Cognitive-behavioral treatments for couples affected by childhood sexual abuse: An extension of the literature

Justin K. Donovan
Pacific University
Abstract
Past research regarding cognitive-behavioral therapy (CBT) for childhood sexual abuse (CSA) survivors tended to focus on individual treatments even though it has been suggested that couples therapy may be beneficial or even necessary for CSA survivors in serious relationships. There is empirical support for CBT treatments for couples impacted by several forms of trauma, but past couples research generally neglected specific issues related to CSA. The purpose of this dissertation is to determine how CBT used for CSA survivors may translate into working with CSA survivors seeking couples therapy. Research on CBT for individual CSA survivors and couples impacted by trauma are reviewed and critically analyzed to determine potential adaptability for couples impacted by CSA. A proposed treatment combining findings from research on individual CSA treatments and couples trauma treatments is presented.

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COGNITIVE-BEHAVIORAL TREATMENTS FOR COUPLES AFFECTED BY CHILDHOOD SEXUAL ABUSE: AN EXTENSION OF THE LITERATURE

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Abstract

Past research regarding cognitive-behavioral therapy (CBT) for childhood sexual abuse (CSA) survivors tended to focus on individual treatments even though it has been suggested that couples therapy may be beneficial or even necessary for CSA survivors in serious relationships. There is empirical support for CBT treatments for couples impacted by several forms of trauma, but past couples research generally neglected specific issues related to CSA. The purpose of this dissertation is to determine how CBT used for CSA survivors may translate into working with CSA survivors seeking couples therapy. Research on CBT for individual CSA survivors and couples impacted by trauma are reviewed and critically analyzed to determine potential adaptability for couples impacted by CSA. A proposed treatment combining findings from research on individual CSA treatments and couples trauma treatments is presented.

Key Words: childhood sexual abuse, couples therapy, cognitive-behavioral therapy, sexual trauma, cognitive-processing therapy, cognitive-behavioral couple therapy
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Introduction and Selected Review of the Literature

Childhood sexual abuse (CSA) can create many difficulties throughout life, including social, psychological, and relationship issues in adulthood (Beitchman et al., 1992; Colman, & Spatz Widom, 2004; Fleming, Mullen, Sibthorpe, & Bammer, 1999). While cognitive-behavioral therapy (CBT) has been found to be effective in treating individuals who have experienced CSA (Cloitre, Koenen, Cohen, & Han, 2002; McDonagh et al., 2005), and CBT has also been demonstrated to be effective in treating couples (Baucom, Shoham, Mueser, Daiuto, & Stickle, 1998; Dattilio, 2010), very few studies have examined the potential for CBT as an intervention modality for couples in which one partner is a CSA survivor. Given that many of the common issues that arise from CSA are likely to impact one’s relationships, it follows logically that such issues may be most effectively treated in a couple’s therapy setting. This paper will explore the utility of modifying existing CBT couples therapy interventions and CBT individual interventions for CSA to create a CBT treatment modality for use in couples in which CSA has impacted the relationship.

Psychological Effects of Childhood Sexual Abuse

Psychological disorders that are associated with CSA include depression, substance-use disorders, eating disorders, and anxiety disorders, particularly posttraumatic stress disorder (PTSD; Rodriguez, Ryan, Vande Kemp, & Foy, 1997). Other maladjustment issues that may arise are low self-esteem (Romans, Martin, & Mullen, 1996), fear and shame (Beitchman et al., 1992), suicidal ideation and attempts (Mullen, Anderson, Romans, & Herbison, 1993), increased likelihood of physical and sexual abuse as an adult (Fromuth, 1986), and sexual dysfunctions (Mullen, Martin, Anderson, Romans, & Herbison, 1994). The effects of CSA are particularly
strong on intimate adult relationships, and the issues mentioned above can create or exacerbate many problems within the relationship (Watson & Halford, 2010).

It is estimated that between 6% and 34% of women and 2%-11% of men in the general population have experienced CSA (Walker, Carey, Mohr, Stein, & Seedat, 2004). When working with two people in a treatment setting, the chances that at least one member in the couple has experienced childhood sexual abuse naturally increases. Additionally, people who have experienced CSA are more likely to receive therapy in general (Briere & Runtz, 1991; Herman, 1992), as well as to specifically seek couples therapy (Anderson & Miller, 2006). In 2009, there were 3.3 million referrals for child abuse in the United States (U.S. Department of Health and Human Services, 2010). Of those 3.3 million, Child Protective Services determined that 9.5% had experienced sexual abuse. Thus, difficulties created and influenced by childhood sexual abuse can be expected to continue to be present within the context of therapy.

People who have experienced sexual abuse as children often encounter difficulties related to the trauma. Many individuals recover fairly quickly by processing the trauma, attributing blame to the abuser rather than the self, and continuing normal activities (Ballard & Alessi, 2002). Many others, however, are at risk of developing posttraumatic stress disorder (PTSD) and/or other anxiety, mood, and sexual disorders. PTSD is characterized by a person re-experiencing a traumatic event, avoiding stimuli associated with the trauma, and experiencing an increase in arousal (American Psychiatric Association, 2000).

**Cognitive-Behavior Therapy for CSA**

Many studies have provided evidence that CBT is a safe and effective treatment for people who have PTSD (e.g., Devilly & Spence, 1999; Harvey, Bryant, & Tarrier, 2003; Klein et al., 2009; McDonagh et al., 2005). Zayfert and Becker (2007) suggested that of all the therapies
developed to help trauma survivors, CBT has the most evidence supporting its efficacy in treating PTSD. CBT is useful in the treatment of people who have experienced many forms of trauma (Harvey et al., 2003), including childhood sexual abuse (Cloitre, Koenen, Cohen, & Han, 2002; McDonagh et al., 2005).

Most treatments for PTSD using CBT include a combination of psychoeducation, exposure, and cognitive restructuring (Zayfert & Becker, 2007). It is important to acknowledge, though, that other forms of anxiety management interventions and relapse prevention are also common (Harvey et al., 2003). Psychoeducation involves providing the client with information about what trauma survivors commonly deal with after the event(s). A frequent way of using psychoeducation for trauma survivors is to highlight common symptoms in order to legitimate their reaction to the trauma and inform the client of the rationale for treatment (Harvey et al., 2003).

Exposure interventions involve having a client imagine the traumatic events. Clients are encouraged to imagine the events vividly, including sensory cues and affective responses, in order to create a sense of reliving the experience. Exposure sessions generally last between 50 and 90 minutes (Foe & Rothbaum, 1998; Harvey et al., 2003), and may incorporate other procedures at the same time, such as psychoeducation, cognitive restructuring, and breathing techniques (Harvey et al., 2003). The exposure itself is thought to desensitize the client to the trauma by allowing him or her to re-experience the event in a safe environment. Clients are often encouraged to do in vivo homework assignments that also expand on the exposure treatment.

Cognitive restructuring involves assisting the client in identifying and evaluating negative automatic thoughts along with beliefs about the trauma, him or herself, the world, and future
events (Marks, Lovell, Noshirvani, Livanou, & Thrasher, 1998). This is theorized to work by integrating corrective information that is inconsistent with fears related to the creation and maintenance of PTSD (Ehlers & Clark, 2000; Foa & Kozak, 1986).

It is important to note that, though the above CBT techniques have been shown to be effective in treating clients with PTSD (Van Etten & Taylor, 1998), the reasons these treatments work are not well understood (Shipherd, Street, & Resick, 2006). Resick, Nishith, Weaver, Astin, and Feuer (2002) conducted a well known study comparing three groups of rape survivors treated by using either CBT with a strong focus on exposure, CBT with a strong focus on cognitive restructuring, or by placing the survivors on a waitlist. Nearly 80% of the people in the study no longer met criteria for PTSD after receiving one of the CBT treatments, while only 2% of those who were in the waitlist control group stopped meeting criteria for PTSD. Most of the 80% who no longer met PTSD criteria also had reductions in depression. This study demonstrates the effectiveness of CBT regardless of the main intervention emphasized. Findings from other studies also suggest there is no clear evidence that one form of CBT is superior to another form of CBT when treating trauma survivors (Bryant, Moulds, Guthrie, Dang, & Nixon, 2003; Foa et al., 1999; Marks, Lovell, Noshirvani, Livanou, & Thrasher, 1998).

**Relationship Problems and CSA**

In addition to PTSD, relationship issues frequently manifest in those who have experienced CSA. Elmone and Lingg (1996) found that common symptoms associated with PTSD include intimacy and sexual disorders, though it is also possible to experience relationship problems after suffering from CSA without meeting criteria for PTSD (Pistorello & Follette, 1998). A study conducted by Pistorello and Follette found that the most common relationship problems that arise in couples work with CSA survivors are difficulties in emotional
communication, including communication about intimacy, and issues related to too much or not enough control within the relationship. These results are compatible with primary coping strategies commonly seen in survivors of CSA: avoiding feelings that are dangerous or threatening, as well as attempting to manage feelings of powerlessness, helplessness, or lack of control (Morrow & Smith, 1995).

Most prior research regarding CSA survivor relationships has been in regards to female survivors. A review of long-term effects of CSA by Cahill, Llewelyn, and Pearson (1991) found that women who experienced CSA are likely to have relationship problems such as difficulties trusting or loving, anxiety about emotional intimacy, anxiety about physical intimacy, feeling undeserving, feeling misunderstood, feeling dependent in relationships, and fearing being rejected, abused, or abandoned. These results were comparable to Colman and Spatz Widom’s (2004) findings that abused women are less likely to perceive their current intimate partners as supportive, caring, and open to communication. Not surprisingly, those researchers also found that abused women were less likely than non-abused women to be sexually faithful to their partners. When compared to non-abused women, those with CSA histories have more dissatisfaction with their marriages and have double the rate of separation from their spouses (Colman & Spatz Widom, 2004; Fleming, Mullen, Sibthorpe, & Bammer, 1999).

CSA seems to influence women’s views of marriage even if they have never been married (Larson & LaMont, 2005). Non-married women who suffered from CSA are more likely to believe that adjustment to marriage will be difficult, conflict is a problem, and that they will have an unhappy marriage. This, along with other social disruptions influenced by CSA, is a likely factor as to why female survivors of CSA are likely to wait longer to marry their partners and feel as if they are not ready for marriage (Larson & LaMont, 2005). Premarital attitudes and
perceived readiness are also strong predictors of marital satisfaction (Holman, Larson, & Harmer, 1994), which may further explain why women with CSA histories are more likely to experience divorce or dissatisfaction with their marriages.

Relationships are difficult enough for people to maintain without considering the unique complications CSA may bring. Approximately 40% to 50% of married couples in the United States get divorced (Americans for Divorce Reform, 2005). About 43% of first marriages end in divorce (Americans for Divorce Reform, 2005), and about 60% of marriages that do end in divorce do so within 10 years (Hurley, 2005). Among those who stay married, 20% are distressed within the relationship (Baucom, Epstein, Rankin, & Burnett, 1996). These statistics do not include all of the other committed relationships that people enter into and end in distress. It is not surprising then, that many couples seek couples therapy.

**CBT Treatment for Couples**

In a survey in which marriage therapists were asked what “their primary treatment modality” was, CBT was the most commonly identified approach (Northey, 2002, p. 448). Out of 27 primary treatment modalities mentioned, CBT was identified by 27.3% of the therapists. The notion that CBT is the most commonly used form of couples treatment was supported in a survey through Columbia University where 1,566 of 2,281 therapists stated that they use CBT in combination with other methods when working with couples (Psychotherapy Networker, 2007).

There is an extensive amount of empirical evidence from treatment outcome studies that suggests CBT is effective when used in couples therapy (Dattilio, 2010). Baucom et al. (1998) provided a review on outcome studies that suggested most CBT studies have focused on behavior interventions, such as communication training, problem-solving training, and behavior contracts. However, they did suggest that cognitive interventions, such as cognitive
restructuring, were also effective. Baucom et al. asserted that couples therapists should want to identify and build on existing strengths, as well as assess and address previously established cognitive and affective problematic patterns.

Specific behavioral interventions that a CBT couples therapists may use generally fall within two categories: guided behavior change and skills-based interventions. (Epstein & Baucom, 2002). Guided behavior change includes interventions that involve changing behaviors that require only already-existing skills (e.g., having one partner take responsibility for a chore). Skills-based interventions involve teaching skills to couples or providing them with information on how to do something differently (e.g., communication training).

It is important to not just address behaviors alone, because the same behavior can have different meanings to different people (Baucom, Epstein, LaTaillade, & Kirby, 2008). Cognitive factors that may influence one’s perception of meaning that were deemed as important by Epstein and Baucom (2002) include, selective attention (i.e., what each person notices about the partner and relationship), attributions (i.e., causal and responsibility conclusions about marital events), expectancies (i.e., predictions of what will happen in the future regarding the relationship), assumptions (i.e., beliefs about what people and relationships are like), and standards (i.e., beliefs about what people and relationships should be like). Two common interventions to address these cognitive factors are Socratic questioning and guided discovery (Baucom et al., 2008). Socratic questioning is a series of questions intended to help clients reevaluate their thinking and understand underlying issues or themes that they were not previously aware of. Baucom et al. (2008) advised that this type of intervention should be done cautiously with couples with more hostile and hurtful partners. Guided discovery involves creating an experience for a couple in which at least one member of the couple begins to
question their thoughts about the other person and gain a new perspective about their partner. This can manifest in many different ways. An example would be having one partner share what he or she was thinking and feeling during a previous conversation in order to present a perspective that was different from what the other partner assumed was being thought and felt. Both of these forms of interventions fit into the common term “cognitive restructuring” and address the goal of replacing irrational and erroneous beliefs with more accurate and helpful beliefs.

Emotional interventions may also be necessary, especially if one of the partners has restricted or minimized emotions, or excessive emotions (Baucom et al., 2008). Strategies for working with clients’ emotions in CBT are often drawn from emotionally focused couple therapy (Johnson, 2004), and may include normalizing emotional experiences, relating thoughts to emotions, using questions and interpretations to draw out primary emotions, using metaphors, discouraging distractions from emotional experiences, and encouraging acceptance of the partner’s emotional experience.

In addition to these ways of working with clients, Baucom et al. (2008) indicated that giving homework assignments is an important part of CBT with couples. Homework allows clients to rehearse new positive interaction patterns in “‘Real life’ conditions that are different and often more challenging than those in the therapist’s office” (Baucom et al., 2008, p. 39). Homework assignments may be useful in practicing and experimenting with new behaviors, cognitions, and emotions.

**Couples Therapy and CSA**

Though most treatment methods for people with CSA histories are with individuals (Zayfert & Becker, 2007), Leonard et al. (2006) stated that, “Recovery from trauma is more of a
journey than a destination, and as such, it is likely that both individual and couple treatment will occur on many trauma survivors’ journeys” (p. 382). Likewise, Maltas (1996) claimed that “couples therapy should be considered a necessary component of treatment when a survivor is in a serious relationship” (p. 355). There are many potential benefits to using couples therapy when one partner is a CSA survivor (Anderson & Miller, 2006; Bacon & Lein, 1996; Button & Dietz, 1995; Johnson, 2002; Serafin, 1996). The couple can discover strengths and work together for mutual healing, share personal stories and emotions in a safe environment, learn communication skills that facilitate expressing themselves and their needs in an accepting and validating way, and ultimately create an intimate relationship where it is safe to be vulnerable and know they are loved and can love in return (Alexander, 2003; Button & Dietz, 1995; Johnson & Williams-Keeler, 1998; Pistorello & Follette, 1998).

Schwartz (1988) explained several limitations of working only with individuals. In his book, he discussed how, in individual treatment, client denial is easier to maintain, therapeutic dyads may perpetuate keeping secrets regarding sexual issues from the partner, and there are less opportunities to practice and develop social skills. These are all issues that likely affect CSA survivors. Working simultaneously with the CSA survivor and partner may help reduce these limitations.

Working with couples is not only beneficial to the partner who experienced CSA, but it is also helpful to the non-abused partner. It is common for male partners of CSA survivors to feel anger towards the perpetrator and/or partner, or to feel fear, loneliness, helplessness, inadequacy, betrayal, or a sense of loss (Bacon & Lein, 1996; Maltz & Arian, 2001). Maltas and Shay (1995) noted that these partners may exhibit behaviors, feelings, and attitudes that are similar to people who have been abused themselves, and defined this vicarious trauma as “trauma contagion.”
Nelson and Wampler (2000) offered further evidence of the construct of trauma contagion and supported the use of couple’s treatment when it is present. Though there seems to be evidence supporting couples therapy with CSA survivors and their partners, Nelson and Wampler (2002) pointed out that there is still a need for additional research with CSA trauma survivors and their spouses or partners.

There is a limited amount of research that focuses specifically on CBT therapy for couples with a partner who experienced CSA (Buttenheim & Levendosky, 1994; McDonagh et al., 2005; Miller & Sutherland, 1999). However, more research exists supporting the use of CBT to treat PTSD in a couples therapy setting (Compton & Follette, 1998; Leonard, Follette, & Compton, 2006), and CSA is strongly associated with PTSD (Kessler, Sonnega, Bromet, Hughes, & Nelson, 1995; Lawrence, Cozolino, & Foy, 1995). Although one might generalize the literature regarding PTSD and CBT treatment for couples in which one partner has experienced CSA, Finkelhor (1988) cautioned providers who use treatments designed around general trauma responses to not neglect specific effects of CSA, including negative attitudes towards the self, distorted beliefs about others, shame, guilt, and sexual confusion. Therefore, further research is needed to take into account specific issues common to CSA survivors and to propose ways in which effective CBT treatment for couples may be conducted with this population.

**Purpose of Review**

Though there is a substantial body of research that addresses the long-term effects of CSA, particularly regarding female survivors, as well as research on couples therapy based around cognitive-behavioral treatments, there is a limited amount of research focused on incorporating CBT in couples therapy settings where at least one member of the couple has experienced CSA.
experienced trauma in the form of CSA. The purpose of this dissertation is to determine how cognitive-behavior treatments used for CSA survivors may translate into working with CSA survivors, particularly abused females, seeking couples therapy.

**Method**

Prior research regarding CBT treatments for individuals who are trauma survivors, particularly those who experienced CSA, as well as CBT used in couples therapy for people who have not experienced sexual trauma will be examined. The individual trauma studies that will be reviewed are CSA and adult sexual assault. Adult sexual assault will be included due to the sexual nature of the trauma that creates similar symptoms to CSA (Elliott, Mok, & Briere, 2004; Thompson et al., 2003; Ullman & Brecklin, 2002). Any studies that specifically address CSA in couples therapy will be highlighted. Using the gathered information, common interventions used for individuals with CSA will be used to identify areas of focus for couple’s therapy with this population. The treatment methods used in individual trauma work will be informed by couples treatment in order to identify and modify treatments for couples where at least one partner had experienced CSA. Complications in adapting individual trauma treatment to couples therapy are anticipated. These complications will be discussed when formulating a treatment model.

Studies published 1996 and after will be utilized. The studies will be selected from relevant articles found on PsychINFO, an electronic database of literature in the field of psychology. Search terms that will be used include combinations of the following key words: relationship, intimate relationship, romantic relationship, couples, couples therapy, marriage, marital, cognitive-behavioral therapy, CBT, cognitive therapy, behavioral therapy, cognitive-behavioral marital therapy, behavioral couples therapy, family focused treatment, functional family therapy, posttraumatic stress, PTSD, trauma, trauma survivors, childhood sexual abuse,
CSA, sexual abuse, sexual assault, and child abuse. Studies that were published before 1996 will occasionally be used to describe treatment processes and interventions that have been utilized in the newer studies.

The term “CSA” in this study refers to at least one documented or reported incident of unwanted or coercive sexual contact or exposure, sexual contact or exposure to a child by a family member, or sexual contact or exposure to a child less than 18 years of age by someone five or more years older. The term “couple” in this study refers to heterosexual married, cohabitating, and dating pairs of individuals. Research regarding same-sex couples will not be thoroughly discussed due to limited research; however, the topic will be discussed in the limitations and future research section. The term “CBT” in this study does not necessarily refer to studies that use both cognitive and behavioral interventions; rather, it refers to any form of cognitive or behavioral therapies. This also applies to couples therapy, meaning that CBT used in couples treatment includes any couples therapy that uses cognitive or behavioral approaches.

**Literature Review**

**Individual Treatments for Trauma**

**Mind-body practices.** Mind and body practices involve activities that are not directly related to cognitive talk therapy, even though they are frequently used as extra support to cognitive-behavioral therapy (e.g., used to bring anxiety back down to baseline during prolonged exposure) and are sometimes an important part of specific interventions (e.g., muscle relaxation in stress inoculation training). Such practices include, but are not limited to, progressive muscle relaxation, breathing techniques, yoga, meditation, and tai chi.

Few studies were found that examined mind and body practices alone with CSA or sexual assault victims, nor were studies found that isolated and measured their impact when combined with other CBT interventions. One form of a mind-body practice that has been tested as an
independent treatment group with trauma survivors is relaxation, but even then it is sometimes used as a placebo-control group because of its lack of effectiveness as an independent intervention (Marks et al., 1998). Gerbarg and Brown (2011), likewise, noted that there is a lack of research on mind-body practices used specifically for sexual trauma. They suggested that mind-body techniques are likely to be effective for CSA survivors because of the research showing effectiveness of the techniques with other populations with PTSD that have overlapping symptoms with sexual trauma.

Much of the way that mind-body practices seem to help trauma victims is by acting as a coping technique when anxiety is high. Gerbarg and Brown (2011) noted that the practices release tension and stress to induce a calm state, as well as allow a sense of security that is not easily obtained while anxiety is high. By reaching a feeling of security, Gerbarg and Brown believe that this increases the chances that trauma survivors can trust and engage with a therapist, as well as others in their lives.

Clark and Beck (2010) echoed Gerbarg and Brown’s (2011) support of using mind-body practices, specifically progressive muscle relaxation and breathing retraining, as a coping tool when anxiety is high; yet, they also expressed that these should be used cautiously. They shared concerns voiced by White and Barlow (2002) that using progressive muscle relaxation, breathing retraining, or any other behavioral intervention that is meant to lower heightened anxiety related could be “teaching avoidance as a coping strategy” (White & Barlow, 2002, p. 317). This theoretical concern had some empirical support in some anxiety disorders such as social anxiety and OCD (Foa & Rothbaum, 1998; Heimberg & Juster; 1995), but using the techniques to lower anxiety has been shown to be somewhat helpful for GAD and PTSD, particularly when used with
other interventions such as exposure (Brown, O’Leary, & Barlow, 2001; Foa & Rothbaum, 1998).

