○ *Clearly Present* ○ *Pronounced* ○ *Extreme*

How much of the time in the past week have you had problems with concentration, as a percentage? % of time _____

Did these problems with concentration start or get worse after (EVENT)? (*Do you think they're related to (EVENT)? How so?*)
Circle: Trauma-relatedness = ○ *Definite* ○ *Probable* ○ *Unlikely*

⓪ *Absent*

① *Mild / subthreshold*

② *Moderate / threshold*

③ *Severe / markedly elevated*

④ *Extreme / incapacitating*

Key rating dimensions = frequency / intensity of concentration problems

Moderate = some of the time (20-30%) / problem concentrating clearly present, some difficulty but can concentrate with effort

Severe = much of the time (50-60%) / pronounced problem concentrating, considerable difficulty even with effort

Item 20 (E6): Sleep disturbance (e.g., difficulty falling or staying asleep or restless sleep).

In the past week, have you had any problems falling or staying asleep?

What kinds of problems? (*How long does it take you to fall asleep? How often do you wake up in the night? Do you wake up earlier than you want to?*)

How many total hours do you sleep each night?

How many hours do you think you should be sleeping?

Circle: Problem sleeping = ○ *Minimal* ○ *Clearly Present* ○ *Pronounced* ○ *Extreme*

How often in the past week have you had these sleep problems?
# of times _____

Did these sleep problems start or get worse after (EVENT)? (*Do you think they're related to (EVENT)? How so?*)
Circle: Trauma-relatedness = ○ *Definite* ○ *Probable* ○ *Unlikely*

⓪ *Absent*

① *Mild / subthreshold*

② *Moderate / threshold*

③ *Severe / markedly elevated*

④ *Extreme / incapacitating*

Key rating dimensions = frequency / intensity of sleep problems

Moderate = at least 1 X week / sleep disturbance clearly present, clearly longer latency or clear difficulty staying asleep, 30-90 minutes loss of sleep

Severe = at least 2 X week / pronounced sleep disturbance, considerably longer latency or marked difficulty staying asleep, 90 min to 3 hrs loss of sleep

Criterion F: -

Duration of the disturbance (Criteria B, C, D, and E) is more than 1 month.

NOTE: Items 21 and 22 are not applicable for the PAST WEEK version. They are listed here without prompts only to maintain correspondence with item numbering on the PAST MONTH version. Onset and duration of symptoms should be assessed with

Item 21: Onset of symptoms.

Item 22: Duration of symptoms.

Criterion G:

The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Item 23: Subjective distress.

Overall, in the past week, how much have you been bothered by these (PTSD SYMPTOMS) you've told me about? [Consider distress reported on earlier items]	⓪ *None* ① *Mild, minimal distress* ② *Moderate, distress clearly present but still manageable* ③ *Severe, considerable distress* ④ *Extreme, incapacitating distress*

Item 24: Impairment in social functioning.

In the past week, have these (PTSD SYMPTOMS) affected your relationships with other people? How so? [Consider impairment in social functioning reported on earlier items]	⓪ *No adverse impact* ① *Mild impact, minimal impairment in social functioning* ② *Moderate impact, definite impairment but many aspects of social functioning still intact* ③ *Severe impact, marked impairment, few aspects of social functioning still intact* ④ *Extreme impact, little or no social functioning*

Item 25: Impairment in occupational or other important area of functioning.

[If not clear:] **Are you working now?** [If yes:] **In the past week, have these (PTSD SYMPTOMS) affected your work or your ability to work? How so?** [If no:] **Why is that?** (*Do you feel that your (PTSD SYMPTOMS) are related to you not working now? How so?*) [If unable to work because of PTSD symptoms, rate at least 3=Severe. If unemployment is not due to PTSD symptoms, or if the link is not clear, base rating only on impairment in other important areas of functioning] **Have these (PTSD SYMPTOMS) affected any other important part of your life?** [As appropriate, suggest examples such as parenting, housework, schoolwork, volunteer work, etc.] **How so?**	⓪ *No adverse impact* ① *Mild impact, minimal impairment in occupational/ other important functioning* ② *Moderate impact, definite impairment but many aspects of occupational/other important functioning still intact* ③ *Severe impact, marked impairment, few aspects of occupational/other important functioning still intact* ④ *Extreme impact, little or no occupational/other important functioning*

Global Ratings

Item 26: Global validity.

Estimate the overall validity of responses. Consider factors such as compliance with the interview, mental status (e.g., problems with concentration, comprehension of items, dissociation), and evidence of efforts to exaggerate or minimize symptoms.	⓪ *Excellent, no reason to suspect invalid responses* ① *Good, factors present that may adversely affect validity* ② *Fair, factors present that definitely reduce validity* ③ *Poor, substantially reduced validity* ④ *Invalid responses, severely impaired mental status or possible deliberate "faking bad" or "faking good"*

Item 27: Global severity.