**Eye-movement desensitization and reprocessing.** Eye-movement desensitization and reprocessing (EMDR) is a form of exposure therapy, developed by Francine Shapiro, which has become a commonly used treatment for trauma. EMDR is a treatment approach that consists of eight phases (Shapiro, 1995):

1. Developing a treatment plan based on a thorough client history
2. Preparing the client to use EMDR
3. Assessing target issues to be addressed
4. Desensitizing the target issue with eye movement or other forms of stimulation
5. Installing desired positive cognitions
6. Conducting a body scan to determine if any residual material from the target issue remains
7. Closure
8. Re-evaluation

It is important during phase three to target the presenting problem, the memory connected to the problem, a mental image of the memory (both negative and desired positive self-assessment related to the memory), emotions related to the memory, and any related physical sensations (Shapiro, 1995). Baselines for validity of cognition (VOC) and subjective units of disturbance (SUDS) are established. The VOC baseline is established by having the client imagine the image and identify their desired positive self-perception, then identify on a scale of 1 to 7 how true the positive self-perceptions feel. The SUDS baseline is established by having the emotions, image, and negative self-perception become present, followed by rating how
disturbing the emotions are on a scale of 0 to 10. Shapiro (1995) stated that a target issue is considered resolved once the SUDS score is 1 or less and the VOC is 6 or more.

During phase four, the therapist instructs the client to follow two of the therapist’s fingers with their eyes in 24 quick side-to-side movements about 12 to 14 inches away from the client’s face (Shapiro, 1995); though, the speed, number, and direction of the eye movements do vary some. Shapiro recommends 90-minute sessions, though the number and length of the sessions to resolve target issues do vary by individual client, with positive results becoming apparent as early as one to four sessions (Shapiro, 1989; Wilson, Becker, & Tinker, 1995).

Van Etten and Taylor (1998) conducted a meta-analysis of 61 treatment outcome studies for PTSD, which compared several studies, including EMDR. The meta-analysis consisted of research on psychological therapies (e.g., cognitive-behavior therapy, EMDR, and relaxation training), drug therapies (e.g., MAOIs, SSRIs, and BDZs), and control conditions (e.g., waitlist, placebo, and supportive psychotherapies). This study included thirteen studies that used cognitive-behavioral interventions, seven of which used imaginal and in vivo exposure, four of which used imaginal but not in vivo exposure, and three that used stress inoculation training. When interpreting the results, Van Etten and Taylor counted all of the different cognitive-behavior therapies together rather than differentiating between the specific interventions used. Eleven EMDR studies were utilized in this meta-analysis. All of the EMDR studies included imaginal exposure with simultaneous lateralized eye movements and coping statements. Psychotherapies were more effective at reducing PTSD symptoms than drug therapies, and both were more effective than the controls. The cognitive-behavioral therapies and EMDR treatments were more effective than the other forms of psychological therapy, including biofeedback-guided relaxation, hypnotherapy, and psychodynamic therapy. The results also showed that both of
these psychotherapy treatments have strong treatment effects and had the lowest dropout rates of all the treatment conditions. It is important to note that the cognitive-behavioral therapies were more effective than EMDR in observer-rated PTSD symptoms at posttests; however, those who received EMDR treatment continued to improve after treatment and there was no significant difference between EMDR and cognitive-behavioral therapy in this measurement at follow-ups 15 weeks later.

Using the EMDR protocol developed by Shapiro (1989; 1995), Edmond, Rubin, and Wambach (1999) sought to answer if EMDR is effective in reducing trauma symptoms in female survivors of CSA, and to answer if it is more effective than a mix of common individual therapies for CSA both short term and at a three-month follow-up. To do so, they randomly assigned 59 female survivors of CSA to one of three groups: EMDR treatment, routine individual treatment, and delayed treatment control. The EMDR group received six 90-minute sessions based on Shapiro’s phases of EMDR treatment. Their treatment was not limited to EMDR, but also included support, information, ego strengthening, cognitive restructuring, journaling, visualization, and dream work. The routine treatment group received six sessions using treatment tailored to each survivor’s unique needs. Combinations of 20 different interventions were utilized for the group, including the additional interventions that were listed above as being used with the EMDR group, as well as interpretation, problem solving, neurolinguistic programming, psychoeducation, behavior modification, gestalt, hypnosis, artwork, assertiveness training, child observation, relaxation exercises, and guided imagery. In the control group, participants simply waited for treatment for six weeks.

The EMDR participants improved significantly more than the control group on all outcome measures at posttest and the three-month follow-up, including assessments of trauma-
specific anxiety, trauma-specific posttraumatic stress, depression, and negative beliefs (Edmond et al., 1999). There were no statistically significant differences between EMDR and the routine treatment interventions at posttest, but EMDR was significantly more effective at a three month follow-up regarding trauma-specific anxiety and depression. These significant differences at the follow-up were due to continued improvements after EMDR treatment was terminated, while effectiveness of routine interventions simply maintained over time. This is comparable with research from Van Etten and Taylor (1998) that showed effect sizes continuing to increase for EMDR treated clients after termination of treatment. The results were surprising considering the therapists in the study had limited experience using EMDR and more experience with the other interventions for trauma survivors. Some participants in both EMDR and the routine individual treatment groups received continued therapy after the six sessions; therefore, the three-month follow-up results should be interpreted cautiously. Due to comparable results between EMDR and the routine treatment interventions on most measures with EMDR having greater improvements over time on anxiety and depression, Edmond et al. (1999) partially supports Shapiro’s (1995) claim that EMDR is more effective than other forms of treatment.

Edmond and Rubin (2004) built further on Edmond, Rubin, and Wambach’s (1999) study with an 18-month follow-up. EMDR and the routine treatments seemed to maintain their effectiveness, while the control group seemed to worsen slightly. Although the effectiveness of both treatments did not change significantly, the statistically significant difference between EMDR and the routine treatment group regarding anxiety and depression found at the three-month follow-up had disappeared at the 18-month follow-up. However, EMDR still endorsed fewer clinical symptoms and scored in every outcome at non-significant levels.
In a qualitative follow-up study, Edmond, Sloan, and McCarty (2004) found different client views towards the therapists conducting the EMDR and routine treatments. All of the women in the routine treatment groups attributed their therapeutic success to their relationship with their therapist, suggesting that their experience was supportive, accepting, validating, and nonjudgmental. The women in the EMDR group tended to attribute their improvements to the EMDR process itself and not their relationship with the therapist. This relational difference in techniques may need to be considered if EMDR is used with couple’s treatment.

EMDR and prolonged exposure were tested as individual treatments, along with a waitlist group, on their effectiveness with women who had rape-related PTSD by Rothbaum, Astin, and Marsteller (2005). Participants who were raped in either childhood or adulthood were included. Both the EMDR and prolonged exposure groups received nine 90-minute sessions that were conducted twice per week. The first two sessions for each treatment group involved information gathering, psychoeducation about trauma, treatment rationale, and treatment preparation. Beginning in session 3, the participants began their respective treatments. Those in the EMDR group received the treatment with the therapist moving his or her fingers back and forth a minimum of 20 times each repetition from approximately 18 inches away from the clients’ faces while simultaneously imagining the worst part of the trauma, rehearsing negative thoughts that matched the image, and focusing on bodily distress. When the clients’ distress rating dropped to 0 or 1 on the subjective units of discomfort scale (SUDs), the clients began rehearsing a new preferred belief. The prolonged exposure treatment followed the same protocol that is described in the prolonged exposure section later in this paper from Foa et al. (1991).

The results of Rothbaum et al. (2005) indicated that both EMDR and prolonged exposure produced equally beneficial results that were superior to the waitlist condition at posttreatment.
Prolonged exposure led to 95% of clients no longer meeting criteria for PTSD, while 75% of those in the EMDR group no longer met criteria; however, these recovery rate differences between the treatment groups were not statistically significant. Likewise, both treatments led to significant improvements in end-state functioning, including depression, anxiety, and dissociation symptoms.

At a 6-month follow-up evaluation, each treatment continued to significantly reduce PTSD symptoms and diagnoses in the participants (Rothbaum et al., 2005). The participants in prolonged exposure at the 6-month follow-up showed significantly higher overall functioning than the EMDR participants, with 78% versus 35.3% of participants meeting criteria for “good end-state functioning.” For PTSD diagnosis, though, there still was not a significant difference between the two treatments at the 6-month follow-up.

Leiner, Kearns, Jackson, Astin, and Rothbaum (2012) wanted to test how EMDR and prolonged exposure worked with women who had PTSD and were avoidant of their rape-related memories. The researchers utilized data from Rothbaum et al. (2005), including recruiting participants from that study. The women who were originally in Rothbaum et al.’s waitlist group and still had PTSD were randomly split into prolonged exposure and EMDR treatment groups for Leiner et al.’s study. The treatment followed the same protocol as outlined in Rothbaum et al.

The results of Leiner et al. (2012) showed that when clients with PTSD related to rape had high levels of coping by avoidance prior to treatment, they are likely to have less severe PTSD after treatment was completed. This was true whether the treatment was EMDR or prolonged exposure. These findings were consistent with and helped validate cognitive-
behavioral theories that recovery from PTSD is related to decreases in trauma-related avoidance (Harvey, 1999).

Though the research indicates that EMDR is typically useful for some CSA survivors, there is less research supporting its use when the trauma is more complicated. Forgash and Knipe (2008) indicated that when children are repeatedly abused by their caretakers, the trauma becomes more complicated due to children relying on the very people that abuse them. They suggested that children often dissociate from their memories of abuse in these situations. In these cases of complicated abuse, it has been observed that the processing is blocked during EMDR and the clients frequently report, “Nothing is different.” “This isn’t helping.” (Forgash & Knipe, 2008, p. 21). The current, yet limited, research suggests that the best way of using EMDR with complicated trauma is to extend the preparation phase (phase 1), slowly process the trauma, and integrate other forms of therapy, including cognitive therapy (Forgash & Knipe, 2008; Korn, 2009).

The above described studies indicated that EMDR can be a very useful tool in the treatment of individuals with CSA histories. There is evidence that EMDR is just as effective as other forms of treatment, and a case can be made for continued improvements even after treatment is terminated. The client-therapist relationship in EMDR does not seem to be as important of a factor as it is in treating individuals using other techniques. This missing relationship factor could be important when addressing CSA survivors in couple’s therapy. Additionally, EMDR alone and in its traditional form may not be sufficient when the trauma is more complicated, thus modifications and supplemental therapies may need to be incorporated.

**Stress inoculation training.** Stress inoculation training (SIT) was developed by Meichenbaum (1985, 1988, 1993) to help clients cope with stress, including stress related to past
trauma such as rape (Meichenbaum, 1988). The intervention involves three phases that are meant to be collaboratively implemented with the client (Meichenbaum, 1988). The three phases according to Meichenbaum include a conceptualization phase, skills acquisition and rehearsal phase, and an application and follow-through phase. These phases are flexible and have overlap. The conceptualization phase involves building rapport between the client and therapist to collaboratively set goals rather than having a set protocol that is dictated by the therapist. Then psychoeducation is used to explain the triggers, emotions, cognitions, and behaviors of the client that have become patterns and discussing them with the client and significant others. The skills acquisition and rehearsal phase involves teaching and practicing new skills that are meant to be combined with, or used in conjunction with, pre-existing skills to break the patterns discovered in the first phase. Due to this being a flexible and collaborative treatment style, the skills vary from client to client, but may include learning how to assess events, have more control of emotions, self-regulate, use cognitive restructuring, use problem solving strategies, use communication and social skills, use relaxation techniques, and to learn acceptance strategies. The final phase, application training, involves preparing the client for real life events that would cause stress. For somebody who has posttraumatic stress due to sexual abuse history, the training would likely involve preparing somebody for emotional, cognitive, or behavioral reactions to triggers of stress that may be directly or indirectly influenced by the past trauma. Ways to train the client in this phase could include role play, imagery rehearsal, in vivo exposure, and experimentation. Stress inoculation training has been used in interventions as brief as a single 20 minutes session and as long as 40 one-hour sessions, though it is usually implemented for 8 to 15 one-hour sessions plus follow-up sessions over the course of 3 to 12 months (Meichenbaum, 1996a). The idea behind this treatment is that exposure to moderately
stressful triggers allows a client to use learned skills that build his or her ability to cope with future stressful events, much like a vaccination exposes a person to a weakened virus so the body can create antibodies to fight off stronger forms of the virus (Meichenbaum, 1985).

Consistent with early research on stress inoculation training with female rape victims having reductions in symptoms of fear, anxiety, intrusion, and avoidance responses (Kilpatrick et al., 1982; Resick, Jordan, Girelli, Hutter, & Marhoefer-Dvorak, 1988; Veronen & Kilpatrick, 1983), Foa et al. (1999) found that when using stress inoculation training with female sexual assault victims, there were reductions in the depression symptoms, anxiety symptoms, and diagnoses of PTSD among participants.

Several complications stand out from the research on stress inoculation. Although stress inoculation training has been shown to be useful in the treatment of sex related trauma immediately after treatment (Foa et al., 1999; Meichenbaum, 1996b), Foa et al. found that, over time, rape victims were better off with prolonged exposure than stress inoculation training. Their research, which was primarily conducted to test their more recently developed prolonged exposure (Foa, Rothbaum, Riggs, & Murdock, 1991), will be discussed in more detail in the prolonged exposure section. Meichenbaum (2003) acknowledged Foa et al.’s research and suggested that when the stressor is traumatic and explicit, interventions that focus on the impact and meaning of the traumatic event may be needed if using stress inoculation training. This means that, although there is much support for the use of stress inoculation training in several forms of posttraumatic stress (Meichenbaum, 1996b, 2001), it may be best to not use it with clients who experienced childhood sexual abuse without further research that tests Meichenbaum’s suggested addition.
**Prolonged exposure.** In prolonged exposure, clients are asked to relive traumatic experiences through imagining the events or confronting situations that trigger memories of the events. Foa et al. (1991) developed prolonged exposure specifically to address rape-related symptoms of PTSD. The use of prolonged exposure is based on the theory that rape-related PTSD is created by a person not thoroughly processing rape stimuli, responses, and the meaning surrounding it (Ballard & Alessi, 2002); therefore, recalling the incidents with therapist guidance should allow the person to sufficiently process their trauma. Traditional prolonged exposure for rape victims, as described by Ballard and Alessi, includes nine biweekly 90-minute sessions. The first two sessions are used for information gathering, treatment planning, and explaining the process to the client, while the remaining sessions are used to have the client relive their traumatic experiences through imaginal recall that they describe vocally. The clients are then asked to listen to audio recordings of their sessions and process their thoughts and emotions as homework.

Foa et al. (1999) compared four treatment conditions for 96 individual female assault victims with PTSD: prolonged exposure, stress inoculation training, prolonged exposure with inoculation training, and a waitlist control. The participants included sexual assault \(n = 69\) and non-sexual assault \(n = 27\) victims. After two sessions gathering information and preparing the participants, the women in the prolonged exposure group participated in seven sessions that included homework review, imaginal exposure, and homework assignments. The imaginal exposure involved the women imagining the traumatic event and describing it in the present tense for 45 to 60 minutes. Homework for this group included listening to audio recordings of their in session account of the event and in vivo exposure to safe situations that caused anxiety or were avoided. The stress inoculation training group also had two sessions of information
gathering and preparing the participants. The seven following sessions were used to teach coping skills for anxiety and other problems related to the prior assault. The coping skills training included deep muscle relaxation, differential relaxation, thought stopping, guided self-dialogue, covert modeling, cognitive restructuring, role-plays, and homework practicing these skills. The women were encouraged to use these skills in daily activities where anxieties and fears are related to the prior assault. The prolonged exposure with stress inoculation training group had nine sessions that were a combination of the two groups previously described. The sessions consisted of homework review, imaginal exposure for 30 to 45 minutes, coping skills training, and homework that included exposure and coping skills practice. Finally, the waitlist group participants were told they could receive treatment in five weeks.

All three active treatments in Foa et al.’s (1999) study were significantly more effective than the waitlist group at reducing PTSD, including reducing the number of participants diagnosed with PTSD, as well as reducing depression and anxiety symptoms. Surprisingly, prolonged exposure was more effective at reducing PTSD and related symptoms than any of the other three treatment conditions, including prolonged exposure combined with stress inoculation training. Those in the prolonged exposure group had the fewest dropouts and largest effect sizes on the posttraumatic stress, depression, and anxiety measurements. However, it was hypothesized that the prolonged exposure with inoculation training group potentially sacrificed quality treatment in order to fit more interventions in a short amount of time, thus it is still possible that combining both forms of treatment could be more beneficial if more time was allowed.

the research to include sexually assaulted females who have borderline personality characteristics. They indicated that this could be important due to individuals with PTSD frequently having comorbid personality disorder, particularly borderline personality disorder (Faustman & White, 1989; Feeny et al., 2002; Southwick, Yehuda, & Giller, 1993). Patients with borderline personality disorder are more likely to have PTSD than those with other personality disorders (55.9% versus 21.6%; Zanarini et al., 1998). Feeny et al. noted that characteristics associated with clients with comorbid borderline personality disorder and PTSD may lead to low tolerance with imaginal or in vivo exposure, which could create challenges with prolonged exposure. Additionally, it is important to not exclude participants with comorbid mental health issues in general, because as Echeburua, Corral, Zubizarreta, and Sarasua (1997) pointed out, it is difficult to find a sample of patients who have undergone sexual assault, suffered from chronic PTSD, and were not affected by other mental health issues.

The participants in Feeny et al.’s (2002) study were females who had experienced either sexual assault or non-sexual assault. Each of the three treatment group received nine sessions that were conducted twice per week, while a fourth group was wait-listed. The prolonged exposure group focused on reliving the trauma through imaginal exposure. The stress inoculation training group focused on anxiety management skills, such as breathing techniques, thought stopping, cognitive restructuring, positive affirmations, and problem solving. The combination group incorporated elements of both treatment methods.

The results of Feeny et al. (2002) indicated that women with borderline personality characteristics still benefited from each CBT method for chronic PTSD. There were significant reductions for each treatment group in the number of participants diagnosed with PTSD, as well as significant improvements regarding PTSD symptoms, depression, anxiety, and social
functioning. The improvements of participants with borderline personality characteristics and participants without borderline personality characteristics were comparable; however, participants with borderline personality characteristics showed slightly lower end-state functioning. Patients with borderline personality characteristics also did not struggle with imaginal or in vivo exposure more than those without. Although the improvements were comparable, it is important to note that, those with borderline personality characteristics were more likely to have been sexually abused, and were more symptomatic at pre- and post-tests for all of the measures in the study. This means that clients who were sexually abused were more likely to have borderline personality characteristics, and if they did have those characteristics, they were likely to have more severe symptoms.

Prolonged exposure with and without cognitive restructuring was analyzed by Rauch, Foa, Furr, and Filip (2004). They analyzed the outcome results from Foa et al. (2005), which included female participants with PTSD due to sexual and nonsexual abuse, to determine the impact of the treatments on imagery vividness and anxiety. The participants were given 9 sessions, but those who had not reached 70% reduction in symptoms by session 8 were offered 12 sessions. The prolonged exposure alone group received psychoeducation about trauma reactions, breathing skills training, in-vivo exposure, imaginal exposure involving reliving the traumatic event with their imaginations, and homework. Those in the prolonged exposure plus cognitive restructuring treatment had cognitive restructuring simply added to the same process as the one described above for prolonged exposure. Further details of the protocol are described in the cognitive restructuring section.

The results of Rauch et al. (2004) indicated that the vividness of the trauma when imagining correlated with anxiety early in treatment. As the participants repeated the process of imaginal exposure, they were able to vividly imagine the trauma with less anxiety. As expected,
PTSD severity also decreased as anxiety decreased. It is important to note that having higher PTSD severity at the beginning of treatment did not result in higher PTSD severity. However, those who still had higher PTSD severity by the third exposure session did have higher PTSD severity at posttreatment.

**Skills training in affect and interpersonal regulation.** Skills training in affect and interpersonal regulation (STAIR) is a treatment developed for trauma survivors from a combination of cognitive-behavioral and dialectical behavioral therapy (DBT) that is intended to focus on the development of emotion management and interpersonal skills (Linehan, 1993). It consists of 8 sessions, as described by Cloitre, Koenen, Cohen, and Han (2002), in which each session focuses on a particular skills deficit related to the trauma and typical client responses. The first session focuses on labeling and identifying feelings. The second session works on emotion management, with an emphasis on anger and anxiety. Distress tolerance is the focus of the third session. In the fourth session, attention is given to acceptance of the client’s feelings and works on increasing positive emotions. The fifth session involves working on day-to-day schemas related to the client’s negative cognitions and beliefs. Focus in the sixth session is on pinpointing conflict between trauma-related feelings and current goals. Power and control related issues are addressed through role plays in the seventh session. In the eighth session, role plays are used to develop flexibility in interpersonal situations related to power. Each of these sessions includes psychoeducation in addition to the skills training, as well as homework in which the client is expected to practice the skills in real life situations. Although there are several studies that examined the treatment combined with other interventions, no studies were found that examined STAIR alone, and Cloitre et al. (2010) stated that the treatment had not yet been tested on its own as of that time.
Cloitre et al. (2002) tested the effectiveness of treating women with PTSD stemming from childhood abuse, including sexual abuse, with STAIR and prolonged exposure. Female participants were split into two groups: a 12-week waitlist or a 12-week treatment group. Those in the treatment group received 16-sessions. STAIR and prolonged exposure were two separate phases rather than being overlapping. The first phase for the treatment group involved eight sessions of STAIR as described at the beginning of this section. The second phase included eight sessions of a modified application of prolonged exposure. In Cloitre et al.’s study, participants repeatedly described their traumatic events with a focus on details and emotions. The modifications to the traditional exposure included three components: guided coping skills after exposure to ensure emotional stability and to make sure the client is present in the moment; emotion-focused processing after exposure of fear, anxiety, dissociation, and sadness that was present during exposure; and reviewing how the client has been able to incorporate new coping skills and schemas to relationships outside of treatment. In vivo exposure was not used in their treatment.

As expected, STAIR followed by modified prolonged exposure was effective at treating the women with PTSD when compared to the waitlist group (Cloitre et al., 2002). The treatment group showed significant improvement in affect regulation issues, interpersonal skill problems, and PTSD symptoms. The interpersonal skills and affect regulation treatment gains were maintained at 3- and 9-month follow-up evaluations, while PTSD symptoms continued to improve at the 3-month and then were maintained at the 9-month follow-up. Additionally, the women reported improved functioning at home, work, and socially. They also found that if there was a strong therapeutic alliance and the client improved affect regulation during the STAIR
phase, they were more likely to continue PTSD reduction during the modified prolonged exposure phase.

When looking more closely at each phase of the treatment, the results of Cloitre et al. (2002) show why it could be important to have both a STAIR phase and a prolonged exposure phase. In the first phase, STAIR led to significant reductions in negative affect regulation and anger expression, but non-significant improvements in PTSD symptoms. Conversely, the participants experienced significant reductions in PTSD symptoms, but non-significant reductions in negative affect regulation or anger expression when in the prolonged exposure phase. Overall, the study indicated that more improvements were made by combining the individual treatments into a two phase treatment. The treatments can still be useful individually, especially if clients express specific symptoms that match with one of the individual treatments or if there are limitations on treatment duration.

Cloitre et al. (2010) wanted to see how STAIR would work when combined with other interventions for women who experienced dissociation related to PTSD brought on by childhood abuse, including a majority (88.5%) of whom experienced CSA. Their study included three treatment groups: STAIR followed by prolonged exposure, STAIR followed by supportive counseling, and supportive counseling followed by prolonged exposure. The STAIR portion of each treatment group followed the same eight session protocol as described in Cloitre et al. (2002). The prolonged exposure portion in each treatment group included eight sessions of traditional exposure with modifications such as replacing in vivo exposure with interpersonal skills practice and analyzing meaning of abuse-related beliefs. The supportive counseling portion of treatments included eight sessions where discussion regarding issues related to the
trauma was client directed. Skills training and discussing memories of the trauma were not included in the eight supportive counseling sessions.

The results of Cloitre et al. (2010) indicated that STAIR followed by prolonged exposure was overall the most effective treatment in terms of reducing PTSD symptoms and ridding clients of PTSD diagnoses. PTSD-related issues, including emotion regulation, anger expression, and anxiety, were also improved more by STAIR with prolonged exposure. Additionally, interpersonal problems were reduced more and clients were less likely to drop out of treatment in STAIR with prolonged exposure (15.2% dropout rate). In the STAIR followed by supportive counseling group, 26.3% of participants dropped out, while 39.4% dropped out of the supportive counseling followed by exposure treatment. The two treatment groups that started with STAIR had fewer problematic symptoms during phase 2 than the supportive counseling followed by prolonged exposure group. Not only was supportive counseling inferior at posttreatment, but the improvements that it did produce were only maintained at 3- and 6-month follow-ups, while the two treatments using STAIR continued to produce improvements. The STAIR followed by prolonged exposure group continued to expand the disparity in improvements when compared to the STAIR followed by supportive counseling at 3- and 6-months posttreatment. These results indicate that STAIR followed by prolonged exposure was the superior treatment.

Combining prolonged exposure with other treatments have often not yielded better results than prolonged exposure alone as shown in several studies previously discussed. Likewise, Foa, Keane, Friedman, and Cohen (2008) pointed out that previous studies indicated that stress management skills training was not as effective when combined with exposure as either intervention alone. Cloitre et al. (2010) pointed out that, besides subtle differences between
stress management skills training and STAIR, their study differed from those previous studies by having prolonged exposure follow STAIR rather than having them overlap. They hypothesized that the reason this worked was because it allows for each treatment intervention to have more focused time and attention.

Cloitre, Petkova, Wang, and Lu (2012) analyzed the results of Cloitre et al. (2010) to see how the treatments impacted participants who experience dissociative symptoms. Part of their reasoning for examining the participants who had dissociation was due to several authors proposing that those with significant dissociation symptoms may not improve as much with exposure or trauma-focused therapies (Ehlers & Clark, 2000; Jaycox & Foa, 1996; Lanius et al., 2010; Shalev, Bonne, & Eth, 1996). They found that, when the clients had high levels of dissociation, STAIR followed by exposure was more useful in reducing dissociative symptoms compared to either treatment that used supportive counseling. There were no differences between the three treatments, which were all beneficial, regarding dissociative symptom outcome when the clients had low levels of dissociation. PTSD symptoms at posttreatment were reduced more by STAIR followed by exposure than by the other two treatments no matter what level of dissociation clients started with. At follow-up evaluations, those who still had high dissociation at posttreatment continued to reduce both their dissociation and PTSD symptoms if they were in the STAIR with exposure group, while the other two treatments did not continue to show improvements after treatment completed. The STAIR followed by supportive counseling group maintained their benefits, while the gains made in the supportive counseling followed by exposure group deteriorated at follow-up evaluations. As with the PTSD symptoms found in Cloitre et al. (2010), Cloitre et al. (2012) found that STAIR in phase 1 was more effective at reducing dissociative symptoms than when supportive counseling was used in phase 1.
The above studies examined STAIR when used with other treatments. None of the studies compared STAIR alone with a control group, but the treatment effects seemed promising during the STAIR phase. Overall, STAIR was found to be a promising intervention for CSA survivors when followed by prolonged exposure, but there is limited research so it is unclear if there are better ways of utilizing the intervention, including as a stand alone intervention.

**Cognitive restructuring.** As mentioned in the introduction, cognitive restructuring is meant to help clients find ways of integrating corrective information to re-evaluate negative automatic thoughts and beliefs. Dysfunctional automatic thoughts and beliefs for traumatized people can be related to themselves, the trauma, and the world (Marks et al., 1998). There is no set protocol for cognitive restructuring, but they all follow the idea of correcting cognitive distortions (Huppert, 2009). Cognitive distortions commonly targeted in the intervention include, but are not limited to, “all-or-none thinking, disqualifying the positive, mental filtering, jumping to conclusions, catastrophizing, emotional reasoning, should statements, and personalization” (Huppert, 2009, p. 247). Each potential cognitive distortion that could be addressed in treatment is not listed and described in this dissertation due to the number of them extending beyond 50 (Boytes, 2013).

Cognitive restructuring can be an adjunct to a treatment in which it is utilized as when needed or it can be the primary treatment for a client. Huppert (2009) noted that, when it is used as the primary treatment, it often involves having the client recall experiences in detail, including internal reactions, so the therapist can notice and identify when distortions are present by evaluating the client’s logic. Socratic questioning is usually utilized in cognitive restructuring in order to allow clients to process and correct the distortions themselves, which leads to them being more likely to remember and apply it (Huppert, 2009). Another way of getting clients to
process and correct their own cognitive distortions is by providing them with a model such as the A-B-C model, based on Albert Ellis’ rational emotive behavior therapy (REBT) that he began developing in 1956 (Ellis, 1991). Clients record the activating event (A), beliefs (B), and resultant consequences (C) of daily experiences to explore and replace irrational beliefs with more rational or helpful ones, either in session or as homework between sessions. An example of an A-B-C sheet is provided in Appendix A.

Huppert (2009) also noted that the most traditional method of implementing cognitive restructuring involves introducing clients to the thought record. The thought record is a step-by-step way of allowing clients to identify their own distortions and make adaptive corrections. When working with clients, it is optional for the therapist to explicitly label the distortions identified or simply work through how they manifest for the clients and focus on developing rational responses. Likewise, it is optional to provide psychoeducation about distortions that have been identified.

Rieckert and Moller (2000) wanted to evaluate the effectiveness of cognitive restructuring with adult victims of childhood sexual abuse. Their ideas that cognitive restructuring would be effective stems from the studies of McCann et al. (1988) and McCann and Pearlman (1990) that suggested that CSA may lead to disruptions in foundational core beliefs that result in dysfunctional beliefs about safety, trust, power and control, self-esteem, and intimacy. Rieckert and Moller’s study split female victims of CSA into a treatment and control group. Both the treatment and control groups received 10 weekly sessions of rational emotive behavior therapy. Those in the treatment group were also assisted in substituting rational beliefs for dysfunctional emotions, behaviors, and beliefs. Rieckert and Moller found
statistically significant reductions in depression, anxiety, anger, guilt, and low self-esteem after the 10 weekly sessions, which were maintained at an eight week follow-up.

In 2002, Moller and Steel re-analyzed the results of Rieckert and Moller (2000) to find if the statistically significant findings were also clinically significant by examining whether clients improved, defined as exhibiting reliable change in a positive direction, or recovered, defined as crossing the cutoff score between the clinical and nonclinical samples for each measure. They found that cognitive restructuring was highly effective for depression, anger, and especially anxiety. For anxiety, all participants at least improved, while 88.46% of participants recovered. For depression, 69.23% of participants recovered, 19.23% improved, and 11.54% showed no improvement. When examining anger, Moller and Steel found that 65.38% recovered, 23.08% improved, and 11.54% showed no improvement. There were less significant changes in guilt and low self-esteem. For self-esteem, 57.69% recovered, 15.39% improved, and 26.92% showed no improvement. Guilt was the least affected of the statistically significant variables with only 30.77% of the participants recovered and 26.92% improved, while 42.31% showed no improvements. Moller and Steel summarized that about 40 percent of the participants gained significantly from the treatment, while about 60% of the participants ranged from no to moderate benefits.

Foa et al. (2005) expanded on their previous studies of prolonged exposure, such as those comparing prolonged exposure with and without stress inoculation, to include a cognitive restructuring comparison group and a combined prolonged exposure and cognitive restructuring group. They examined the effectiveness of each treatment for a sample of female participants with PTSD related to sexual or nonsexual assault. The prolonged exposure treatment group received 9 sessions following the same protocol as Foa et al. (1999). The treatment of prolonged
exposure combined with cognitive restructuring followed the same protocol as the prolonged exposure group with two exceptions. The first exception is that in session 3, participants were taught to identify and challenge erroneous and unhelpful beliefs related to their trauma. They were expected to record and challenge these beliefs in a diary at home. Second, in the fourth session, the discussion of anxiety from the imaginal and in vivo exposure was replaced by 25 minutes of cognitive restructuring using Beck’s Socratic Method (Beck & Emory, 1985). Unlike the other related prolonged exposure studies, Foa et al. (2005) in this study offered an additional 3 sessions to participants who did not have a 70% reduction in self-reported PTSD symptoms by session 8. They also conducted follow-up evaluations at 3-, 6-, and 12-months posttreatment.

The results of Foa et al.‘s (2005) study indicated that prolonged exposure alone and prolonged exposure combined with cognitive restructuring were equally effective at reducing PTSD and depression symptoms. Additionally, both treatments improved work and social functioning of the participants. Although both treatments provided significant improvements for the participants, 58% of the participants had not reached at least 70% reduction in their self-reported PTSD severity by session 8, and therefore received the total of 12 sessions. The participants continued to show improvements between sessions 8 and 12, meaning they had not already plateaued, but the participants who terminated by session 9 were less symptomatic. The benefits of the treatments were maintained at the follow-up evaluations for PTSD, depression, and work functioning. Surprisingly, social functioning continued showing improvement at the 3-month follow-up, which was maintained at the subsequent follow-ups.

Aderka, Gillihan, McLean, and Foa (2013) examined how prolonged exposure with and without cognitive restructuring impacted depression and PTSD symptoms of female assault survivors. The participants included adult women with PTSD related to CSA, sexual assault, or
nonsexual assault. Like Foa et al.’s 1999 and 2005 studies comparing prolonged exposure with stress inoculation and cognitive restructuring, respectively, Aderka et al. followed a 9 session format for each treatment group. The prolonged exposure treatment group followed the protocol developed by Foa et al. (1999) that was already discussed above. The prolonged exposure combined with cognitive restructuring followed the same protocol as Foa et al. (2005).

The results of Aderka et al.’s (2013) study indicated that each treatment produced similar improvements, but each method promoted positive change in different ways. Prolonged exposure conducted without cognitive restructuring impacted posttraumatic symptoms, which positively influenced depressive symptoms. The changes in posttraumatic symptoms were responsible for 80.3% of the changes in the depressive symptom. The symptomatic changes in depression, on the other hand accounted for 45.0% of the positive changes regarding posttraumatic symptoms. When examining the impact of prolonged exposure combined with cognitive restructuring, changes in posttraumatic symptoms were only responsible for 59.6% of the changes in depressive symptoms, whereas 50.7% of the changes in posttraumatic symptoms were accounted for due to the positive changes in depressive symptoms. Other means of change included time and potentially other unmeasured confounds. Aderka et al. suggested that these results may mean that imaginal exposure and in vivo use in prolonged exposure affect PTSD factors, such as fear and guilt, which in turn reduce symptoms that are common between PTSD and depression, such as negative beliefs of the self, as well as reduce depression symptoms, such as mood. In contrast, they suggested that the addition of cognitive restructuring to prolonged exposure may target shared PTSD and depression factors, such as negative thoughts, which reduces factors that are specific to PTSD and depression separately. Due to the different pathways to reducing symptoms, it is possible that each treatment style could potentially have
different outcomes depending on unique client symptom characteristics; however, more research still needs to be done to increase understanding of the treatments before determining which treatments will be more helpful given individual circumstances.

Several of the studies summarized in this dissertation have compared the results of treatments using prolonged exposure alone and prolonged exposure combined with either stress inoculation or cognitive restructuring. In each of these studies, results of prolonged exposure treatment were not improved by adding another treatment to it. In fact, combining stress inoculation with prolonged exposure was less effective than the individual treatments. Bryant, Moulds, Guthrie, Dang, and Nixon (2003) found an exception in which adding cognitive restructuring to prolonged exposure did improve outcomes for participants with PTSD when the prolonged exposure included imaginal exposure and excluded in vivo exposure. Their study, however, did not include sexual assault victims; thus, more research would need to be conducted to see if this is true for sexual assault and CSA victims.

Long-term effects of exposure therapy and cognitive restructuring versus relaxation as a placebo were examined by Echeburua, Corral, Zubizarreta, and Sarasua (1997). The participants included females over the age of 16 with PTSD due to CSA or adult sexual assault. The exposure included re-introducing rewarding activities the client avoids, exposure to common stimuli that the client tends to avoid due to anxiety, exposure to nightmares and intrusive thoughts through imagination, and exposure along with training in specific abilities for those with sexual dysfunction. Unlike the other studies combining exposure with cognitive restructuring in this dissertation, Echeburua et al. used exposure to stimuli and intrusive thoughts that participants avoid and find anxiety provoking rather than traumatic memories. The cognitive restructuring combined with the exposure in this treatment is used to explain and process normal reactions to sexual assault, to modify negative thoughts and possible guilt, to
make sure the event is evaluated properly by the client, and to incorporate looking at the
positives of the present and future. The placebo group of participants received training in
progressive relaxation (Bernstein & Borkovic, 1973) and were expected to practice it twice per
day at home. Each group received 6 weekly sessions. The exposure and cognitive restructuring
participants received 7 total hours of treatment while the progressive muscle relaxation
participants received 4.15 hours of training.

In their study, Echeburua et al. (1997) found no differences between the victims of CSA
and rape as an adult, which is consistent with previous findings discussed. There was
improvement in both the progressive relaxation group and the exposure with cognitive
restructuring group regarding PTSD symptoms, but as expected, the exposure with cognitive
restructuring group showed significantly more reduction in the symptoms than the relaxation
group at posttreatment and at 1-, 3-, 6-, and 12-month follow-ups. All of the symptoms assessed
improved more with exposure and cognitive restructuring than with relaxation training, including
symptoms of re-experiencing the trauma, avoidance, and arousal, as well as a Global scale of
PTSD symptoms. The more moderate improvements made by the progressive muscle relaxation
group at posttreatment were maintained at the follow-ups. In contrast, the improvements in
PTSD symptoms resulting from exposure and cognitive restructuring continued through follow-
ups at 1 month and 3 months after treatment before stabilizing and being maintained at the 6- and
12-month follow-ups. More moderate improvements were found for anxiety, depression, fears,
and inadaptation for the exposure with cognitive restructuring group compared to the progressive
muscle relaxation group. These differences, however, only became significant at the 12-month
follow-up as the exposure combined with cognitive restructuring group continued to show
improvement in depression and fears. The differences between the 2 groups were greater for the
inadaptation variable and became significant by the 6-month follow-up, while the differences between the two treatment groups never became significant for anxiety.

The reviewed studies indicated that cognitive restructuring can be an effective intervention for CSA survivors, whether utilized alone or when combined with prolonged exposure.

**Cognitive-processing therapy.** Cognitive-processing therapy was developed specifically to treat symptoms of PTSD in rape victims (Resick & Schnicke, 1992). This treatment is comprised of two main components: cognitive therapy and exposure through writing out and reading the traumatic experience. In its original form, the treatment consisted of twelve 90-minute sessions. In the first session, clients are provided psychoeducation regarding PTSD and are asked to write about the personal meaning of their traumatic event as homework. In the second session, they are then taught to identify the differences between feelings and thoughts, and provided with A-B-C sheets as homework to practice identifying those differences. Sessions three and four involve having the clients write out their rape experience with as much detail, emotions, and thoughts as they can remember. Clients are trained in identifying and challenging their cognitive distortions and maladaptive beliefs in the fifth session. Self-blame and acceptance of the event are generally the primary focus. The focus shifts to faulty thinking patterns in session six. In session seven, an expanded version of an A-B-C sheet (Beck & Emery, 1985) is given to the clients to continue challenging their beliefs. Also starting at session seven and continuing through session 11, one of five areas of beliefs affected by rape (McCann, Sakheim, & Abrahamson, 1988) are introduced each session. The five beliefs include safety, trust, power, esteem, and intimacy. The clients are expected to read modules regarding the five beliefs as homework, which is discussed in the following session to address challenges. In the
11th session, clients re-write the meaning of their traumatic event now that they have received treatment. The final session is used to review and process the intimacy homework, the client’s re-written meaning of the traumatic event, and the treatment as a whole.

The effectiveness of cognitive-processing therapy with female rape victims who have PTSD was compared to prolonged exposure and waitlisted clients by Resick et al. (2002). Although cognitive-processing therapy was developed as a weekly treatment, Resick et al.’s study conducted the sessions twice per week. Additionally, 30 minutes of writing exposure was added to sessions four and five to make the treatment time equal to the 13 hours of treatment received if in the prolonged exposure treatment group. Otherwise, they followed the treatment protocol as laid out by Resick and Schnicke (1992). The prolonged exposure group received an initial 60-minute session followed by 90-minute sessions until reaching 13 total hours (9 total sessions). The prolonged exposure treatment involved four components: education, breathing restraining, behavioral exposure, and imaginal exposure. The first session of prolonged exposure includes psychoeducation and treatment rationale, as well as breathing retraining. Session two continues the psychoeducation and rationale, and then the therapist begins establishing in vivo assignments with the client. Sessions three through nine include reviewing homework, which involves listening to imaginal exposure recordings and following through with increasingly difficult behavioral exposure experiments, as well as conducting 45 to 60 minutes of imaginal exposure and processing the experience.

As expected, cognitive-processing therapy and prolonged exposure were both successful at treating PTSD for rape victims (Resick et al., 2002). There were no significant differences between the two treatments regarding effectiveness in treating PTSD, even though cognitive-processing therapy requires less homework and only two sessions in which trauma is recalled.
with reading and writing. Additionally, both treatments had positive effects on depressive symptoms. Resick et al. also compared how the treatments impacted the guilt of participants, including four guilt variables: global guilt, hindsight bias-responsibility, lack of justification, and wrongdoing. These guilt variables all improved by posttreatment for both treatments and the waitlist group, with participants in both treatment groups improving significantly more than the waitlist group on global guilt and wrongdoing. Surprisingly, there was not a significant difference between the waitlist group and the prolonged exposure group on hindsight bias and lack of justification, although the cognitive-processing therapy group did report significantly better results than both the waitlist group and the prolonged exposure group on both of those guilt variables. These patterns persisted through a nine-month follow-up. This was partially consistent with Foa and McNally’s (1996) assertion that exposure may be ineffective for guilt. Resick et al.’s study indicates that this may depend on the type of guilt that is present in the client. Overall, Resick et al.’s study indicated very little outcome differences between cognitive-processing therapy and prolonged exposure therapy; however, if clients are showing more signs of guilt, it may be wise to consider choosing cognitive-processing therapy.

Resick, Nishith, and Griffin (2003) created a study to expand on Resick et al. (2002) to compare how rape victims with and without CSA history responded to cognitive-behavioral treatments, including changes in PTSD, depression, and complex trauma response symptoms. The complex trauma responses, also known as complex PTSD, include five symptom groups (Herman, 1992): (1) alterations in regulation of affect and impulses, (2) alterations in attention or consciousness, (3) somatization, (4) chronic characterologic changes, and (5) alterations in systems of meaning. The female participants were split into cognitive-processing therapy,
prolonged exposure, and waitlist groups, all of which followed the protocols described in Resick et al. (2002).

The rape victims who had experienced CSA were likely to have more complex PTSD symptoms than the rape victims without CSA prior to treatment in Resick et al. (2003). The results indicated that both cognitive-processing therapy and prolonged exposure were effective in addressing PTSD, depression, and complex symptoms for women with CSA histories. After treatment and at a 9-month follow-up evaluation, the rape victims without CSA had crossed from clinical to nonclinical population norms on all measured subscales and rape victims with CSA had crossed clinical thresholds for most measured subscales. The remaining elevated symptoms after treatment for those who experienced CSA included slightly higher impairments in self-reference (i.e., identity confusion) and sexual concerns; however, it is important to note that both groups made similar levels of improvement in therapy and the higher posttreatment scores appear due to higher pretreatment scores for the CSA group. There were no differences in the amount of improvement between the women with CSA histories and those without regarding PTSD and depression symptoms. Although women with and without CSA improved in Self factor and Trauma factor on the Trauma Symptom Inventory (TSI; Briere, 1995), there were differences between the two groups of women such that women with CSA histories improved more for both factors. The Self factor on the TSI consists of Sexual Concerns, Dysfunctional Sexual Behavior, and Tension Reduction Behavior; and the Trauma factor consists of Intrusive Experiences, Defensive Avoidance, Dissociation, and Impaired Self-Reference. Those participants with CSA histories started with higher scores on those factors and the greater improvements among them led to similar posttreatment and 9-month follow-up scores between both groups of women, which were in the normal range. The third factor on the TSI, the
Dysphoria factor, consists of depression, anger-irritability, and anxious arousal, and both treatment groups had the same levels of improvement on this factor, with both groups ending in the normal range of symptoms. Resick et al. (2003) noted that there were significant improvements in dysphoria without paying special attention to such symptoms.