Estimate the overall severity of PTSD symptoms. Consider degree of subjective distress, degree of functional impairment, observations of behaviors in interview, and judgment regarding reporting style.	⓪ *No clinically significant symptoms, no distress and no functional impairment* ① *Mild, minimal distress or functional impairment* ② *Moderate, definite distress or functional impairment but functions satisfactorily with effort* ③ *Severe, considerable distress or functional impairment, limited functioning even with effort* ④ *Extreme, marked distress or marked impairment in two or more major areas of functioning*

Item 28: Global improvement.

Rate total overall improvement since the previous rating. Rate the degree of change, whether or not, in your judgment, it is due to treatment.	⓪ *Asymptomatic* ① *Considerable improvement* ② *Moderate improvement* ③ *Slight improvement* ④ *No improvement* ⑤ *Insufficient information*

Specify whether with dissociative symptoms: The individual's symptoms meet the criteria for posttraumatic stress disorder, and in addition, in response to the stressor, the individual experiences persistent or recurrent symptoms of either of the following:

Item 29 (1): Depersonalization: Persistent or recurrent experiences of feeling detached from, and as if one were an outside observer of, one's mental processes or body (e.g., feeling as though one were in a dream; feeling a sense of unreality of self or body or of time moving slowly).

In the past week, have there been times when you felt as if you were separated from yourself, like you were watching yourself from the outside or observing your thoughts and feelings as if you were another person? [If no:] (***What about feeling as if you were in a dream, even though you were awake? Feeling as if something about you wasn't real? Feeling as if time was moving more slowly?***) **Tell me more about that.** **How strong is this feeling?** (*Do you lose track of where you actually are or what's actually going on?*) **What do you do while this is happening?** (*Do other people notice your behavior? What do they say?*) **How long does it last?** --- Circle: Dissociation = ○ *Minimal* ○ *Clearly Present* ○ *Pronounced* ○ *Extreme* [If not clear:] (***Was this due to the effects of alcohol or drugs? What about a medical condition like seizures?***) [Rate 0=Absent if due to the effects of a substance or another medical condition] **How often has this happened in the past week?** # of times _____ **Did this feeling start or get worse after (EVENT)?** (*Do you think it's related to (EVENT)? How so?*) Circle: Trauma-relatedness = ○ *Definite* ○ *Probable* ○ *Unlikely*	⓪ *Absent* ① *Mild / subthreshold* ② *Moderate / threshold* ③ *Severe / markedly elevated* ④ *Extreme / incapacitating* ***Key rating dimensions = frequency / intensity of dissociation*** **Moderate** = at least 1 X week / dissociative quality clearly present but transient, retains some realistic sense of self and awareness of environment **Severe** = at least 2 X week / pronounced dissociative quality, marked sense of detachment and unreality

Item 30 (2): Derealization: Persistent or recurrent experiences of unreality of surroundings (e.g., the world around the individual is experienced as unreal, dreamlike, distant, or distorted).

In the past week, have there been times when things going on around you seemed unreal or very strange and unfamiliar?

[If no:] (***Do things going on around you seem like a dream or like a scene from a movie? Do they seem distant or distorted?***)

Tell me more about that.

How strong is this feeling? (*Do you lose track of where you actually are or what's actually going on?*)

What do you do while this is happening? (*Do other people notice your behavior? What do they say?*)

How long does it last?

Circle: Dissociation = ○ *Minimal* ○ *Clearly Present* ○ *Pronounced* ○ *Extreme*

[If not clear:] (***Was this due to the effects of alcohol or drugs? What about a medical condition like seizures?***) [Rate 0=Absent if due to the effects of a substance or another medical condition]

How often has this happened in the past week? # of times _____

Did this feeling start or get worse after (EVENT)? (*Do you think it's related to (EVENT)? How so?*)

Circle: Trauma-relatedness = ○ *Definite* ○ *Probable* ○ *Unlikely*

⓪ *Absent*

① *Mild / subthreshold*

② *Moderate / threshold*

③ *Severe / markedly elevated*

④ *Extreme / incapacitating*

Key rating dimensions = frequency / intensity of dissociation

Moderate = at least 1 X week / dissociative quality clearly present but transient, retains some realistic sense of environment

Severe = at least 2 X week / pronounced dissociative quality, marked sense of unreality