Nisheth, Nixon, and Resick (2005) also expanded on Resick et al.’s (2002) study to determine if the differences in guilt results between cognitive-processing therapy and prolonged exposure were based on potential comorbid PTSD with major depressive disorder. To do this, they re-examined the findings by Resick et al. to find out how each treatment worked with clients who had PTSD only compared to PTSD with comorbid major depressive disorder. Their findings were generally consistent with Resick et al.’s in that cognitive-processing therapy was more effective at treating trauma-related guilt for clients with PTSD than prolonged exposure. Like with Resick et al.’s findings, the differences in guilt were within the hindsight bias and lack of justification variables. These differences persisted when the participants had PTSD with comorbid major depressive disorder. This indicates that, whether clients have PTSD with comorbid depression or not, guilt is impacted similarly by cognitive-processing therapy and prolonged exposure; therefore, this supports the idea that cognitive-processing therapy is the ideal choice between the two treatments if guilt seems to be one of the issues of a client. These outcome differences between the two treatments did not persist at a 9-month follow-up. Nisheth et al. stated the lack of persisting significance at follow-up may have been due to their methods of analysis, and requires more research for clarification on sustaining effects.

Cognitive-processing therapy was found to be an effective treatment for individuals with CSA histories. It was generally as effective as prolonged exposure, which has already been
established as an effective treatment for CSA survivors, and cognitive-processing therapy was shown to have the additional benefit of reducing feelings of guilt in the survivors.

**Imagery rescripting.** Imagery rescripting was designed to treat PTSD symptoms and change abuse-related beliefs and schemas of adult survivors of CSA (Smucker, Dancu, Foa, & Niederee, 1995). The treatment is meant for those who meet criteria for PTSD and experience images, flashbacks, or nightmares of the abuse. The treatment starts with imaginal exposure before the imaginal rescripting can begin. The rescripting involves the therapist facilitating the client in reimagining the abuse with mastery imagery in which the client creates a new scenario where she imagines her current adult self intervening to assist her child self. If the client is unable to visualize her adult self adequately protecting her younger self, additional people can be brought into the rescripted scene for support (e.g., spouse, police officer, therapist). Smucker et al. explains that during imaginal rescripting, the adult self’s role is to “rescue” and protect the child, “drive out” the perpetrator, and “nurture” the child. Throughout this process, the therapist’s role is to facilitate the client in choosing her own coping strategies during the rescripting.

Smucker et al.’s (1995) treatment program was designed to include 9 sessions. The sessions range from 90 minutes to 2 hours. In addition to the imaginal exposure and imaginal rescripting, the clients are given the homework of listening to audio of the imagery sessions, writing a letter to the perpetrator (that is not sent), and their reactions are processed.

The impact of imagery rescripting when combined with imaginal exposure was tested by Arntz, Tiesema, and Kindt (2007). To do this, they created two treatment groups: One group with imaginal exposure alone, and one group with imaginal exposure with imagery rescripting. These treatment groups were compared with a wait-list control group. The participants included
sexual and nonsexual assault victims. Both treatment groups followed similar protocols overall, except after the initial story recall, the rescripting group processed mastery imagery instead of continuing story recall. It is also worth noting that in vivo exposure was not utilized in this study.

As expected, Arntz et al.’s (2007) study demonstrated that both treatments showed significant improvements when compared to the results of the waitlist control group for PTSD severity and symptoms. Consistent with previous findings comparing exposure alone to exposure combined with another treatment, there were no differences in effectiveness between each of the treatment groups on PTSD severity and symptoms; however, there was a significant difference in the dropout rate of each group. In the exposure combined with imagery rescripting group, 25% of the clients dropped out of treatment. That is considerably lower than the 51% of clients who dropped out of the imaginal exposure group, and suggests one potentially large advantage to the combined treatment.

In addition to examining PTSD symptoms, Arntz et al. looked at the effectiveness of the treatments on PTSD-related variables, including anger, anger control, guilt, and shame. They found that, of those variables, exposure combined with imagery rescripting was more effective at posttreatment in addressing anger control and guilt. At follow-up, anger control, externalization of anger, hostility, and guilt improved more with the combination of the treatments than with exposure alone. Internalized anger and shame showed similar improvements between both treatment groups.

A common issue with CSA survivors that has limited research and is rarely addressed in therapy is the feeling of being contaminated (Fairbrother & Rachman, 2004; Foa & Rothbaum, 1998; Rachman, 2006). The feeling of being contaminated frequently involves feeling strong
senses that relate to the abuse, such as sensing or smelling a ‘dirty film on their skin’ (Rachman, 2006); vivid sensory imagery that is believed to be left behind by the perpetrator, such as smells, dirt, or slimy deposits (Jung & Steil, 2012); and strong negative beliefs, such as sperm or sweat from the perpetrator still being inside the victim (Jung & Steil, 2012).

To address the feeling of being contaminated, Jung and Steil (2012) created a treatment that they called cognitive restructuring and imagery modification, which is a two-session treatment that combines cognitive restructuring with a form of imagery rescripting. The first session is a treatment session that lasts 90 minutes. In the session, the therapist and client discuss the client’s experiences with feelings of contamination. After getting an idea of the client’s feelings, sensations, and beliefs, they are instructed to search for information on the internet in the session to find out the speed that cells regenerate completely at the specific trauma-related locations of their bodies. The client’s research is supposed to be client led, although they are allowed to ask for help. Jung and Steil indicated that clients are likely to find information such as that by Wolff et al.’s (2007), who found that skin cells rebuild every 4 to 6 weeks and mucous membranes regenerate even quicker; therefore, any contaminated cells from childhood would have been gone a long time ago and regenerated many times since then. After the research is conducted to give the client the understanding that no parts of their body still has contaminants from the assault and that it is not rational to believe they are still physically contaminated, the therapist guides the client in creating imagery that represents skin or cell renewal. An example of this representative imagery is described by Jung and Steil in which a client developed images of herself in a bedroom wearing a suit that she peeled off piece by piece until she felt clean, and then freed herself of the contaminated suit by sinking it in a river with stones. The guided imagery modification is audiotaped and the clients are expected to listen to it
once each day for a week as homework. The second session is a 50-minute session that is simply a booster session where the impact of the treatment and challenges are discussed.

In Jung and Steil’s (2013) study, women who experienced CSA were recruited to test the effectiveness of their treatment when compared to a waitlist control group. They found that the women experienced greater improvements, with large effect sizes, in intensity, vividness, and uncontrollability in their feelings of contamination and associated distress, such as self-esteem and depression. Although not a direct target, PTSD symptoms were improved by the treatment.

The reviewed studies showed that imagery rescripting is an effective treatment when the individual survivors of abuse experience images, flashbacks, nightmares, or the feeling of being contaminated. The intervention even had several more benefits than exposure when such symptoms were present.

**Exposure, relaxation, and rescripting.** Davis and Wright (2007) examined how exposure, relaxation, and rescripting therapy combined affects clients with nightmares resulting from trauma history. A majority of the participants (59.2%) in their study experienced unwanted sexual contact; however, 40.8% had not and differences between the trauma types, which also included car accidents and other forms of assault, were not measured.

Participants in the treatment group of Davis and Wright’s (2007) study received 3 weekly sessions that lasted 2 hours each. The first session of the treatment consisted of psychoeducation about trauma reactions, PTSD, nightmares, and sleep hygiene. They were also trained in progressive muscle relaxation and given homework that included practicing the relaxation exercise, choosing a sleep habit to modify for the week, and monitoring nightmares, sleep quality, sleep quantity, habit changes, and PTSD symptoms. The second session consisted of homework review, continued training in relaxation that included diaphragmatic breathing,
writing out and reading aloud clients’ nightmares, psychoeducation on trauma themes that stand out in the nightmare (e.g., feelings of powerlessness), and having the client re-write and read aloud a rescripted version of the nightmare to correct negative trauma themes (e.g., increasing sense of power). The homework provided at session 2 included rehearsing the rescripted dream for 15 minutes each day, doing progressive muscle relaxation after the rescripted dream rehearsal, changing another sleep habit for the week, and doing diaphragmatic breathing twice per day. The third session included homework review, discussing and problem solving any difficulties with the process of changing the dreams, training in slow breathing techniques, practicing previously taught skills, and rescripting any other nightmares that the client may be having.

Results from Davis and Wright’s (2007) study indicated that their method of combining exposure, relaxation, and rescripting therapy was effective when compared to a wait-list control group at lowering the severity and frequency of chronic nightmares related to past trauma as well as nightmares that were not targeted with exposure and rescripting. This method also improved sleep quality and quantity as expected. In addition to the improved sleep patterns, the treatment improved psychiatric distress. All of these improvements remained stable at a 6-month follow-up. This form of treatment had the strongest effect on sleep related symptoms, including nightmare severity, sleep problems, sleep quality, and restfulness in the mornings, rather than other PTSD related symptoms. The authors acknowledged that they are unsure based on their study and previous studies what the mechanism of change is for exposure, relaxation, and rescripting therapy.

**Psychoeducation.** The term “psychoeducation” refers to educating clients in a psychotherapeutic setting about their psychological disturbances to help them gain knowledge
and understanding of their experiences. It can include information about psychological or behavioral reactions that the survivor may have, or coping strategies for dealing with those reactions. Additionally, psychoeducation can be used simply to increase the understanding of other treatment interventions. Psychoeducation can be provided to clients through several different means, including direct verbal communication, written material, video, audio equipment, and the internet (Wesseley et al., 2008).

The understanding of treatments can be very important for clients as they consider therapy. For example, Allen (2001) showed that clients who are aware of the benefits of exposure treatments and the problems associated with avoidance are more likely to tolerate discomforts in exposure therapy.

Providing information can directly benefit clients who have experienced trauma. Knowledge of chronic reactions to trauma is a protective factor against PTSD, and it is particularly important for the therapist to normalize symptoms (Mills, 2001; NSW Institute of Psychiatry and Centre for Mental Health, 2000). Although general information about common symptoms and reactions are helpful, further research is needed to determine what specific information may be beneficial (Wessely et al., 2008).

The number of studies conducted to test the usefulness of psychoeducation on sexual trauma is limited. There are several that indicate the effectiveness in combination with other forms of treatments, particularly in group treatment settings with women (Choate & Henson, 2003), but the majority of the literature on the subject specific to individuals and couples using psychoeducation alone tends to be speculation with limited empirical evidence (Davis, Resnick, & Swopes, 2011; Phoenix, 2007).
Summary. Many of the individual treatments for trauma reviewed have been found to be useful with adult survivors of CSA and other forms of sexual abuse. It is good news for therapists and clients that so many existing treatments have been found to be effective, thus creating multiple intervention options for sexual abuse survivors; however, lacking a consensus pick for most beneficial treatment makes it difficult to choose a best option. One of the reasons there does not seem to be a consensus choice for sexually traumatized individuals is because there are so many symptoms related to sexual trauma and each treatment can impact each trauma-related symptom differently.

Many of the studies examined for this paper simply showed that the treatment group in a given study achieved greater improvements than a control group, while other studies actually set out to compare treatments to determine which may be more effective. The studies comparing one treatment to another are generally more telling for deciding which treatments may be a better choice to use with clients, but much can be gathered from the studies comparing treatments to control groups as well, and their findings should not be dismissed. Likewise, looking at which interventions targeted trauma-related symptoms likely to impact relationships will help determine which treatments may be a better choice when adapting sexual abuse treatments for couples impacted by CSA. Before identifying which treatments may be best for couples impacted by CSA, it is also important to review existing studies on CBT with couples, particularly any CBT couples treatments that address trauma.

Couples Treatments

TBCT vs. IBCT. Christensen et al. (2004) compared the efficacy of traditional behavioral couples therapy (TBCT) versus integrative behavioral couples therapy (IBCT) on chronically distressed married couples. TBCT in Christensen et al.’s (2004) study was based on
procedures from the treatment manual of Jacobson and Margolin (1979) and supplemented by a shorter, updated manual from Jacobson and Christensen (1994). Christensen et al. described TBCT as having the goal to promote positive change through direct instructions and skills training. The three primary treatment strategies for TBCT are behavioral exchange (i.e., generating a list of behaviors that each person could do for his or her partner), communication training (i.e., speaking skills such as “I” statements or listening skills such as reflective listening), and problem-solving training (i.e., teaching how to negotiate alternative options).

IBCT in this study (Christensen et al., 2004) was based on a book by Jacobson and Christensen (1998) and was supplemented by a chapter from Christensen, Jacobson, and Babcock (1995). IBCT focuses more on emotional acceptance and reactions to difficulties in the relationship than on finding active solutions. Three primary strategies used in IBCT are empathic joining around the issue (i.e., attempting to bring forth vulnerable emotions from both partners related to the issue, then communicating empathy and understanding), working together to detach from the issue (i.e., being descriptive of patterns rather than placing judgments), and building tolerance to reactions the issues trigger (i.e., allowing partners to engage in problem behaviors during sessions so that positive functions in addition to negative functions can be identified and made more aware for both partners so that patterns are taken less personally).

To compare the two treatment modalities, Christensen et al. (2004) recruited 134 married couples, who were randomly selected to receive one of the two forms of treatment. Each treatment allowed up to 26 sessions. Treatment was considered completed if the couple completed 10 or more sessions. This was based on 10 sessions being the mean and mode of number of sessions used in a previous meta-analysis of couples therapy research (Vu & Christensen, 2003). The mean number of sessions was 23.5 ($SD = 4.7$) for IBCT and 21.7 ($SD =$}
for TBCT, which are not significantly different. Of the 134 couples in Christensen et al., 7 in TBCT did not complete up to 10 sessions and only 1 did not complete up to 10 sessions in IBCT. The study did not specify if this dropout rate was significant.

The results from Christensen et al. (2004) suggest that both forms of behavioral couples therapy significantly improve relationship satisfaction, stability, and communication. Both forms of therapy showed quicker improvements for husbands than wives, and rates of improvement were comparable regardless of whether dissatisfaction at pre-test was moderate or severe. TBCT and IBCT overall showed similar effectiveness across the measures, though slight differences were present. On the Dyadic Adjustment Scale (DAS; Spanier, 1976), which measured marital satisfaction, couples treated with TBCT evidenced larger initial gains, but their improvement slowed and leveled off as time went on, while couples treated with IBCT steadily and consistently improved over the entire course of treatment. Ultimately, posttreatment outcomes were not significantly different between the two therapy styles even though the rates of change differed throughout treatment.

To determine whether the IBCT and TBCT groups would eventually have significantly different outcomes after treatment concluded, a follow-up study was conducted by Christensen, Atkins, Baucom, and Yi (2010). After two years, the couples in the IBCT group had significantly higher satisfaction than those who received TBCT, though the effect size differences were minimal. At the fifth year follow-up, 50.0% of the IBCT clients and 45.9% of the TBCT clients still showed significant improvements, while 25.7% of IBCT and 27.9% of TBCT couples separated or divorced. Previous differences between IBCT and TBCT were no longer significant at the five year follow-up. Thus, the final results comparing TBCT and IBCT indicated that both treatments produced substantial effect sizes in seriously and chronically
distressed married couples, and though there were differences in results at different times, the two treatments ultimately were comparable in effectiveness.

**Cognitive-behavioral couple therapy.** Cognitive-behavioral couple therapy (CBCT) for couples with relationship issues in which one partner has PTSD was tested by Monson et al. (2012). In their study, 40 couples were recruited from veteran affairs settings and included both heterosexual and same-sex couples, although most couples were heterosexual with the female partner being the identified patient with PTSD. Even though the couples were recruited from veteran affairs settings, the participants with PTSD had varying trauma incidents, including adulthood and childhood sexual trauma. The treatment group consisted of 20% \( n = 4 \) who had adulthood sexual trauma and 15% \( n = 3 \) who had childhood sexual trauma, while a waitlist group consisted of 20% \( n = 4 \) who had adulthood sexual trauma and 40% \( n = 8 \) who had childhood sexual trauma.

The treatment group in Monson et al.’s (2012) study received 15 sessions of manualized CBCT (Monson & Fredman, 2012). In the study, sessions were twice per week for the first two phases and weekly for the third phase. Each session is scheduled for 75 minutes. CBCT has three phases. The first phase, which is only the first two sessions, focuses on psychoeducation about trauma and relationship functioning, treatment rationale, and the therapeutic relationship. In addition to those focuses, each partner completed a questionnaire called the Trauma Impact Questions, which includes their thoughts about their self, partner, relationship, how PTSD impacts the relationship, trust, control, emotional closeness, and physical intimacy. At the end of the first session, the couple is also encouraged to notice each other doing positive things rather than focusing on negativity as homework. The partners share their thoughts recorded on the
Trauma Impact Questions with each other in session 2. They also learn conflict management strategies, breathing techniques, and early warning signs of anger in this session.

The second phase of the CBCT treatment in Monson et al.’s (2012) study begins at session 3. This phase focuses on trauma avoidance in daily life that are not simply related to specific trauma memories and reminders, including emotional numbing and other internal states, that sustain PTSD and relationship problems. In the third session, reflective listening is taught to the couple to discuss situations they have avoided because of the PTSD, such as people, places, events, and feelings. The avoided situations are then used to create an “approach” list in the fourth session, which is used for in vivo homework assignments following sessions throughout the remainder of treatment. Typically, clients start with listed situations that can be rewarding activities for couples and are the most anxiety inducing. The assignments involve in vivo exposure to the situations in manageable ways (e.g., watching an activity) and building up to the full experience (e.g., participating in an activity). Beginning in session 6, additional communication skills are added that are intended to build on each other, starting with a dyadic process meant to increase flexibility by getting each partner to discuss and evaluate thoughts that sustain PTSD and relationship problems. Problem solving and decision-making skills are taught in the seventh session in order to help accurately identify problems and potential solutions before taking behavioral action.

The third and final phase of the treatment focuses the remaining seven sessions by utilizing the couples’ communication improvements to have discussions focused on resolving as many PTSD symptoms and relationship problems as possible, as well as beginning to implement cognitive interventions (Monson et al., 2012). Remaining maladaptive beliefs that each partner may have are explored and challenged, particularly core beliefs in the domains of trust, control,
emotional closeness, and physical intimacy. The final session includes discussions examining growth made regarding PTSD and the relationship, as well as expected future challenges.

When compared to a 3-month waitlist control group, couples who received CBCT had significantly greater reductions in PTSD and comorbid symptoms, as well as greater improvements in relationship satisfaction (Monson et al., 2012). The patterns were consistent regardless of client sex, trauma experience, and sexual orientation. Treatment gains were maintained at a 3-month follow-up. These results are important because they show that couples therapy when a partner has PTSD with sexual assault can simultaneously be helpful with both the relationship in general and with the PTSD symptoms of CSA victims.

The pilot study for cognitive-behavioral conjoint therapy conducted by Monson, Schnurr, Stevens, and Guthrie (2004) found somewhat different results from the larger Monson et al. (2012) study; however, there were several differences between the two studies that may account for the discrepant findings. The two studies were comparable regarding results indicating PTSD and relationship improvements as assessed by the partners of the traumatized patient, as well as by independent assessors. In Monson et al. (2004), however, the traumatized patients did not show significant improvements in self-reported PTSD symptoms or relationship satisfaction, though they did demonstrate significant gain in their self-reported depression and anxiety scores. There are some reasons why the self-report measures may have not shown significant improvements for the individual with PTSD in Monson et al. (2004) when the same measures were significant in Monson et al. (2012). First, the number of couples who participated in Monson et al. (2004) was smaller, which means that it is harder to find statistical significance. Second, the gender of the traumatized victims was generally different. Monson et al. (2004) studied males with PTSD and their non-traumatized female partners, while Monson et al. (2012)
varied regarding the gender of the traumatized partner and consisted mostly of females with the PTSD diagnosis. The idea that this could have caused differences in the results is supported by Kiecolt-Glaser and Newton (2001) and Cason, Grubaugh, and Resick (2002), who indicated that there are gender differences in relationship satisfaction related to health and PTSD treatment outcomes, respectively. Also, the trauma types differed, with Monson et al. (2004) studying Vietnam combat veterans and Monson et al. (2012) including varying trauma types with few combat related traumas and many abuse related traumas. This indicates that, although there are studies showing CBCT may not make as much improvements for the traumatized victim as some may hope, it tends to be more effective when the traumatized partner is male and when the trauma is combat-related.

**Behavioral family therapy.** Behavioral family therapy (BFT) is a treatment that is not used strictly for couples, but it can be used as a couples treatment (Glynn et al., 1999). The treatment is conducted in 16 to 18 one-hour sessions as described by Mueser and Glynn (1995). The first three sessions focus on orientation and assessment. The therapist’s and the clients’ goals and expectations for treatment are discussed. Family history, strengths, and conflicts are also assessed. Sessions four and five give attention to educating the clients regarding PTSD in hopes of validating, developing realistic expectations, and allowing the clients to be more informed about mental health services. For sessions six through eight, communication training is utilized to improve expressing feelings and empathic listening, which is taught with coaching, modeling, practice assignments, feedback, and reinforcement. The ninth and tenth sessions work on managing anger and conflict in a direct, constructive manner, as well as compromise, negotiation, and de-escalation. It is important to note that the emphasis on these two sessions is typically based on veteran males with PTSD; however, such sessions would presumably be
useful with any couple regarding their conflict. The final six to eight sessions are used for improving problem-solving skills, which is the primary goal of BFT. In these sessions, the clients are encouraged to solve problems with their partners or family members in six steps: (1) identify a problem, (2) brainstorm ways to handle the problem, (3) evaluate potential consequences of proposed strategies, (4) agree on the best choice, (5) plan how to apply the strategy, and (6) apply the strategy and review if it worked. Multiple problems could be identified and worked on in these sessions, but it is encouraged to use at least one identified problem related to a specific PTSD issue. To accomplish these goals successfully, the clients are trained in behavioral rehearsal techniques.

Glynn et al. (1999) compared BFT following directed therapeutic exposure, an individual exposure and cognitive restructuring based treatment, with directed therapeutic exposure alone and a waitlist control group. To do this, they recruited Vietnam veterans with PTSD along with one other family member, spouse, or partner. Although the study was not limited to romantic couples, 89% of the traumatized participants attended the BFT with a wife or other romantic partner. They followed the BFT protocol described above. They conducted the treatment in 16 sessions with the first 12 sessions conducted weekly, the following 2 sessions every other week, and the last 2 sessions once per month.

Directed therapeutic exposure in Glynn et al.’s (1999) study was based on Carroll and Foy’s (1992) protocol. It was conducted in 18 twice-per-week sessions that were 90-minutes each. The first two sessions of the treatment involved building a therapeutic alliance, providing treatment rationale, and assessing traumatic events to identify the 2 most anxiety-provoking events to be used for reexposure later in the treatment. The next 13 or 14 sessions were used for reexposure and cognitive restructuring. The reexposure included reviewing the two most
anxiety-provoking events in minimal detail to allow arousal to dissipate after repeated rehearsals. Two 30-minute exposure trials were conducted each session. It took 10-15 trials to achieve desired anxiety reduction, which was measured using self-reports and heart-rate monitoring instruments. Cognitive restructuring was utilized for 15 minutes of each of these sessions assuming a minimum of 6 exposure rehearsals for each event. The final sessions of directed therapeutic exposure reviewed the progress made and provided instructions for the client to continue “self-reexposure” outside of treatment to address potential traumatic events that were not worked on with the therapist.

The results of Glynn et al. (1999) indicated that directed therapeutic exposure significantly reduced positive PTSD symptoms, such as re-experiencing and hyperarousal, but had no impact on negative PTSD symptoms, such as avoidance and numbing. There were no further improvements when BFT followed the exposure and cognitive restructuring treatment.

It is important to note that the dropout rate for the couples was high as they prepared to begin BFT (35%) after directed therapeutic exposure was completed (Glynn et al., 1999). This dropout percentage did not seem to be due to receiving exposure treatment because it is similar to the percentage of participants that declined to start BFT after being in the waitlist group (32%). Even though the dropout rate seemed to be due to time, potential disinterest in the rationale for the treatment, conflict with introducing somebody new into the treatment, or some other unknown factor, this still indicates that it is difficult to rely on couples attending BFT after a delay in time after making initial contact with the therapist.

Glynn et al. (1999) noted that adapting behavioral family therapy for couples was more challenging than they anticipated. They explained that many of the relationships were fragile and did not demonstrate the levels of cooperation, commitment, and positive feelings towards the
other partner that were expected to be there. The authors stated that the female partners of the veterans were “clearly angry and burdened.” These observations may be potential reasons for the findings of the study that behavioral family therapy did not lead to further progress in resolving PTSD symptoms. Overall, Glynn et al. (1999), based on their findings, did not support the addition of behavioral family therapy to other treatments for couples.

Rational emotive behavior therapy. It has been suggested that rational emotive behavior therapy (REBT) is useful with couples due to its combination of cognitive, emotive, and behavioral methods of integrating communication, intimacy, relationship, and other skills into the relationship (Ellis, 2001). REBT is not simply one intervention; rather it is a broad treatment approach that incorporates multiple interventions and philosophies. It commonly known under the umbrella term “CBT” even though CBT and REBT are somewhat different (McMahon & Woo, 2012). According to Ellis, REBT therapists are active and use behavioral interventions, including, but not limited to, in vivo desensitization and operant conditioning; role play; reframing; philosophical, functional, and empirical disputes; experiential, encounter, and feeling methods; and psychoanalysis. For trauma, the in vivo exposure is frequently used to desensitize traumatic memories.

An integral part, and most well-known aspect, of REBT involves using the same A-B-C model described in the cognitive restructuring portion of the individual treatment section (Ellis, 1991). With couples, each person’s A-B-C sequence can impact the other’s, often creating a back and forth reaction. For example, if one partner criticizes the other, that criticism serves as an activating event for the other, which leads to an interpretation (i.e., belief) followed by an anger response (i.e., consequence) that becomes an activating event for the partner who was initially critical, and therefore creating a cyclical pattern.
There are six phases of REBT, which were described by Cluxton-Keller (2011). Phase 1 consists of building rapport, and collecting intake information in order to establish therapeutic needs and goals. This also involves assessing irrational thoughts and self-defeating behaviors. Phase 2 involves developing further understanding of client issues, including identifying specific triggers and self-talk. In phase 3, the therapist and the clients work together to assess what prevents the clients from being happy. The fourth phase includes the therapist asking questions about the clients’ goals, values, ideals, and disturbances. While doing this, preferences (i.e., rational beliefs) and demands (i.e., irrational beliefs) are identified. These goals can also be assessed during other phases of treatment to assess change. Methods of amplifying change are utilized in phase 5. These methods can include skills training and challenging the clients’ irrational beliefs, as well as reinforcing rational statements and techniques mentioned at the beginning of the REBT subsection. Termination is the final phase, which involves reviewing treatment, assessing for issues not addressed, and potentially scheduling follow-up sessions for maintenance. The number of sessions varies based on the speed of improvement in clients.

There are three major insights to REBT, according to Ellis (2003). The first insight is that when the consequences of the A-B-C model are dysfunctional negative emotions, they are only partially caused by the activating event, while a majority of dysfunctional emotional consequences are influenced by irrational beliefs about the activating event. Second, if people are upset or disturbed in the present, it is because they continue to hold irrational beliefs and keep on reaffirming them as if they are valid. The third insight of REBT is that insight alone, meaning that being aware of the two previously described insights, usually does not relieve people of emotional disturbances; thus, continuous attempts at examining core irrational beliefs and incorporating cognitive, emotional, and behavioral changes aimed at fixing emotional issues
are the best chances at alleviating emotional disturbances. Regarding relationships, it was hypothesized that having more insight into the beliefs of one’s partner would allow a partner to address conflicts based on irrational beliefs in order to correct cyclical negative interactions and emotional consequences in the relationship (Ellis, 1991).

Theories of REBT, as described by Ellis, Sichelm, Yeager, DiMattia, and DiGiuseppe (1989), indicate that relationship problems stem primarily from each partner having irrational needs and demands of the other partner and of the relationship that lead to unrealistic expectations. The irrational demands result in exaggerating the seriousness of events, awfulizing the other’s shortcomings, underestimating the other’s frustration tolerance related to those shortcomings, and blaming one’s self or others (Dryden, 1985; Ellis, 1991).

Moller and Van Der Merwe (1997) surveyed married couples to test the relationship between marital adjustment and the four major categories of irrational evaluative beliefs addressed in REBT, to examine the relationship between accuracy of partner perceptions regarding their significant other’s rational and irrational beliefs with levels of marital adjustment, and to test if similar rational and irrational beliefs among spouses correlated with their levels of marital adjustment. Their study indicated that relationship dissatisfaction was associated with demandingness, low frustration tolerance, and self-worth beliefs; all of which support Dryden’s (1985) and Ellis’ (1991) theories listed above.

With regards to accurately predicting partner beliefs in Moller and Van Der Merwe (1997), only one outcome supported the idea that having insight about a significant other predicted high adjustment to marriage: husbands who were aware of low frustration tolerance in their wives had high levels of marital adjustment. In contrast, wives in relationships with lower marriage adjustment levels had more insight regarding awfulizing and demandingness than those
in the high marital adjustment group, and husbands in the low marital adjustment group had more insight into demandingness of their wives than those in the high adjustment group. These results therefore indicated that Ellis’ (1991) theories that having insight into their partners rational and irrational beliefs are not always associated with better adjustments in marriage, and three of those four results actually indicated the opposite. Although these results do not support this particular theoretical justification for REBT with couples, Moller and Van Der Merwe’s study examined pre-existing insight in couples with marital adjustment rather than how REBT as a treatment actually impacts the couples; thus, receiving training and guidance through REBT in how to address conflicts related to A-B-C interaction patterns could still be useful even if part of the theory was not supported.

It is important to note that REBT, like its larger umbrella term CBT, is not often studied as a whole with couples; rather, certain aspects and interventions found in the treatment are studied on their own (e.g., in vivo exposure). Additionally, many treatments studied are likely to follow REBT philosophies while labeling it under the term CBT. For these reasons, the studies finding empirical evidence for REBT for couples under the term REBT are limited; however, the philosophies described above may be important for a therapist implementing CBT for couples to keep in mind.

**Mind-body practices.** As found with individual mind-body practices with sexually traumatized clients, research for couples therapy with such interventions is limited (O’Kelly & Collard, 2012). O’Kelly and Collard stated that there had been no research studies using mind-body interventions as the sole means of addressing issues with distressed couples and none were found when researching for this dissertation.
However, minimal research has been done using mindfulness with non-distressed couples. Carson, Carson, Gill, and Baucom (2004) designed a program, based on mindfulness-based stress reduction (MBSR; Kabat-Zinn, 1982), called mindfulness-based relationship enhancement (MBRE) that is meant to strengthen relationships that are already relatively happy. The intervention consists of eight 2.5 hour meetings plus a 7-hour weekend retreat that occurred during the sixth week. MBRE starts off with mindful communication, which includes taking turns speaking from the heart (i.e., avoiding mental rehearsal) while the other partner silently listens attentively. Eventually, partner-based yoga exercises and a mindful touch exercise (i.e., a gentle back rub) are incorporated and followed by a discussion of the exercises between the two partners. A dyadic eye gazing exercise is also used, which is often perceived as uncomfortable, to teach each partner to be nonreactive and receptive of their partner during stressful events.

The results from Carson et al. (2004) indicated that non-distressed couples benefited from MBRE at posttreatment and the gains were maintained at a 3-month follow-up. Couples reported improved measures of relationship satisfaction, acceptance of partner, autonomy, relatedness, closeness, and relationship distress. MBRE also had non-relationship related benefits for the individuals, including measures of psychological distress, optimism, spirituality, and relaxation. When examining diaries of those who were in the treatment group, results indicated that, the more couples practiced mindfulness in their relationship, the more increases in relationship happiness and coping efficacy they experienced, as well as greater decreases in relationship stress and overall stress.

Carson, Carson, Gil, and Baucom (2007) further examined the results of Carson et al. (2004). They set out to find what aspect of mindfulness led to positive change. They found that
couples believing the mindfulness activities were exciting and self-expanding was the only factor leading to the relationship improvements.

In addition to those studies showing mindfulness with non-distressed couples, a few non-intervention studies showing correlation between mindfulness and relationship satisfaction exist (Barnes et al., 2007; Burpee & Langer, 2005; Jones, Welton, Oliver, & Thoburn, 2011; Saavedra, Chapman, & Rogge, 2010; Wachs & Cordova, 2007). Wachs and Cordova (2007) found that couples with higher mindfulness scores were more likely to adjust better to marriage. They also found that anger control and self-soothing were higher, while hostile anger expression was lower, when mindfulness scores were higher; thus, aggressive impulses and hostility were minimized in couples that were more mindful.

Mindfulness was useful for older couples in longer lasting relationships as well as younger couples in shorter term relationships, showing generalizability. Wachs and Cordova (2007) from the paragraph above included married couples who are older, have been married longer, and were more likely to have children than the college aged participants in Barnes et al. (2007). Even with younger, more inexperienced couples, Barnes et al. found that relationship satisfaction, self-control, and accommodation were all positively correlated with mindfulness.

Barnes et al. (2007) also conducted a second study with college students in which both members of couples in college were assessed before and after discussing conflict. The researchers again found correlations between mindfulness and romantic satisfaction, as well as less severe anxiety and anger before and after stressful conflict discussions. Negative changes in love and commitment scores were also lower when mindfulness scores were high. The positive impact of mindfulness on one partner’s experience did not impact the experience of the other;
thus, Barnes et al. suggested that relationship satisfaction of one partner does not indicate the state of the relationship.

A study with a much larger sample size conducted through an online survey collected responses regarding hostile conflict, attachment avoidance and anxiety, and mindfulness (Saavedra et al., 2010). The average age of participants in Saavedra et al. was between the average ages of Wachs and Cordova (2007) and Barnes et al. (2007), while also having a greater variety of relationship status (i.e., dating, engaged, married). At 1, 2, 3, 4, 6, 9 and 12 month follow-ups, participants consistently showed higher levels of mindfulness related to higher relationship satisfaction and reduced attachment anxiety, which in turn reduced the chances of the couple breaking up.

The trait of being mindful was tested to see if it had a direct relationship with spousal attachment and marital satisfaction by Jones et al. (2011). Their study recruited married couples of all ages, all durations of marriage, and with any number of children. As expected following the studies described above, the results from their survey supported trait mindfulness being related to marital satisfaction, notably using different questionnaires as measurements that were not previously used in past studies on this subject. Jones et al. stated that they believe this expansion by use of different measurements makes the results more generalizable. Additionally, Jones et al.’s results indicated that those who are mindful are more likely to have high levels of security due to feeling close to and dependent on their partners which account for much of the marital satisfaction. Also, spousal attachment seemed to be the mechanism in which trait mindfulness potentially leads to higher levels of marital satisfaction. Finally, Jones et al. also suggested that being mindfully attuned with one’s partner may be associated with neural circuitry growth related to safety, security, and positive affect.
As indicated above, some of these studies provide evidence of an association between mindfulness and happier relationships, and others showed that mindfulness practices, which include mindful thought and behavioral activities, tend to strengthen already healthy relationships; however, none of them provide direct evidence that mindfulness interventions would benefit distressed couples. The studies showed generalizability among different age groups as well as among varying relationship durations and experience. The studies unfortunately were not racially diverse in their samples, though there is nothing to indicate that mind-body practices or trait mindfulness would not have similar responses among people of other races and ethnicities.

**Eye-movement desensitization and reprocessing.** Although it is typically considered an individual treatment, EMDR could have some benefits in couples therapy. It potentially could be used to process CSA trauma with a partner present, which in theory could help give the non-traumatized partner some insight into the experiences of the traumatized partner. Shapiro (2005) explained that it can also be used when dealing with trauma as it relates to the relationship. She explained that EMDR can be especially useful when actions by the partner trigger reactions based on traumatic history. An example of this relating to CSA could be using the intervention when the partner has a re-occurring behavior that reminds the traumatized partner of his or her abuser. Shapiro theorized that conducting EMDR in couples treatment can help further establish differentiation in the relationship, which is the ability for a person to see each member of the relationship for who they are with tolerance and understanding. Differentiation is considered a healthy characteristic that allows a member of the relationship to appropriately know when to yield or not yield in disagreements without losing his or her sense of identity (Bader & Pearson, 1988; Schnarch, 1997). Even though there are strong theories as to why EMDR works with
couples, there are limited research studies testing the impact of EMDR when used in couples therapy.

Errebo and Sommers-Flanagan (2012) suggested that EMDR could be adopted for couples therapy for combat-related trauma survivors. They said that the standard eight phases could be used with little or no modifications. Feeling that you are in a safe place and desensitizing through various forms of stimulation can be an important part of the intervention. Errebo and Sommers-Flanagan proposed that an additional modification to EMDR that can be used in couples therapy to add another option of safety and desensitizing is for the traumatized individual to be physically touched by their partner during the lateral eye-movement stimulation phase. It was also suggested that the EMDR could be used to address emotional wounds inflicted on one partner from another. Although their theoretical application was described for veterans with PTSD and their partners, the same modifications could theoretically apply to EMDR for couples in which one partner has PTSD related to other forms of trauma, including CSA.

**Stress inoculation training.** Meichenbaum (2007) mentioned that the flexibility of stress inoculation training has allowed it to be used with individuals, couples, families, and groups; however, research on its use with couples seems to be limited. Neff and Brody (2011) stated that to their knowledge, their 2011 studies were the first to show empirical evidence of stress inoculation creating resilience to stress in the context of marriage. Their studies addressed theories of stress resilience in early years of marriage. To do this, they drew from Meichenbaum’s (1985) stress inoculation theory to determine if adapting appropriately to moderately stressful situation would help develop resilience to stress within the marriage. They performed two studies to test whether manageable stressors will build resiliency. The first study
recruited couples in their first six months of marriage. It addressed whether couples who begin marriage with more effective problem-solving behaviors and have more experience facing stress have more resilience to stress and have larger increases in confidence in their ability to resolve marital issues during their next 2 years of marriage. They found that wives, but surprisingly not husbands, who had effective problem-solving skills and had more experiences with stress early in the marriage did have more resilience to future stress and had increased confidence in resolving marital issues than wives who had effective problem-solving skills but did not have as much experience practicing the skills during stressful situations. Neff and Brody hypothesized that husbands may not have had significant results due to the lower reported amounts and different types of stressors than the wives reported. This may have provided the wives with more opportunities to build stress resilience. Neither husbands nor wives who displayed poor problem-solving behaviors showed an increase in resilience or confidence in resolving marital issues if they had more experience with stress early in the marriage. Overall, couples who demonstrated good support-seeking behaviors and had experienced more stress early in the marriage reported higher marital happiness at the end of the two year study.

The second study by Neff and Brody (2011) involved couples who had their first child within the first 4 years of their marriage. In this second study, resilience was monitored as the married couples transitioned into parenthood. The results indicated that both husbands and wives who had good support-seeking behaviors early in marriage and had experienced stress within the relationship prior to the birth of their first child were more resilient to the added stress of a child entering the family. Similar to their first study, Neff and Brody found that couples who demonstrated good support-seeking behaviors and experienced stress early in the marriage reported higher marital satisfaction at the end of the four year study.
Research on stress inoculation training seems to be even more limited with couples in which one member has a trauma history. Much of the discussion on stress inoculation training for couples with a partner experiencing PTSD have been discussed only in regards to trauma related to military service (Meichenbaum, 2007; Sautter, Armelie, Glynn, & Wielt, 2011). Cognitive-behavioral therapies for couples have been shown to be useful with veterans to reduce partner and clinician-rated PTSD symptoms, as well as increase partner-rated relationship satisfaction (Monson, Schnurr, Stevens, & Guthrie, 2004).

Based on research that indicates that strong social support is associated with positive mental health outcomes (Bland et al., 1997), low levels of social support are risk factors for PTSD (Brewin, Andrews, & Valentine, 2000), and that there is strong justification to use couples therapy for trauma disorders (Riggs, Monson, Glynn, & Canterino, 2009), Sautter et al. (2011) proposed the use of stress inoculation training, because of its involvement with significant others and its efficacy with veterans with PTSD (Meichenbaum, 2007), in combination with empathic communication training to help couples where one member of the couple has PTSD related to military combat. Their treatment, which they refer to as Structured Approach Therapy, was tested in a small study by Sautter, Glynn, Thompson, and Franklin (2009) that indicated a significant reduction in emotional numbing and avoidance PTSD symptoms among six Vietnam combat veterans and their partners (Glynn et al., 1999). In addition to the study on Vietnam veterans and their partners, an unspecified number of clinicians working with Iraqi and Afghanistan combat veterans estimated that only about 10% of couples who have committed to treatment terminated prematurely (Sautter et al., 2011). Sautter et al. (2011) indicated that the combination of stress inoculation training and empathic communication seems effective in working with PTSD and marital problems, but acknowledged that more research is needed to
determine its efficacy. They also suggested that it is important for clinicians to begin their treatment within the first several years following deployment to prevent chronic PTSD and relationship problems.

**Summary.** There were less CBT studies found for couples with a focus on trauma or using treatments that are commonly used for trauma than there were for individuals with sexual trauma. This is likely due to trauma being more frequently treated as an individual treatment than a couples treatment in practice (Zayfert & Becker, 2007).

Unlike with individual treatments for clients with CSA histories, the research regarding CBT for couples tended to focus on broader treatment approaches rather than specific interventions. Only three interventions were found for couples that directly overlapped with interventions found for individual CSA survivors: mind-body practices, EMDR, and stress inoculation. Most of the broader treatment approaches were described in general themes and phases of treatments, rather than having session by session breakdowns that were more common in the individual treatment studies. Additionally, articles and studies found regarding couples treatment were more likely to discuss theories or test for correlations related to theories of why certain treatments are likely to help rather than directly testing the treatments to determine their effectiveness.

Of the couples treatments that were tested for effectiveness with couples impacted by trauma, all were found to be effective; although there was evidence directly suggesting BFT is not an ideal choice (Glynn et al., 1999). This means that, with the exception of BFT, all of the treatments reviewed in this section may potentially be useful for adapting to couples in which one partner experienced CSA. In the following section, the individual and couples treatments described above will be compared and discussed from a critical perspective to determine
potential advantages and disadvantages of adapting them to a treatment for couples affected by CSA.

**Adaptation Considerations**

**General Challenges**

There are several challenges to consider for any treatment of couples in which CSA impacts the relationship. First, the therapist needs to determine if the issues the couple seeks are individual or couples issues. Several of the treatments discussed above focus on the traumatic issues of the CSA survivor and have few direct ways of adapting them to couples treatment. If the primary issues a couple attends treatment for are the trauma and they are looking for increases in understanding related to the trauma, such individual treatments may be useful to be adapted to couples treatment with the non-traumatized partner serving more as an observer or supplementary part of the treatment. Generally, however, the goal of couples therapy is to work on the relationship. Under the assumption that most couples attend to improve their relationship, and CSA has impacted the relationship, it may be more beneficial to strongly consider treatments that balance the presence of both partners in the sessions, including allowing room for the impact of the trauma to be processed by both members of the couple.

It is necessary to determine that a couple is appropriate for couples therapy and would likely benefit from a conjoint therapy approach. CSA survivors are likely to be vulnerable and, therefore, it is important to evaluate if there is enough safety in the relationship to even begin couples therapy (Alexander, 2003; Button & Dietz, 1995; Johnson & Williams-Keeler, 1998; Pistorello & Follette, 1998). Safety would be important for allowing the couple to open up and discuss issues relating to the relationship, including how trauma impacts the relationship from each partner’s perspective. Additionally, couples therapy carries the risk of blatant violations of
safety, such as using information discussed in treatment as weapons against each other during conflicts, which could be especially damaging for vulnerable clients such as those with CSA histories. Severe violations of safety, such as when domestic violence is present, generally are not appropriately treated through couples therapy (Good Therapy, 2013).