CAPS-5 SUMMARY SHEET

Name: _____ ID#: _____ Interviewer: _____ Study: _____ Date: _____

A. Exposure to actual or threatened death, serious injury, or sexual violence	
Criterion A met?	(0) = NO (1) = YES

B. Intrusion symptoms (need 1 for diagnosis)		Past Week
Symptom	*Sev*	*Sx (Sev ≥ 2)?*
(1) B1 – Intrusive memories		(0) = NO (1) = YES
(2) B2 – Distressing dreams		(0) = NO (1) = YES
(3) B3 – Dissociative reactions		(0) = NO (1) = YES
(4) B4 – Cued psychological distress		(0) = NO (1) = YES
(5) B5 – Cued physiological reactions		(0) = NO (1) = YES
B subtotals	*B Sev* = 0	*#B Sx* = 0

C. Avoidance symptoms (need 1 for diagnosis)		Past Week
Symptom	*Sev*	*Sx (Sev ≥ 2)?*
(6) C1 – Avoidance of memories, thoughts, feelings		(0) = NO (1) = YES
(7) C2 – Avoidance of external reminders		(0) = NO (1) = YES
C subtotals	*C Sev* = 0	*#C Sx* = 0

D. Cognitions and mood symptoms (need 2 for diagnosis)		Past Week
Symptom	*Sev*	*Sx (Sev ≥ 2)?*
(8) D1 – Inability to recall important aspect of event		(0) = NO (1) = YES
(9) D2 – Exaggerated negative beliefs or expectations		(0) = NO (1) = YES
(10) D3 – Distorted cognitions leading to blame		(0) = NO (1) = YES
(11) D4 – Persistent negative emotional state		(0) = NO (1) = YES
(12) D5 – Diminished interest or participation in activities		(0) = NO (1) = YES
(13) D6 – Detachment or estrangement from others		(0) = NO (1) = YES
(14) D7 – Persistent inability to experience positive emotions		(0) = NO (1) = YES
D subtotals	*D Sev* = 0	*#D Sx* = 0

E. Arousal and reactivity symptoms (need 2 for diagnosis)		Past Week
Symptom	*Sev*	*Sx (Sev ≥ 2)?*
(15) E1 – Irritable behavior and angry outbursts		(0) = NO (1) = YES
(16) E2 – Reckless or self-destructive behavior		(0) = NO (1) = YES
(17) E3 – Hypervigilance		(0) = NO (1) = YES
(18) E4 – Exaggerated startle response		(0) = NO (1) = YES
(19) E5 – Problems with concentration		(0) = NO (1) = YES
(20) E6 – Sleep disturbance		(0) = NO (1) = YES
E subtotals	*E Sev* = 0	*#E Sx* = 0

PTSD totals	Past Week	
Totals	*Total Sev*	*Total # Sx*
Sum of subtotals (B+C+D+E)	0	0

F. Duration of disturbance	Current
(22)	NOT APPLICABLE

G. Distress or impairment (need 1 for diagnosis)	Past Week	
Criterion	*Sev*	*Cx (Sev ≥ 2)?*
(23) Subjective distress		0 = NO 1 = YES
(24) Impairment in social functioning		0 = NO 1 = YES
(25) Impairment in occupational functioning		0 = NO 1 = YES
G subtotals	*G Sev* = 0	*#G Cx* = 0

Global ratings	Past Week
(26) Global validity	
(27) Global severity	
(28) Global improvement	

Dissociative symptoms (need 1 for subtype)	Past Week	
Symptom	*Sev*	*Sx (Sev ≥ 2)?*
(29) 1 – Depersonalization		0 = NO 1 = YES
(30) 2 – Derealization		0 = NO 1 = YES
Dissociative subtotals	*Diss Sev* = 0	*#Diss Sx* = 0

APPENDIX D

SELF-ASSESSMENT TOOL FOR TRANSITIONING INTO PROCEEDING PHASES

Question 1: Our assessments indicate you may be ready to transition into the next phase of the program. As you reflect on the work you have done in this phase, do you perceive that you are ready to transition to the next phase? If so, why? If not, why not?

Question 2: If you do not perceive that you are ready to transition to the next phase, what goals would you like to work on prior to moving on to the next phase? Please create a SMART goal (Specific, Measurable, Achievable, Realistic, Time-Oriented).

Question 3: If you perceive that you are ready to transition into the next phase, what goals would you like to work on? Please use SMART goal format.

APPENDIX E

SCALE OF BODY CONNECTION

S B C

Instructions: For each statement please check the box that best answers the way you generally feel. There are no right answers, please answer as truthfully as you can. There are two questions about sexual activity; please consider all sexual activity including self-stimulation. If you do not engage in sexual activity, please leave these questions blank.