Another challenge is getting both partners motivated and invested in couples therapy and preventing dropout. It is already more difficult to prevent couples dropout than individual dropout based on the potential challenges of matching up three different schedules. Further, through sheer probability, treatment dropout is more likely when there are two clients who can possibly decide they no longer want to continue treatment instead of just one. Sometimes a partner may feel as if the therapist is on the other person’s side, even though the therapist tries to remain impartial, or he or she may feel there is too much focus on one individual rather than the other (McMahon & Woo, 2012). The presence of CSA history potentially makes it more likely that focus tends to be geared more towards the traumatized client. Not only is there a chance that the non-traumatized partner could feel that not enough attention is paid towards him or her, but it is possible that the non-traumatized partner could deflect attention or blame relationship issues on the traumatized partner. The non-traumatized partner may even feel that their presence is not necessary and they may not be motivated to make changes of their own, even if the issues do seem to involve them.

Psychoeducation is the key to establishing the structure of therapy at the beginning of treatment so that both partners are aware of these potential dynamic issues. It generally is used at the beginning of CBT to explain treatments as it is, and in couples therapy it can be used to express that, even though there may be moments of focusing on one partner’s issues, the goal is to focus on that individual’s issues in terms of how they impact the relationship as a whole.
Psychoeducation can also be used any time throughout therapy to explain that any trauma issues discussed in treatment have an impact on the non-traumatized partner, even if their role may be to simply increase understanding so they can be more a more supportive partner.

**Gender**

When considering adapting treatments for couples based on past research, it is important to consider roles gender may have played in the past research results. Cason et al. (2002) looked at past research on individuals with PTSD, including several studies dealing with sexual trauma. The research reviewed included CBT treatments such as exposure, EMDR, cognitive processing, and skills training. They reviewed 18 PTSD studies, seven of which involved both male and female participants, but only three of those seven addressed gender differences when analyzing the results. Tarrier et al. (1999) was the only study reviewed that included an analysis of effect size based on gender. They found that women responded better to imaginal exposure and cognitive-processing therapy than men. Outside of the Tarrier et al. study, Cason et al. interpreted differences in effect size results between studies by comparing the female results from multiple studies to male results from multiple studies that examined the same treatments. Cason et al. indicated that the data from the past studies indicated that women were more likely to develop PTSD than men and responded as well or better than men to treatment.

It was hypothesized by Cason et al. (2002) that both the higher rates of PTSD symptoms reported and the greater changes resulting from treatment could potentially be due to women in our society being more attuned to or willing to share their emotions, as well as being more experienced with intimate interpersonal communication. Their hypothesis was based on previous research on gender roles in psychotherapy (Gilbert, 1987; Kaplan, 1976). The implications of Cason et al.’s findings on adapting treatments to couples indicate that caution should be used
when applying a treatment that was tested with one gender onto a traumatized client of the opposite gender.

The hypothesized gender difference of women being more open with their emotions than men could have an impact on relationship treatment results in addition to PTSD treatment results. For instance, several studies of couples interventions for trauma-affected couples discussed in this dissertation examined couples in which the male has PTSD, while the vast majority of the studies on the relational impact of trauma and individual treatment for sexually-related traumas examined primarily women. There could be differences in the effectiveness of a given treatment if the gender of the traumatized client and the supporting partner are reversed. It is conceivable that gender differences could influence a supporting male partner struggling to provide the emotional understanding his traumatized female partner desires, and thus having a different impact on relationship satisfaction than the research indicated was likely when the genders were reversed.

Blaming tendencies are another aspect of couples treatment that changes depending on the gender of each partner. Davies, Rogers, and Whitelegg (2009) used a hypothetical vignette about a 15-year-old sexual assault victim of his or her uncle to analyze the responses of male and female participants. The variables manipulated in the vignettes were victim gender, victim sexual orientation, and victim response (submissive vs. resistant).

The results showed that male victims were viewed as more to blame for their abuse than were female victims, and male participants were more likely to blame the victims in general (Davies et al., 2009). Males were also more likely to blame submissive victims than resistant victims. These results indicating that males are more likely to blame victims could be another factor as to why women sexually abused as children feel misunderstood, undeserving, unloved,
and anxious about intimacy in their heterosexual relationships (Cahill et al., 1991). This could mean that couples entering therapy with traumatized female partners could start with exacerbated relationship and PTSD issues based on the sense of having a lower feeling of support, particularly if the male partner views the female as submissive rather than resistant to her abuse. Traumatized males, on the other hand, who have female partners less likely to blame the male for the abuse they experienced in childhood, may feel more supported.

**Treatments and Interventions**

Mind-body practices. There is limited research for both sexually traumatized clients in individual therapy and couples therapy regarding mind-body interventions. Such practices for trauma victims are used as coping techniques when anxiety is elevated, but they do not address underlying issues that help clients process and improve beyond individual moments of distress. There is also concern that mind-body techniques used alone may teach avoidance (Foa & Rothbaum, 1998; Heimberg & Juster, 1995; White & Barlow, 2002), but could be useful as long as it is used with other interventions that allow for processing client distress (Brown, O’Leary, & Barlow, 2001; Foa & Rothbaum, 1998).

Regarding couples therapy, all of the research conducted with couples was with non-distressed couples. The findings indicated that more mindful couples tend to have more satisfying relationships than non-distressed couples who are less mindful. These findings were consistent regardless of age, relationship duration, and other factors in the relationships such as having children. The problem with implementing this into couples therapy with partners with CSA histories is that a history of CSA increases the chance that a given relationship is distressed, and therefore it is unclear what the impact of mind-body practices will be on treatment.
There is little reason to believe that mind-body practices would be harmful to distressed couples; however, without research supporting its usefulness with distressed couples, as well as limited support for usefulness with sexually abused women in individual treatment, it is likely not a good use of session time when more pressing issues exist in the relationship. It could be useful if the clients want to continue treatment after reaching healthy levels in their relationship, or as the clients prepare for termination and want means of continuing improvements posttreatment.

**Eye-movement desensitization and reprocessing.** The studies reviewed looking at EMDR with individual women who were sexually traumatized showed similar effectiveness to other treatments. Like other CBT treatments tailored to sexually traumatized individuals, EMDR leads to improvements that continue even after treatment is terminated. The intervention tended to show quicker improvements related to anxiety and depression associated with the trauma (Edmond et al., 1999; Edmond & Rubin, 2004), and slower improvements than many other CBT treatments for PTSD symptoms (Van Etten & Taylor, 1998).

When directly comparing prolonged exposure with EMDR, it appeared that prolonged exposure was overall more effective (Rothbaum et al., 2005). This was particularly evident by clients being twice as likely to have high levels of overall functioning 6-months after treatment if they received prolonged exposure instead of EMDR. Additionally, 95% of clients who received prolonged exposure no longer met PTSD criteria, compared to only 75% with EMDR, but this difference was not significant (Rothbaum et al., 2005).

A major concern with using EMDR with CSA survivors is the usefulness of the treatment when sexual trauma is more complicated. CSA, especially when the client was repeatedly abused by a caretaker, leads to more complicated trauma often involving dissociations from
trauma memory that block processing during EMDR (Forgash & Knipe, 2008). It was suggested that, for individuals with complicated trauma such as CSA, it may be best to incorporate more cognitive forms of therapy into EMDR to better process the trauma (Forgash & Knipe, 2008; Korn, 2009).

Overall, the research on EMDR shows that it is useful with sexually traumatized women, but is less so for complicated trauma, and is also less effective than prolonged exposure; therefore, its use with couples in which a partner experienced CSA may depend on adaptability of the treatment to a couples modality. One aspect to consider regarding the adaptability of EMDR to couples treatment is the role of the therapeutic relationship. Success of EMDR is attributed to the treatment itself, while most other CBT treatments acknowledge the role of the therapeutic relationship in treatment success (Edmond et al., 2004). It is unclear how strong the therapeutic relationship tends to be with EMDR; meanwhile, a strong therapeutic relationship predicts strong retention, midtreatment improvements, and final outcomes with a strong effect size in couples therapy (Friedlander, Escudero, Heatherington, & Diamond, 2011). Additionally, a strong therapeutic relationship with the male partner in heterosexual relationships is strongly associated with successful outcome in couples therapy (Symonds & Hovath, 2004), which also indicates that more relationship based treatments may be more beneficial for CSA affected couples than a treatment that focuses solely on the intervention used with a traumatized client.

Studies testing the use of EMDR in couples therapy were not found; however, Shapiro (2005) proposes theories regarding how the treatment can be effective for couples therapy. One of the primary ways a therapist could use EMDR in couples therapy is by allowing the non-traumatized partner to witness the traumatized partner receive EMDR treatment, allowing the non-traumatized partner to gain insight into their partner’s experience and increase
differentiation. Insight and increased differentiation would theoretically lead to understanding and tolerance of the symptoms and reactions of their traumatized partner. This can be especially helpful in theory for couples with a member who experienced CSA when behaviors of the non-traumatized partner remind the traumatized partner of their abuser and serve as PTSD triggers that the non-traumatized partner did not understand or was not able to tolerate (Shapiro, 2005).

Another way in which EMDR has been proposed for use with couples includes using the safety of the partner’s presence to help desensitize the traumatized partner during the intervention, particularly by using touch during the lateral eye-movement stimulation phase (Errebo & Sommers-Flanagan, 2012). Although this aspect sounds like it can be useful for clients, this justification for its use seems to be more of a trauma treatment for an individual using the safety of the partner rather than actual couples therapy working on the relationship. The idea of using the partner as a source of safety to guide the process becomes even more problematic if the relationship is particularly strained and the partner is not a source of emotional safety at the time of the intervention. CSA history could potentially add more concern by using the sense of touch during the process if physical touch is at all a trigger for the traumatized partner. Being exposed to the traumatic memories while being touched by their partner could create a stronger association between the traumatic memories and the physical touch of the partner; thus, if EMDR is considered for use with couples with a partner who experienced CSA, it may not be best to involve partner touch without studies providing evidence for its use.

The concerns listed above regarding the research on individual treatment for sexually traumatized individuals and the theories of using EMDR in couples treatment indicate that EMDR may not be ideal for adapting to couples therapy in which one member of the relationship experienced CSA. The treatment does not seem to focus enough on processing complex
traumatic events as is likely more necessary for CSA than for adult sex-related traumas. Further, relationship issues are not as strongly addressed in EMDR due to the focus being more on the traumatized individual with the partner present to witness and assist if possible. In addition, the therapeutic relationship is not focused on as much which generates concerns of retention. Finally, empirical findings do not suggest a superior effectiveness that would justify overlooking the other concerns.

**Stress inoculation training.** The research on individual treatment for sexually abused women indicates several reasons why SIT may not be the most useful treatment to adapt to couples therapy. Although it has been shown to be effective for PTSD and related symptoms, such as depression and anxiety (Foa et al., 1999), it is not as effective as prolonged exposure on any of those diagnoses or symptoms. In addition to having lower effect sizes, there is a greater dropout rate among clients in stress inoculation training than in prolonged exposure. Additionally, Foa et al. (1999) showed that combining stress inoculation and prolonged exposure into a brief therapeutic treatment was actually less effective than doing either treatment alone. However, each group tested had 9 sessions and it was hypothesized that it was too short of a treatment to incorporate overlapping treatments. This indicates that if a brief sexual abuse treatment is adapted for couples, who already bring more potential issues to work with due to two clients, only one tested treatment should likely be used; however, if there is time for more extended therapy, it is possible that following up one treatment with the other could provide additional benefits.

Although the individual treatment research indicates that stress inoculation training is effective, but not ideal for sexual trauma, it is worth considering the adaptability of the treatment for couples. The studies on stress inoculation with couples showed promise regarding its use.
Research on the relationship between early marital stress and effective coping skills supports the theory of stress inoculation (Neff & Brody, 2011). Overall, it was found that experiencing moderate stress early in marriage while having the means to cope with it allowed for greater chances of happiness and resilience later in marriage, including during transition to parenthood. This was particularly true with good support seeking behaviors. Although the research is on more moderate stressors than the stress that would be caused by a history of CSA, the emphasis in the results was on the importance of effective skills in order to create an inoculation effect. When partners had poor problem-solving and coping skills, experiencing stress did not create an inoculation effect and confidence in dealing with problems was lower. This indicated that stress inoculation training is likely to be helpful with couples by teaching the clients problem-solving and coping skills that are needed, especially by showing them how to appropriately seek support from the other partner. With CSA history creating additional stress, support seeking skills are likely to be even more important to achieve marital satisfaction.

The findings by Neff and Brody (2011) were promising for stress inoculation training for couples; however, their research does not provide empirical evidence that demonstrates the effectiveness of stress inoculation training as a therapeutic intervention. Another limitation to their research is that all of the couples started with low to moderate levels of stress. This means that it is unclear if stress inoculation training would have a positive impact on couples entering therapy with already high levels of stress, which CSA makes more likely.

The studies that best parallel the goals of this dissertation regarding stress inoculation training were Sautter et al. (2009) and Sautter et al. (2011), which combined stress inoculation training with empathic communication, a treatment they called structured approach therapy, in order to treat couples where one partner had PTSD related to combat. Their studies found that
the treatment was effective for marital problems and PTSD, while also decreasing the chance of dropout by reducing PTSD avoidance and emotional numbing. This information is very important because it shows that even though stress inoculation training was not as effective overall with sexually traumatized individuals, with couples it has the added bonus of positively impacting marital satisfaction. Although the combat veterans tended to be male while sexually traumatized clients are more likely to be female, and the nature of the traumas can create different issues, the research does show hope for couples affected by CSA by providing evidence of its effectiveness with trauma and relationship issues. The PTSD avoidance and emotional numbing reductions also give hope that the dropout rate concerns in sexually traumatized individuals can be curbed when stress inoculation training is used in couples treatment. It is likely that the empathic communication portion is at least partially responsible for the avoidance and numbing reductions, and therefore should be integrated in any use of stress inoculation training with couples impacted by CSA trauma.

The research on the use of stress inoculation training used with couples with PTSD still presents several challenges that should be considered regarding its incorporation with couples in which at least one partner experienced CSA. Even the combat veteran research regarding this treatment is limited and needs further research to determine its efficacy. Sautter et al. (2011) also indicated that it could be important to implement the treatment shortly after the trauma occurs, which would be impossible for couple if the trauma is CSA, with the possible exception of younger adult couples in which one partner experienced the abuse during late adolescence.

Overall the research seems to indicate that stress inoculation training would likely be an effective treatment for couples with CSA history in at least one partner. The use of this training would likely need to be contingent on whether other treatments, particularly prolonged exposure,
can supply necessary improvements in relationship issues in addition to trauma symptoms. If stress inoculation is used, structured approach therapy would be the best modification of the treatment to use at this time based on current research. If structured approach therapy and another intervention such as prolonged exposure therapy are both used as part of couples treatment, they should not be overlapping; rather, one form of treatment should begin after completion of the other.

Regardless of whether stress inoculation training is used or not for couples impacted by the CSA history of a member of the relationship, the theory of stress inoculation sets a worthwhile goal for treatment. Couples would benefit from acquiring skills that allow them to more successfully deal with stress within the relationship, whether the stress is due to past CSA trauma or more typical relationship issues. Practicing newly found coping skills on more manageable stressors would likely help the clients create an inoculation effect that would make them more likely to adequately handle more stressful events.

**Prolonged exposure.** As described above, prolonged exposure is a strongly supported individual treatment for sexually abused females, reflected in studies that examine the intervention compared to control groups and in studies that examine it compared to other interventions such as EMDR and stress inoculation training. Several studies examined the use of prolonged exposure alone in comparison to prolonged exposure combined with other treatment interventions. The stress inoculation training section described evidence that prolonged exposure alone is more effective and has less dropout among clients than stress inoculation training alone or stress inoculation combined with prolonged exposure in brief treatment; thus, prolonged exposure is the ideal choice between the three options with the sexually abused female population.
However, prolonged exposure alone was not shown to be the clear favorite treatment when examined in conjunction with cognitive restructuring and STAIR interventions. Rather, prolonged exposure was equally effective used by itself or combined with cognitive restructuring in addressing depression symptoms, PTSD symptoms, work functioning, and social functioning (Aderka et al., 2013; Foa et al., 2005). Aderka et al. also showed that the path to recovery differed between the two approaches. Their study indicated that, though each treatment impacted both PTSD and depressive symptoms, prolonged exposure alone was more effective at directly improving PTSD symptoms, while the combined treatment was somewhat more effective at directly improving depressive symptoms.

These results indicate that prolonged exposure alone or combined with cognitive restructuring is a reasonable choice for treatment of individuals with sexual abuse related trauma; however, the different pathways should be considered when choosing which treatment to use in couples therapy. Barring vicarious trauma or separate trauma events of the non-sexually abused partner, only one partner would be entering couples treatment with PTSD symptoms; thus, it is more probable that both partners could begin treatment with depression but only one needs direct trauma intervention. If that assumption is true and the traumatized partner is expected to improve equally no matter which method is used, it makes more sense to use the treatment that may improve depression more directly so as to provide therapeutic benefit to both partners.

While the protocol for prolonged exposure works directly with trauma, the protocol that includes both prolonged exposure and cognitive restructuring as described by Foa et al. (2005) would be more easily adaptable for use with the non-traumatized partner. In the combined treatment approach, prolonged exposure occupies most of the intervention time, but cognitive restructuring is briefly used to teach clients to identify and challenge erroneous and unhelpful
beliefs. This portion of the treatment could be used to educate both clients on how to correct such problematic beliefs regarding the relationship in addition to problematic trauma-related beliefs that are typically addressed in individual treatment.

Further support for the combination of prolonged exposure with cognitive restructuring was found by Bryant et al. (2003). The study showed, in a sample of traumatized participants, which included physical but not sexual assault victims, that adding cognitive restructuring to prolonged exposure improved PTSD outcomes when in vivo exposure was not included. Bryant et al. also taught cognitive restructuring prior to providing imaginal exposure intervention because they thought it would be helpful for clients to know of principles and techniques of challenging cognitions prior to exposure. After teaching cognitive restructuring in the first session, 25 minutes were dedicated to cognitive restructuring in each of the next six 90-minute sessions prior to conducting prolonged exposure in those sessions.

Both the exclusion of in vivo exposure and the application of cognitive restructuring prior to exposure in Bryant et al. (2003) were methods that differed from protocols used in the studies involving sexual trauma (Foa et al., 1999; Marks et al., 1998; Resick et al., 2002). Even though Bryant et al. did not involve sexually traumatized participants, the modifications proposed seem reasonable to apply to sexually traumatized participants based on existing theories and research regarding the population. It is possible that in vivo exposure somehow disrupts the impact of cognitive restructuring, and removing in vivo exposure allows imaginal exposure and cognitive restructuring to more effectively complement each other; however, it is also possible that removing in vivo exposure makes imaginal exposure alone less effective. In support of the former option, Cloitre et al. (2002) showed that prolonged exposure with in vivo exposure excluded was still more effective than other combinations of treatment. They removed situation-
specific in vivo exposure, such as exposure to the perpetrator, because of the vulnerabilities of child abuse populations. The vulnerability of clients who were abused as children, particularly if they were sexually abused, may lead to difficulties in applying in vivo exposure that makes it not as useful for CSA victims.

The successful application of cognitive restructuring before exposure (Bryant et al., 2003), rather than implementing it mid-treatment, further supports the idea of exposure therapy being better if used before or after other potential interventions rather than simultaneously. Foa et al. (1999), Marks et al. (1998), and Resick et al. (2002) each failed to find benefits of using another treatment in addition to prolonged exposure; however, all of those studies incorporated another intervention in the middle of treatment and sometimes even mid-session rather than setting up the supplemental intervention prior to exposure. If simultaneous use of multiple interventions has tended to complicate treatment for clients and not allow enough time to focus on exposure with individual treatment, it raises the possibility that trying to use prolonged exposure with another intervention while also trying to balance two clients simultaneously in the room would be even more problematic.

All of the studies using STAIR and exposure that were examined also incorporated phase-based interventions rather than having the two treatments co-occur, and also only used imaginal exposure. Using STAIR followed by exposure led to improvements in PTSD symptoms, affect regulation, anxiety, anger expression, and interpersonal problems (Cloitre et al., 2002; Cloitre et al., 2010; Cloitre et al., 2012). When improvements were examined by specific intervention, affect regulation, anger expression, and interpersonal problems significantly improved in the STAIR phases of the studies, while PTSD symptoms significantly improved during the prolonged exposure phase. This indicated that STAIR should not be used alone for clients that
have sex-related traumas; however, the STAIR benefits of improving affect regulation, anger expression, and interpersonal issues could provide extra benefits for clients and could be especially relevant to and couples. Being able to regulate emotions and appropriately express anger could help each partner internally as well as improve their relationship with their partner. The improvements in anger expression may be especially useful given that males commonly feel anger towards their partners who experienced CSA (Bacon & Lein, 1996; Maltz & Arian, 2001).

Prolonged exposure combined with STAIR was also more effective than prolonged exposure combined with supportive counseling (Cloitre et al., 2010; Cloitre et al., 2012). There were more improvements in all of the symptoms listed and, importantly, there was much less dropout among clients in treatment. STAIR followed by prolonged exposure also was more effective at reducing high levels of dissociative symptoms, which could be useful considering it is believed that high levels of dissociation, experienced by many CSA survivors, may hinder the effectiveness of exposure and other trauma treatments (Ehlers & Clark, 2000; Jaycox & Foa, 1996; Lanius et al., 2010; Shalev, Bonne, & Eth, 1996).