	Not at all 0	A little bit 1	Some of the time 2	Most of the time 3	All of the time 4
1. If there is tension in my body, I am aware of the tension					
2. It is difficult for me to identify my emotions					
3. I notice that my breathing becomes shallow when I am nervous					
4. I notice my emotional response to caring touch					
5. My body feels frozen, as though numb, during uncomfortable situations					
6. I notice how my body changes when I am angry					
7. I feel like I am looking at my body from outside of my body					
8. I am aware of internal sensation during sexual activity					
9. I can feel my breath travel through my body when I exhale deeply					
10. I feel separated from my body					
11. It is hard for me to express certain emotions					
12. I take cues from my body to help me understand how I feel					
13. When I am physically uncomfortable, I think about what might have caused the discomfort					
14. I listen for information from my body about my emotional state					
15. When I am stressed, I notice the stress in my body					
16. I distract myself from feelings of physical discomfort					
17. When I am tense, I take note of where the tension is located in my body					
18. I notice that my body feels different after a peaceful experience					
19. I feel separated from my body when I am engaged in sexual activity					
20. It is difficult for me to pay attention to my emotions					

APPENDIX F

DYADIC ADJUSTMENT SCALE

DYADIC ADJUSTMENT SCALE

Most persons have disagreements in their relationships. Please indicate below the approximate extent of agreement or disagreement between you and your partner for each item on the following list.

	Always Agree	Almost Always Agree	Occa-sionally Disagree	Fre-quently Disagree	Almost Always Disagree	Always Disagree
1. Handling family finances	O	O	O_	O	O	O
2. Matters of recreation	O	O	O_	O	O	O
3. Religious matters	O	O	O	O	O	O
4. Demonstrations of affection	O	O	O	O	O	O
5. Friends	O	O	O	O	O	O
6. Sex relations	O	O	O	O	O	O
7. Conventionality (correct or proper behavior)	O	O	O	O	O	O
8. Philosophy of life	O	O	O	O	O	O
9. Ways of dealing with parents or in-laws	O	O	O	O	O	O
10. Aims, goals, and things believed important	O	O	O	O	O	O
11. Amount of time spent together	O	O	O	O	O	O
12. Making major decisions	O	O	O	O	O	O
13. Household tasks	O	O	O	O	O	O
14. Leisure time interests and activities	O	O	O	O	O	O
15. Career decisions	O	O	O	O	O	O

	All the time	Most of the time	More often than not	Occa-sionally	Rarely	Never
16. How often do you discuss or have you considered divorce, separation, or terminating your relationship?	O	O	O	O	O	O
17. How often do you or your mate leave the house after a fight?	O	O	O	O	O	O
18. In general, how often do you think that things between you and your partner are going well?	O	O	O	O	O	O
19. Do you confide in your mate?	O	O	O	O	O	O
20. Do you ever regret that you married? (*or lived together*)	O	O	O	O	O	O
21. How often do you and your partner quarrel?	O	O	O	O	O	O
22. How often do you and your mate "get on each other's nerves?"	O	O	O	O	O	O

	Every Day	Almost Every Day	Occa-sionally	Rarely	Never
23. Do you kiss your mate?	O	O	O	O	O

	All of them	Most of them	Some of them	Very few of them	None of them
24. Do you and your mate engage in outside interests together?	O	O	O	O	O

How often would you say the following events occur between you and your mate?

	Never	Less than once a month	Once or twice a month	Once or twice a week	Once a day	More often
25. Have a stimulating exchange of ideas	O	O	O	O	O	O
26. Laugh together	O	O	O	O	O	O
27. Calmly discuss something	O	O	O	O	O	O
28. Work together on a project	O	O	O	O	O	O

These are some things about which couples sometimes agree and sometime disagree. Indicate if either item below caused differences of opinions or were problems in your relationship during the past few weeks. (Check yes or no)

	Yes	No	
29.	O	O	Being too tired for sex.
30.	O	O	Not showing love.

31. The circles on the following line represent different degrees of happiness in your relationship. The middle point, "happy," represents the degree of happiness of most relationships. Please fill in the circle which best describes the degree of happiness, all things considered, of your relationship.

O	O	O	O	O	O	O
Extremely Unhappy	Fairly Unhappy	A Little Unhappy	Happy	Very Happy	Extremely Happy	Perfect

32. Which of the following statements best describes how you feel about the future of your relationship?

O I want desperately for my relationship to succeed, and *would go to almost any length* to see that it does.

O I want very much for my relationship to succeed, and *will do all I can* to see that it does.

O I want very much for my relationship to succeed, and *will do my fair share* to see that it does.

O It would be nice if my relationship succeeded, but *I can't do much more than I am doing now* to help it succeed.

O It would be nice if it succeeded, but I *refuse to do any more than I am doing now* to keep the relationship going.

O My relationship can never succeed, and *there is no more that I can do* to keep the relationship going.