Similar to the difficulties discussed of implementing EMDR, which itself is a form of exposure, the primary concern about adapting prolonged exposure for couples with a partner who was sexually abused as a child is that the treatment is individually focused. Likely due to this individual focus, research studies were not found for treatment of couples with prolonged exposure. If prolonged exposure were adapted to couples treatment, the potential benefits would be similar to the ones described for EMDR, particularly the notion of using the treatment to allow the non-traumatized partner to increase insight and differentiation. Other interventions would likely need to be utilized in order to cater to the relationship. One such sequence of interventions could begin with psychoeducation and cognitive restructuring to prepare the couple
to challenge beliefs and understand the benefits of treatment for both clients individually and for the relationship; followed by STAIR to further address relationship issues; and ending with prolonged exposure, potentially without in vivo exposure, to improve trauma symptoms and increase the non-traumatized partner’s understanding.

**Skills training in affect and interpersonal regulation.** As discussed in the previous section, STAIR followed by prolonged exposure was more effective than supportive counseling followed by prolonged exposure or STAIR followed by supportive counseling (Cloitre et al., 2010; Cloitre et al., 2012). There were no studies that tested the use of prolonged exposure prior to STAIR administration or STAIR and prolonged exposure as overlapping interventions; however, given the inferior results documented for combining SIT and exposure (Foa et al., 2008), it may be best to continue completing one treatment before moving on to the next. It is possible that using prolonged exposure before STAIR could be just as effective as Cloitre et al. found for the reverse order; however, there is no current research to support such a switch. Additionally, since the use of cognitive restructuring to prepare clients for prolonged exposure seems to yield greater effects, it is possible the reason STAIR followed by prolonged exposure is successful may also be partially due to STAIR preparing clients for exposure. Cloitre et al. (2002) concluded in their study comparing the treatment to a waitlist group that much of the success of the prolonged exposure was due to affect regulation skills taught in STAIR, which further suggests the value of keeping STAIR before prolonged exposure if both treatments are used. Based on the existing research and a lack of justification to change the order, it seems that the best use of STAIR for clients with CSA, at least regarding individuals, is by utilizing it before implementing prolonged exposure.
Although no research was found examining the use of STAIR with couples, the protocol of STAIR seems as if it would be easily adapted to couples therapy. The treatment consists of collaboratively identifying feelings; working on emotion management, including anger and anxiety; learning how to handle distress; increasing positive emotions; addressing power and control issues through role plays; and using role play to develop flexibility in interpersonal situations related to power; all of which are issues that can impact relationships. Not only do the themes of STAIR match many goals of couples treatment, but psychoeducation and skills training are interventions that are easily conducted with couples (Christensen et al., 2004; Christensen et al., 2010; Ellis, 1991; Monson et al., 2012) unlike many other interventions discussed previously that focus on individuals. Some of the typical STAIR psychoeducation and skills training could potentially be merged with forms of psychoeducation and skills training that have been shown to be useful with couples working through other forms of trauma.

**Cognitive restructuring.** In every research article found for sexually abused individuals, cognitive restructuring produced positive results whether conducted alone or in conjunction with other treatments. When utilized alone, the treatment was effective at improving depression, anger, guilt, low self-esteem, and especially anxiety (Rieckert & Moller, 2000; Moller & Steel, 2002). It is important to note that the both of those studies excluded clients with PTSD diagnoses, which explains why trauma symptoms were not listed as a symptom that was significantly affected.

No studies were found that compared cognitive restructuring alone with other therapies for sexually abused clients, but several comparison studies existed that utilized cognitive restructuring combined with other treatments. As discussed earlier, cognitive restructuring combined with exposure was as successful with sexually traumatized individuals as prolonged
exposure alone, but worked through different pathways that may be more useful when relationship issues are also a factor and the non-traumatized partner is present for couples therapy. If used in combination, there was also evidence that cognitive restructuring may be more beneficial if used before prolonged exposure.

Adapting cognitive restructuring to couples treatment is ripe with possibilities because there is no set protocol. There are cognitive distortions present in both relationship difficulties and trauma issues that can be addressed. Socratic questioning could be used to allow clients to identify and correct distortions that affect the partners individually and as a unit. This would also allow flexibility for the couple to examine how trauma impacts the relationship, as well as give them opportunities to repair disruptions in their relationship that are not related to CSA trauma.

The A-B-C model and thought records could also be used for each partner. Each partner could be taught both ways of evaluating their internal processes. Understanding each process could improve their own approach to the relationship. Once they have insight into their own distortions, they can share their process with their partner in hopes of gaining mutual understanding. For example, insight about low frustration tolerance in their traumatized partners can be especially important for non-traumatized males to develop in order to increase relationship satisfaction (Moller & Van Der Merwe, 1997). Additionally, by opening up about their internal thoughts and beliefs, greater differentiation can be created that may further improve the relationship.

There is much overlap between cognitive restructuring and REBT that could potentially help guide the adaptation of cognitive restructuring for couples. Similar to cognitive restructuring, REBT frequently focuses on challenging internal processes by using the A-B-C
model and can utilize exposure. In vivo exposure is frequently used to desensitize traumatic memories in individuals when using REBT (Ellis, 2001); however, there was no empirical evidence found supporting this method and there was research showing that excluding in vivo exposure was more effective with cognitive restructuring (Bryant et al., 2003; Cloitre et al., 2002).

Psychoeducation is an important component of teaching the A-B-C model to couples because it helps each partner to understand how their experience can directly start a cyclical A-B-C pattern that goes back and forth between them. If the couple is aware of problematic cyclical A-B-C patterns, such as arguments that go back and forth, they may become better at breaking the pattern.

Although there is no set protocol for REBT, Cluxton-Keller (2011) described six phases of REBT treatment that overlap with cognitive restructuring, which were already summarized in the rational emotive behavior therapy section of the above literature review. Each phase includes open dialogue between clients and the therapist, which make them easy to use in couples therapy.

Cognitive restructuring related to the relationship and sex-related trauma seems as if it would be an easy treatment to adapt to couples; however, there was no research on cognitive restructuring or similar REBT treatments with couples to justify their use. More concerning than the lack of research supporting the use of the treatment is that Moller and Van Der Merwe (1997) found that several of the assumptions used to justify REBT for couples use were not supported and could potentially create more complications in the relationship. Because of the evidence supporting the use of cognitive restructuring in limited use before prolonged exposure for sexually abused clients, and the concerns related to theories used to justify the use of REBT with
couples, it may be best to adapt cognitive restructuring, but not REBT, to couples therapy prior to prolonged exposure as previously established for individuals in Bryant et al. (2003).

**Cognitive-processing therapy.** It should come as no surprise that research on cognitive-processing therapy supported the use of the treatment because it was designed specifically for female rape victims. It was as useful as prolonged exposure at decreasing PTSD and depression symptoms, and more so at reducing guilt (Resick et al., 2002). Even more important is that the benefits of cognitive-processing therapy were also seen for clients who have depression or complex PTSD symptoms associated with CSA (Nishith et al., 2005; Resick et al., 2003).

Adapting cognitive-processing therapy for use in couples therapy could include similar methods of adaptation that prolonged exposure and cognitive restructuring use because there is much overlap in the protocol of the treatments. The trauma is written out in detail, including related thoughts and emotions that could be informative to the non-traumatized partner and create differentiation. A benefit to using cognitive-processing therapy compared to prolonged exposure is that it has all of the benefits of prolonged exposure, yet it only requires two sessions of individual focus on recalling the trauma, which allows more time for treatment aspects that are more easily adapted to couples work.

Like cognitive restructuring, cognitive-processing therapy heavily focuses on identifying and challenging cognitive distortions and maladaptive beliefs, including the utilization of A-B-C sheets. This could be modified to explore each partner’s distortions about the trauma and how it affects the relationship, as well as non-trauma related distortions that impact the relationship. Outwardly processing, challenging, and sharing feelings and distortions could be used to expand partner insight and break cyclical A-B-C patterns between the partners.
Cognitive-processing therapy also involves extra focus on self-blame and acceptance of the traumatic event. This focus could provide a powerful opportunity for non-traumatized partners to practice supporting their significant others. For several sessions, psychoeducation and processing of common rape-related beliefs (i.e., safety, trust, power, esteem, intimacy) are utilized. The themes of the beliefs directly relate to common issues in couples therapy, which means that that cognitive-processing therapy easily opens up an opportunity for the couple to discuss relationship issues, including how beliefs about the CSA may impact their relationship.

Overall, the similarities of cognitive-processing therapy to prolonged exposure and cognitive restructuring make the treatment a strong candidate for use with couples with a partner with CSA history. Although cognitive-processing therapy was not compared with cognitive restructuring followed by prolonged exposure, the protocol includes less time on individual-focused exposure interventions and allows for more time on interventions that are more easily adapted to couples therapy. This, coupled with empirical evidence showing that the treatment improves depression, PTSD, and complex PTSD symptoms that are present in CSA survivors, means that it may be worth considering this treatment instead of cognitive restructuring followed by prolonged exposure.

**Imagery rescripting.** Imagery rescripting involves adding other elements to prolonged exposure. It requires the use of imaginal exposure, and therefore, the same benefits and limitations described in the adapting of prolonged exposure section apply to the exposure portion of imagery rescripting. Much of the rescripting portion of the treatment is individually focused, which again can limit the non-traumatized partner to serving as a witness that can learn and gain insight into their partner’s experience, rather than being an active participant in that phase of therapy.
One aspect of the treatment that can be potentially modified for couples work could be to include the non-traumatized partner in the rescripted imagery. In individual rescripting, the clients visualize their adult selves entering the recalled memory to protect their younger selves, but another person, such as a romantic partner, can be visualized for additional help if the clients cannot view themselves as able to help enough. Potentially, the romantic partner in couples therapy could provide input as to how they would help protect the client in the rescripted scene. This adaptation would require much caution, however, because the general purpose of imagery rescripting is to empower the traumatized client; therefore, partner input could take away from the traumatized client’s empowering experience and should not be forced in place of the client protecting their younger self in the scene. Additionally, the way the partner suggests they would protect the traumatized client (e.g., using violence against the perpetrator) may not be helpful.

As an individual treatment for sexually traumatized clients, imagery rescripting was more successful than imaginal exposure alone, including having fewer dropouts and greater reductions in anger control, externalization of anger, hostility, and guilt (Arntz et al., 2007). Those findings could potentially indicate benefits for couples therapy. Translating the dropout rates could be tricky, but getting one half of the couple to buy into the treatment is likely better than having high dropout rates among individuals. Treatment benefits of reducing hostility and creating more appropriate expressions of anger could directly impact relationship satisfaction.

A modified version of imagery rescripting, called imagery modification, combined with cognitive restructuring was also found to be successful with individuals who feel contaminated due to CSA (Jung & Steil, 2012). This form of treatment again suffers from the limitation of being individually focused when adapting it for couples. Focused exploration of ways in which the traumatized client may feel worthless and unlovable could potentially be difficult for non-
traumatized partners to understand, which could negatively impact the relationship. Normalizing the feeling of being contaminated could be especially useful for both clients in couples therapy. The treatment also involves the traumatized client doing research on cell regeneration, and for couples therapy this could potentially be modified into a homework assignment that the couple does together in order to gain understanding and practice working productively together as a team.

Generally, there seems to be major issues that may raise concerns about using imagery rescripting for couples therapy in which a partner experienced CSA. The treatment was designed for those who experience images, flashbacks, or nightmares of the abuse (Smucker et al., 1995), and therefore may not be useful for clients without those symptoms. Imagery modification with cognitive restructuring is even narrower in its focus, and would make no sense to be utilized for clients that do not have beliefs or feelings of contamination. Even if the traumatized partner does have the symptoms shown to be improved by different forms of imagery rescripting, the concerns that the relationship is not a sufficient focus of treatment and that the non-traumatized partner could interfere with the empowerment aspects of the treatment remain.

Exposure, relaxation, and rescripting. The combination of exposure, relaxation, and rescripting was examined in one study in which three 2-hour sessions were used to treat clients with nightmares related to their trauma (Davis & Wright, 2007). In individual treatment, the sessions focus on exposure and rescripting the nightmares, psychoeducation regarding trauma and related sleep issues, and training the client to use relaxation techniques at home. Homework is a strong focus of the treatment. The treatment had a strong effect on various sleep related problems, such as nightmares and the amount of sleep, but only slight improvements in PTSD-related distress.
Adapting the treatment to couples therapy would involve the same problems as described for each component of the treatment in their respective sections above, particularly the individual client focus of exposure and rescripting. However, the relaxation techniques done by both partners in a relationship could increase the mindfulness of the couple and have some positive impact on the relationship. Overall, the study by Davis and Wright (2007) indicated that their approach is useful for trauma-related nightmares, but it had limited functionality for PTSD-related stress and there was no indication for how it would impact a relationship, which indicates that following their protocol would not be the best use of time for couples in which one partner experienced CSA. If the traumatized partner does express concern regarding nightmares, elements of exposure and rescripting could potentially be utilized if it is not already part of the established treatment for the couple, while relaxation could be focused on primarily as homework to decrease the sleep issues.

**Traditional behavioral couples therapy.** TBCT was shown to be effective for distressed couples through attempting to promote positive change through direct instructions and skills training (Christensen et al., 2004). The couples treatment is based on three primary strategies: behavioral exchange, communication training, and problem-solving training. Both the behavioral exchange and problem-solving training strategies of TBCT do not have overlap with individual sexual trauma treatments described above, but communication training does have some evidence of its support with CSA victims.

Behavioral exchange is based on the idea of reciprocity, in which both partners change behaviors for the other. This can include, but is not limited to, doing something new, eliminating or reducing the frequency of a behavior, or modifying a behavior that is already performed in the relationship. Bargain and compromise are therefore an important part of behavioral exchange,
with the overall goal of replacing undesirable behaviors with desirable ones (Rappaport & Harrell, 1972). In adapting this aspect of couples therapy to couples in which one partner experienced CSA, there are several considerations to keep in mind. First, it can set up a model that allows the traumatized partner to request modifications to behaviors that may trigger negative memories or reactions related to the trauma. Likewise, it could help the traumatized partner feel she can request additional supportive behaviors from her partner. Meanwhile, the non-traumatized partner can also feel that he is benefitting directly by having undesirable behaviors of the traumatized partner replaced with more desirable behaviors.

A significant concern of teaching the behavioral exchange model is that it could be used by one partner as manipulation in which one partner has expectations of specific behaviors in return for something they did for their partner. This form of manipulation, even if unintentional, can be problematic in any relationship, but it could be especially dangerous if it is used against a victim of CSA in which quid pro quo was used against the client as a child as part of the abuse; therefore, it could be useful to keep much of the negotiating in-session so the therapist can monitor for inappropriate uses of behavioral exchange before suggesting the use of the strategy at home. Even if quid pro quo was not used as a form of manipulation during the abuse, power and control issues that impact the victim can still be present (McCann et al., 1988; Morrow & Smith, 1995). Another concern for this approach is simply that behavioral exchange does not seem to have any research supporting its use for CSA victims. CSA victims are often vulnerable, and therefore it may not be wise to expose them to treatments that do not have empirical support behind them.

Communication training was not described in detail in the research articles summarized above for either couples therapy or the individual treatment for CSA survivors. This is likely
due to communication training being customized for the specific needs of clients. It is likely that training will be geared towards teaching partners to be empathic, supportive, and caring of each other due to those being issues in relationships impacted by CSA (Colman & Spatz Widom, 2004). To accomplish this, both speaking skills (e.g., “I” statements) and listening skills (e.g., reflective listening) are likely to be implemented. Communication training can help each partner feel understood regarding relationship issues, as well as when one partner wants to be understood when talking about more individual issues, including trauma issues.

Problem-solving training is a common couples intervention, but it is not a common CSA intervention. It has been shown to be useful as parts of TBCT, CBCT, BFT, and stress inoculation training for couples; however, BFT was not very useful with couples in which one partner was a combat veteran with trauma symptoms. It is likely that it is not frequently used in individual CSA treatment because problem-solving usually involves environmental problems while CSA treatment for adults often involves dealing with internal issues resulting from the past trauma. It is possible that training couples in problem-solving skills helps them appropriately handle such environmental problems without negatively impacting the internal issues of the traumatized client; although, there are potentially times in which reactions to trauma do create tension in the relationship that could appropriately be dealt with through problem-solving techniques taught in couples therapy. Additionally, there may be times in which one partner could help brainstorm for potential solutions to individual problems of the other partner, which could include issues related to trauma or stress (e.g., sleep difficulties).

Adaptation of the communication training aspect of TBCT is supported by several studies. Communication between partners, including communication about intimacy, is the most common relationship problem when a history of CSA exists (Pistorello & Follette, 1998).
Survivors of abuse are also likely to not view their partners as open to communication (Colman & Spatz Widom, 2004). Improving communication in couples can generate mutual healing and allow them to create a relationship in which it is safe to be open and vulnerable and to therefore increase satisfaction (Alexander, 2003; Button & Dietz, 1995; Johnson & Williams-Keeler, 1998; Pistorello & Follette, 1998). Additionally, support for communication training, including interpersonal skills training, was found when it was included as a component of useful individual treatments for CSA survivors in stress inoculation training and STAIR.

**Integrative behavioral couples therapy.** Like TBCT, IBCT was shown to be effective at improving relationship quality (Christensen et al., 2004). According to Christensen et al., IBCT attempts to improve relationships primarily through emotional acceptance and reactions to difficulties, which is done through three main strategies: empathic joining around the issue, working together to detach from the issue, and building tolerance to each partner’s reactions to issues. Likely due to functional differences between individual and couples therapy, there were no individual CSA studies found that support the three IBCT strategies.

Empathic joining is when vulnerable emotions are brought up related to an issue so that communicating with empathy and understanding can be practiced in therapy sessions. Vulnerable emotions are likely to be elicited in couples therapy if a partner has a history of CSA, which means it may be wise for the therapist to facilitate understanding and empathic communication. As discussed throughout this dissertation, improving understanding and empathy are common goals for the relationships of CSA survivors even though no treatments with individual survivors explicitly addressed those goals.

Working together to detach from an issue means that the therapist encourages the partners to describe and evaluate issues that arise rather than continuing with judgmental
reactions that escalate problems. Again, it makes sense that this is not a focus during individual treatments of CSA survivors because the non-traumatized partner would not be in the sessions to address it. With couples in which one partner has a CSA history, it is important to create a safe space to be vulnerable (Alexander, 2003; Button & Dietz, 1995; Johnson & Williams-Keeler, 1998; Pistorello & Follette, 1998); thus, it would be beneficial to incorporate this form of communication to increase that sense of safety, particularly when issues related to the trauma are present. Reducing judgmental reactions could also help reduce symptoms of self-blame.

During tolerance building to each partner’s reactions, the therapist analyzes both positive and negative functions when the couple is exhibiting problematic patterns and helps them become aware of their patterns so they can try to reduce how personally they perceive their partner’s reactions. Problematic behaviors can be encouraged in sessions and at home while the clients are paying attention to the patterns to allow for increased tolerance to be built. Much of the focus of this is to reduce strong negative reactions to the patterns of the partners, but attempts to directly change the original problematic behavior can be made as well. This form of intervention seems logical for couples therapy with clients who were sexually abused as children. People who experienced CSA are likely to have traumatic symptoms that are triggered and lead to problematic patterns in their relationships (Morrow & Smith, 1995; Pistorello & Follette, 1998), and their non-traumatized partners are likely to have anger and other reactions to their partners (Bacon & Lein, 1996; Maltz & Arian, 2001). It would be beneficial for non-traumatized partners to be able to identify their partners’ patterns, whether directly related to the CSA trauma or not, and understand them to prevent engaging in more problematic responses or taking them personally. Likewise, it would be helpful for the traumatized partners to have tolerance to their partners’ problematic patterns in order to prevent their own negative reactions that are taken
personally. Even though there are no individual studies supporting this approach for CSA survivors due to the nature of individual therapy, the intervention makes sense when considering the common relationship problems that couples experience when CSA has occurred in one member of the couple.

**Cognitive-behavioral couple therapy.** CBCT is one couples treatment that may not require much, if any, modifications for couples affected by CSA because it already has some, but limited, evidence supporting its use with this population (Monson et al., 2012). Research on the treatment with traumatized clients was not exclusively focused on CSA or other sexual trauma, with over half of the couples in the treatment group having a partner whose trauma was non-sexual. Treatment in Monson et al. (2012) was, however, more effective at improving relationship satisfaction and reducing PTSD symptoms of traumatized partners, which were mostly women, than a similar study that had fewer sexually traumatized participants and had more traumatized male partners (Monson et al., 2004), which seems to indicate that either the trauma type or the gender of the traumatized partner may be the key difference, or perhaps that both differences led to the greater improvement in Monson et al. (2012) than Monson et al. (2004). If the key difference is the gender of the traumatized partner, caution should be used when generalizing the treatment to men who have experienced trauma, but the research overall suggests the possibility that CBCT may be useful for couples impacted by CSA, particularly if the traumatized partner is female.

Due to the treatment already taking into account trauma and couples issues, there are not many modifications to be made in CBCT for couples affected by the CSA history of one member of the relationship. The treatment is summarized in the CBCT section of the literature review above, and is described in more detail in Monson and Fredman (2012). If modifications are
made to CBCT to make it more specific for CSA survivors instead of general trauma, they could include extra attention on traumatic symptoms that are more common in CSA survivors than people who have experienced other forms of trauma, such as negative attitudes towards the self, distorted beliefs about others, shame, guilt, and sexual confusion (Finkelhor, 1988).

**Proposed Treatment**

Based on the adaptation considerations described above, the following treatment is proposed for couples in which at least one partner had experienced childhood sexual abuse. It is also based on the idea that the couple is primarily looking to improve their relationship that has been impacted by the CSA history of one of the partners, rather than focusing more heavily on improving individual trauma responses with the supplemental help of a partner who is present in the treatment sessions.

The treatment proposed is based primarily on cognitive-processing therapy (Resick & Schnicke, 1992) followed by CBCT (Monson et al., 2009). This is because cognitive-processing therapy seemed to be the most effective therapy for CSA survivors that also allowed for balancing relationship issues that arise, and CBCT was the couples treatment that had the most support for treating couples while trauma issues are present. They are presented consecutively rather than concurrently due to findings suggesting too much overlap in different types of treatments can decrease the effectiveness of treatments for CSA survivors. The only sessions derived from each treatment that seem to have any overlap are the introduction to treatment and the treatment review sessions being conducted at the same time, but the actual interventions do not overlap. Cognitive-processing therapy precedes CBCT in order to reduce much of the trauma symptoms so that trauma responses are less disruptive when getting into more thorough couples treatment. The proposed treatment is 20 sessions in length at 60-minutes per session,
which means both treatments will need some modifications to fit within the allotted sessions. CBCT is originally designed to be 15 sessions at 75 minutes each (18 hours and 45 minutes total) and cognitive-processing therapy has been conducted effectively in 12 sessions with a total of 13 total hours. The proposed CBCT modification is partly based on a modification proposed by Monson, Fredman, and Macdonald (2009), which consisted of eight, two-hour long sessions and included additional homework to compensate for less time in session. In the proposed treatment, homework is reviewed at the beginning of every session.

The proposed treatment is intentionally designed to be 20 sessions in length. CBT treatments tend to be short term, with the median length of couples therapy being about 12 sessions (American Association for Marriage and Family Therapy, n. d.) and many managed care companies have historically not reimbursed treatment beyond 20 hour-long sessions (Carlock, 1999), although this may change with the advent of mental health parity laws and the Affordable Care Act. Even in Christensen et al. (2004) when couples were given up to 26 sessions, which they admitted knowing exceeds what most managed care organizations are likely to provide, couples still tended to opt for just over 20 sessions when encouraged to complete treatment for research. In order to make the treatment more inclusive for couples requiring treatment at managed care companies, and for those likely to not want to complete lengthy therapy, 20 sessions that are each 60-minutes in length seems to be reasonable.

As mentioned above, the following treatment is a modification of cognitive-processing therapy and CBCT protocols described in Resick and Schnicke’s (1992), and Monson et al. (2009; 2012):

**Stage 1: Rationale and Psychoeducation**

Session 1: Introduction to Treatment
Session 1: Introduction to Treatment

Summary: Begin building rapport. Educate couple on common relationship issues and how trauma impacts the relationship, as well as trauma in general and comorbid symptoms. Explain treatment rationale, including that trauma is a heavier focus early in treatment to limit trauma responses that could disrupt more relationship oriented interventions.

Homework: Traumatized client asked to write about the meaning of the traumatic event for them. Begin weekly You’ve Been Caught Doing Something Nice form to inject more positive behaviors in the relationship (Appendix B).

Session 2: Safety Building

Summary: Goal is to decrease negative, hostile, and critical behavior through psychoeducation and basic communication and coping skills training to create a safe environment throughout treatment, including in session and at home. The difference between thoughts and feelings are taught to prepare clients for homework.

Homework: A-B-C sheets (Appendix A) provided for both clients. Each is expected to attempt at least one A-B-C sheet related to the relationship. Practice the timeout technique (Appendix C) without provoking an argument. Utilize Learning About My Anger at least once before next session (Appendix D).

Stage 2: Cognitive Processing Therapy

Session 3: Written Account of Exposure

Summary: Traumatized client is expected to write out traumatic event with as much detail, emotions, and thoughts as they can remember. They are expected to allow
their feelings to come out genuinely, and read the account aloud. The non-traumatized client is expected to observe and understand to the best of their abilities what the trauma means to the traumatized client, as well as offer support when appropriate.

Homework: Partners are expected to read the traumatic account together. Each client is expected to complete at least one A-B-C sheet regarding their personal reactions related to the trauma.

Session 4: Challenging Cognitive Distortions

Summary: The couple is taught to identify and challenge their maladaptive beliefs with extra focus on self-blame and acceptance when discussing beliefs regarding trauma. Focus is also spent on teaching the couple how to break A-B-C patterns that have become evident in sessions and A-B-C homework sheets.

Homework: Clients are expected complete at least one A-B-C of their choice.

Session 5: Faulty Thinking Patterns

Summary: Beck and Emery’s (1985) six types of faulty thinking (i.e., Arbitrary inference, selective abstraction, overgeneralization, magnification and exaggeration, personalization, polarized thinking) are taught. Patterns most common in each client are identified for treatment focus.

Homework: Each client is expected to do an A-B-C sheet relating to a faulty thinking pattern they commonly do.

Session 6: Beliefs Affected by Trauma: Safety

Summary: Clients are educated about the first of five beliefs likely affected by CSA and the traumatized client’s beliefs are identified and analyzed. Positive beliefs that
may have been disrupted and negative beliefs that may have been confirmed are explored and the maladaptive beliefs are worked on. The belief discussed in this session is safety. Each partner’s beliefs related to safety are discussed after they are educated about trauma’s effects on them.

Homework: The written traumatic experience should be read and A-B-C sheets are completed by each partner, related to safety if possible.

Session 7: Beliefs Affected by Trauma: Trust

Summary: Maladaptive beliefs related to trust are taught, identified, and explored. Each partner’s beliefs related to trust are discussed after they are educated about trauma’s effects on them.

Homework: The written traumatic experience should be read and A-B-C sheets are completed by each partner, related to trust if possible.

Session 8: Beliefs Affected by Trauma: Power

Summary: Maladaptive beliefs related to power are taught, identified, and explored. Each partner’s beliefs related to power are discussed after they are educated about trauma’s effects on them.

Homework: The written traumatic experience should be read and A-B-C sheets are completed by each partner, related to power if possible.

Session 9: Beliefs Affected by Trauma: Esteem

Summary: Maladaptive beliefs related to esteem are taught, identified, and explored. Each partner’s beliefs related to esteem are discussed after they are educated about trauma’s effects on them.
Homework: The written traumatic experience should be read and A-B-C sheets are completed by each partner, related to esteem if possible.

Session 10: Beliefs Affected by Trauma: Intimacy

Summary: Maladaptive beliefs related to intimacy are taught, identified, and explored. Each partner’s beliefs related to intimacy are discussed after educated about trauma’s effects on them.

Homework: The written traumatic experience should be read and A-B-C sheets are completed by each partner, related to intimacy if possible.

Session 11: Re-written Trauma Meaning

Summary: The traumatized client re-writes and shares the meaning of the traumatic event now that there has been treatment regarding CSA trauma. Clients are reminded that although the cognitive-processing phase is over, they are encouraged to continue working on maladaptive beliefs and faulty thinking patterns on their own and they are welcome to bring up issues related to them if they are stuck. Clients are prepared for transition to modified cognitive-behavioral couples therapy.

Homework: Both clients are provided Trauma Impact Questions (Appendix E) to be completed and shared with each other prior to the next session.

Stage 3: Cognitive-Behavioral Couples Therapy

Session 12: Listening and Approaching

Summary: Education on identifying avoidance related to trauma and relationships. Communication techniques worked on to decrease conflict and increase positive interactions. Primary communication skills taught are listening, paraphrasing, sharing thoughts and feelings, problem-solving, and decision-making.
Homework: Write down day-to-day people, places, things, and feelings avoided that were discussed in session (i.e., creating an approach list). Spend 5 minutes communicating with each other prior to future session, with an emphasis on paraphrasing.

Session 13: Listening and Approaching/Introduction to Sharing Thoughts and Feelings:

Emphasis on Feelings

Summary: The themes of session 12 are likely to carry into this session due to time. Transition to sharing thoughts and feelings with an emphasis on feelings should begin. Clients are taught to identify when their partners are seeking understanding of thoughts and feelings rather than requesting problem-solving help (i.e., communication channels). Clients are taught to identify, express, and reflect feelings. Sharing is practiced with an emphasis on feelings.

Homework: Complete at least one in vivo behavior off of the approach list to reduce trauma stress problems. Practice identifying what channel of communication their partner is using at least once per client. Each partner is to identify a feeling their significant other expresses on the Catch Your Significant Other’s Feeling (Appendix F) form once per day.

Session 14: Sharing Thoughts and Feelings: Emphasis on Feelings

Summary: Complete any tasks unfinished in session 13 and continue sharing with an emphasis on feelings and paraphrasing.

Homework: Each client completes an in vivo behavior off of the approach list, practices identifying channels of communication once before the next session, and completes another week of the Catch Your Significant Other’s Feeling form.
Session 15: Sharing Thoughts and Feelings: Emphasis on Thoughts

Summary: Clients are taught to share thoughts, rather than leaving partners with assumptions, so that they can understand each other better. Remind that trauma influences reactions of feeling under threat. Educate that thoughts lead to feelings and actions. Sharing is practiced with an emphasis on thoughts.

Homework: Complete another in vivo behavior off of the approach list, preferably building off of a previous one (e.g., talking to a stranger if a previous in vivo behavior was being in the presence of a stranger). Once per day, each partner is expected to identify a thought and feeling of their partner’s related to an event, and record these on the *Catch Your Significant Other’s Thoughts and Feelings* form (Appendix G). At least one thought should be related to a problem influenced by CSA trauma.

Session 16: Sharing Thoughts and Feelings

Summary: Complete any tasks unfinished in session 15 and continue sharing with an emphasis on thoughts and paraphrasing. Towards end of session, practice sharing and paraphrasing both thoughts and feelings.

Homework: Complete another in vivo behavior off of the approach list and complete another *Catch Your Significant Other’s Thoughts and Feelings* form.

Session 17: Problem-Solving

Summary: Focus is on the problem-solving and decision-making communication channel. The goal is to reduce the impact of CSA trauma by improving communication, decreasing conflict, and decreasing behavioral avoidance of places or situations that are still avoided. Suggested guidelines for problem-solving include using
listening and paraphrasing skills to identify the problem, sharing thoughts and feelings to identify why the issue is important and what each person’s needs are, brainstorming, deciding on an agreeable solution, and deciding when to try the solution.


Session 18: Problem-Solving

Summary: Continue problem-solving training. Review identifying communication channels and any stuck points.

Homework: Complete What Have We Learned? form together (Appendix H).

Session 19: Review and Applying to Other Relationships

Summary: Homework from last session is used as starting point for discussion. Clients are given the opportunity to discuss further topics related to treatment that they feel need more focus. Review understanding of trauma and its impact on the relationship, increasing positivity, safety building, and communication.

Additional focus is on identifying what they can do when interacting with others outside of the relationship (e.g., other family members, friends, co-workers) who have not received the same training. Models and role plays are utilized for practice.

Homework: Notice and record positive behaviors of others outside of the relationship at least daily (Appendix I). Practice a communication skill with at least one person other than their significant other daily and document it (Appendix J). Complete Trauma Impact Questions Review (Appendix K).

Session 20: Treatment Review and Future Planning
Summary: Compare Trauma Impact Questions from the beginning of treatment with the Trauma Impact Questions Review and discuss gains made. Partners are expected to use communication skills learned during review and planning for future without treatment. New goals that clients want to work on after treatment are written down. A plan for how to approach any relapse of issues is discussed.

Discussion

Many studies examine CBT treatment effectiveness for adult survivors of CSA and several studies focus on CBT tailored to couples, but the amount of research examining CBT treatments for couples impacted by the CSA history of one partner is limited. A common starting place for practitioners working with this population is modifying couples therapy to include interventions designed for general PTSD that does not take into consideration complications of CSA. The proposed treatment in this paper is a potential new starting point for treating couples with a history of CSA that impacts their relationship, while also considering pragmatic treatment constraints that many clinicians and clients face.

When looking at individual treatments designed for survivors of CSA, cognitive processing therapy had the best mix of empirical data supporting improvements in symptoms related to CSA trauma, including complex trauma and depression (Nishith et al., 2005; Resick et al., 2002; Resick et al., 2003), and has a protocol easily adapted to couples treatment. Cognitive-processing therapy was not compared to all of the other individual treatments for CSA in past research; however, there was support for its use over prolonged exposure (Resick et al., 2002), which was as or more effective at treating sexual assault victims than EMDR, stress inoculation training, and cognitive restructuring (Foa et al., 1999; Foa et al., 2005; Rothbaum et al., 2005). Also, there was evidence that cognitive-processing therapy supports improvements in complex
trauma, which is a significant concern for CSA survivors, as the only other treatment found to show evidence supporting improvements in complex trauma is prolonged exposure (Resick et al., 2003). Additionally, cognitive-processing therapy was less limited than the other CSA focused treatments in individual-focused interventions and with more attention paid to maladaptive beliefs and thoughts, which makes it easier to include a non-traumatized partner as an active participant in therapy without simply relegating the partner to being a passive observer for a majority of the treatment.

When looking at CBT oriented treatments for couples, CBCT seemed to be the best choice for use with CSA survivors. There were several treatments that focused almost entirely on the trauma and utilized the non-traumatized partner simply as a supplemental tool for treating the traumatized partner (e.g., prolonged exposure, EMDR): As such they are inappropriate for use with couples that are also working on relationship issues. There were also several treatments that were shown in past research to be effective with treating couples in general (e.g., TBCT, IBCT; Christensen et al., 2004). Although these may be useful if trauma symptoms are reduced to normal functioning levels, CBCT is effective in improving both general PTSD trauma and relationship issues, with the possibility of it being even more effective if the traumatized partner was sexually traumatized and female (Monson et al., 2004; Monson et al., 2012).

When formulating the proposed treatment, it was determined that a safe approach would be to include both cognitive processing therapy and CBCT to ensure both CSA-related issues and relationship-related issues are treated. It was also determined that it may be wise to limit overlap in the treatments due to studies showing that interventions of two different types of treatments being conducted simultaneously can reduce effectiveness of treatments (Foa et al., 1999; Foa et
al., 2008), while treatments that were conducted sequentially often added benefits and did not detract from each other (Cloitre et al., 2010; Cloitre et al., 2012).

The sequence recommended in this study is to use cognitive-processing therapy first to reduce trauma, including symptoms more prominent in CSA survivors, then to use CBCT. The only sessions designed to simultaneously incorporate elements of both treatments were the first two sessions and the final session. These sessions overlapped to reduce redundancy since both treatments involve similar introductory sessions that include educating about trauma, building rapport, and creating a safe environment, as well as similar termination sessions that include reviewing treatment gains and preparing for life after treatment.

Modifications were made for both cognitive-processing therapy and CBCT stages of the proposed treatment. Cognitive-processing therapy modifications involved creating discussions that incorporated the non-traumatized partner whenever possible, particularly during cognitive-processing portions that involved challenging cognitive distortions and maladaptive beliefs, including homework assignments (e.g., A-B-C sheets), which easily can be opened up for discussion with both partners. Additionally, modifications were made to fit the proposed treatment into 20 one-hour sessions, while keeping the primary goals and interventions of both stages of treatment intact, for the sake of making the treatment more accessible to those who have treatment duration limitations. If there are no limits to time per session or number of sessions, and couples are willing to attend for longer-term treatment, it may be more useful to use each session of cognitive-processing therapy as described in Resick and Schnicke (1992), but modified for couples, followed by unmodified CBCT as described by Monson and Fredman (2012).

Limitations and Future Research
Although the proposed treatment and the research found supporting it are promising, there are several limitations that require attention. First, a majority of the articles examined do not focus directly on the impact of singular interventions; rather, the interventions utilized in most articles are combined with other interventions. This creates the problem of pinpointing how much each intervention impacts clients.

Another limitation to this dissertation is that there was a gender bias in articles found regarding CSA. A majority of the articles examined treatments for sexual assault survivors that focused on female participants. In the few studies that referred to CSA trauma in couples work, there was also a focus on the females being the victims of the abuse rather than males who were victims of CSA. The few studies found on couples therapy in which it was the male who was traumatized, tended to be about combat related trauma rather than CSA trauma. In samples in which males were the patients with PTSD accompanied by non-traumatized female partners in couples therapy (Monson et al., 2004), the results were less positive for treatment improvements and, therefore, larger samples with male patients with PTSD may show completely different results for both individual treatments for CSA and for couples interventions. It is therefore recommended that for future research focus more on individual males with CSA histories as well as couples treatment with males who experienced CSA, to make treatments more generalizable.

Additionally, this dissertation is based on examinations of previous studies, which tend to be biased towards heterosexual couples. The majority of the studies on couples found while searching for articles for the review section, focused on heterosexual couples. The results of Monson et al. (2012) were promising because they suggested that the few same-sex couples in their sample showed the same trends as the heterosexual couples in improvements in both PTSD and relationship satisfaction. However, not enough same-sex couples participated to show
statistically significant results for the population or to feel confident in generalizing those findings. Thus, it cannot be assumed that same-sex couples would respond similarly to treatments designed based on research on heterosexual couples. Like the limitations due to gender bias, treatments could potentially become more generalizable if future research focused more on same-sex couples.

It should be noted that a majority of the research examined lacked ethnic diversity. The studies generally consisted of samples that were comprised of over 50 percent Caucasian participants. However, none of the studies reviewed identified race or ethnicity as having any impact on the outcomes.

Finally, an obvious limitation of this dissertation is that there was no test of the proposed treatment. The proposal is based on numerous studies that have found evidence for certain interventions, but the accumulated treatment is based on a hypothesis established through critical thinking to assemble the supported interventions. Although it is likely that the proposed treatment is beneficial for couples in which CSA history exists, further research testing the treatment will be necessary to provide empirical evidence to support its use.

Conclusion

Those who have experienced CSA are likely to have additional challenges in their relationships. Although CSA is frequently viewed as an issue that requires individual attention (Zayfert & Becker, 2007), couples therapy can be important or even necessary for those in serious relationships (Maltas, 1996). Couples therapy can potentially benefit the survivor of the abuse, the survivor’s partner, and the relationship as a whole. Many CBT interventions have been found in prior research to be effective for adult individuals who experienced CSA. Some
CBT trauma treatments that can be used in couples therapy, but research on CBT treatments for couples impacted by CSA was very limited.

It was concluded in this dissertation that a combination of modified cognitive-processing therapy and CBCT may be a strong treatment that could prove to be effective for couples in which one partner experienced CSA. The treatment was designed based on previous research that focused primarily on heterosexual couples and traumatized females; therefore, the proposed treatment is more likely to be supported as a useful treatment for heterosexual couples with the traumatized partner being female.

The proposed treatment would allow clinicians to address specific issues that couples are likely to face when one partner experienced CSA. The cognitive-processing therapy portion can address distorted beliefs related to CSA, such as shame, guilt, and sexual anxieties, while also opening up the conversation for the partner to understand and process his own distorted beliefs. The CBCT portion ensures that there is empirically supported treatment for couples impacted by trauma involved, and due to the cognitive-processing therapy preceding it, specific CSA concerns that are not addressed by CBCT should not be of concern.

This dissertation provided a critical look at how individual CBT interventions for CSA survivors and for couples may translate into a treatment for couples impacted by CSA. There is much evidence from prior research that indicates the proposed treatment is likely to be effective, but more research on the subject is still needed, including a test of the proposed treatment. Although this dissertation does not provide direct empirical evidence supporting the proposed treatment, it does offer an important starting place for future CBT research for couples effected by issues related to CSA.
References


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<tr>
<td>Activating event</td>
<td>Beliefs</td>
<td>Consequences: (A) Emotions (B) Behaviors</td>
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<td>Example: Alex not looking at me when I talk</td>
<td>Example: Alex doesn’t find me interesting. I bore everybody)</td>
<td>Example: A: Ashamed, depressed. B: Left party, more likely to decline party invitation.</td>
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Binggeli (2010).

http://www.nelsonbinggeli.net/NB/CBT-CR.html
Appendix B

You’ve Been Caught Doing Something Nice (Monson et al., 2009)

Week of _______

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Appendix C

Steps to Stop: Calling an Effective Time-Out (Monson et al., 2009)

S = Self
1. What is the level of your own distress?
(0 = none, 10 = as intense as you can imagine)
5-6 = yellow light
7-8 = red light
2. Time-outs are for your sake.

T = Time-out
1. Nonverbal and verbal indication
2. Immediate stop in communication
3. Agree on an amount of time and circumstance for returning

O = Outlet
1. BREATHE.
2. Avoid activities that fuel your negative emotions.
3. Clarify what one or two things are most upsetting.
4. Consider what one thing you can do to improve communication.

P = Process
1. Return at agreed upon time and circumstance.
2. Resume communication, with focus on your goal for improvement. REMEMBER: TIME-OUT IS ONLY AS GOOD AS TIME-IN.
Appendix D

Learning About My Anger (Monson et al., 2009)

_______________________________ (Name)

Situation: ____________________________________________________________

What were the earliest signs that I was angry? ________________________________

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

What did I do to increase or decrease my anger (e.g., breathing)? _________________

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

What are the earliest signs that my significant other is angry? ____________________

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
Appendix E

Trauma Impact Questions (Adapted from Monson et al., 2009)

1. How has trauma or traumatic stress-related problems (TSP) affected our relationship to date? How has it impacted my thoughts, feelings, and behaviors about our relationship?

___________________________________________________________________________
___________________________________________________________________________
___________________________________________________________________________
___________________________________________________________________________
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2. How has trauma or traumatic stress-related problems (TSP) affected other important relationships for me or my loved one?

___________________________________________________________________________
___________________________________________________________________________
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Appendix F

Catch Your Significant Other’s Feeling (Monson et al., 2009)

Week of ______

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<td>Annoyed</td>
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Appendix G

Catch Your Significant Other’s Thoughts and Feelings (Monson et al., 2009)

<table>
<thead>
<tr>
<th>Significant other:</th>
<th>Event</th>
<th>Thought</th>
<th>Feeling</th>
</tr>
</thead>
<tbody>
<tr>
<td>Example</td>
<td>Hear a noise outside</td>
<td>“Someone is trying to break in”</td>
<td>Afraid</td>
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</table>
Appendix H

What Have We Learned? (Adapted from Monson et al., 2009)

Trauma Impact Questions

1. What specific ideas or skills have we learned through therapy that we want to remember and keep doing? Put a star next to your favorite skill that you use.

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2. When we recognize that we are getting away from practicing these skills, we will:

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Appendix I

Someone Else has Been Caught Doing Something Nice (Monson et al., 2009)

Week of ______

<table>
<thead>
<tr>
<th>Person Caught:</th>
<th>Thing They Did:</th>
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<tbody>
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<td>Sunday</td>
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Appendix J

Applying the Skills to Other Relationships (Monson et al., 2009)

Week of _______

<table>
<thead>
<tr>
<th></th>
<th>Significant Other 1 Skill used, person used with</th>
<th>Significant Other 2 Skill used, person used with</th>
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</thead>
<tbody>
<tr>
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Appendix K

Trauma Impact Questions Review (Adapted from Monson et al., 2009)

1. How have my or my significant other’s TSP symptoms improved as a result of this treatment?

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2. How has my relationship with my loved one and others improved as a result of this treatment?

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