AN INTAKE INTERVIEW AND ASSESSMENT INSTRUMENT FOR ADULTS PRESENTING WITH A HISTORY OF CHILDHOOD SEXUAL ABUSE

by

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TABLE OF CONTENTS

TABLE OF CONTENTS (continued)

TABLE OF CONTENTS (continued)

LIST OF TABLES

ABSTRACT

The prevalence of adults having a history of childhood sexual abuse (CSA) is estimated to be approximately 28% for females and about 16% for males. Since the mid-1980s several programs have been developed for treatment of this population. Much has been written to guide therapists who are trying to detect this history in clients who have repressed or suppressed the abuse. However, little research has been done in the area of interview and assessment of that portion of this population that presents with a known history of CSA. This project used counselor and research input to develop an instrument that is thorough, yet reduces interview time, and that offers the potential of greater use by counselors to whom clients with known CSA histories are referred. A field test of the preliminary instrument was conducted and a copy of the intake used for that field evaluation is included.

CHAPTER 1

INTRODUCTION

Child sexual abuse first began to appear on the agenda of mental health and child welfare professionals in the mid-1970s. Since then, the field has developed rapidly. It was only in the early 1980s that mental health workers, and society in general, began to become aware of the substantial adult population who had experienced childhood sexual abuse (CSA) and programs began to be established in the mental health community for adult survivors of CSA. Initially, one of the key problems in serving that population was that clients did not typically present with a history of CSA, because most adults had repressed or suppressed the memory of the abuse. Programs developed specifically to treat this population have only been in existence for a very few years (Finkelhor, 1986). Because of these reasons, research on assessment instruments specifically for this population has been minimal, and has focused primarily on the use of existing instruments and techniques in detecting a CSA history in adults. This project was developed specifically to arrive at a design for an intake and assessment instrument for use in adults presenting with a known history of CSA.

Prevalence of a History of Childhood Sexual Abuse in Adults

The existence of a large population of adults in the United States who have a history of CSA has been well documented (Finkelhor, Hotaling, Lewis & Smith, 1990; Peter, Wyatt, & Finkelhor, 1986). In the most recently documented nationwide study of this population, completed in 1985, a sample of 1,145 men and 1,481 women responded to screening questions about their sexual abuse

experiences (Finkelhor et al., 1990). In this study, a history of sexual abuse was acknowledged by 27% of the women and 16% of the men.

Adult Symptomatology

In a review of the research on the impact of child sexual abuse, Browne and Finkelhor (1986) identified several long term effects as observed in studies of adult females. The breadth of these effects is nearly as broad as the subject of psychology itself. In the studies researched, major effects were noted on emotional well-being, self-perception, interpersonal relating, sexuality, and social functioning. Adult women victimized as children were more likely to manifest depression, self-destructive behavior, anxiety, feelings of isolation and stigma, poor self-esteem, a tendency toward revictimization, and substance abuse. Difficulty in trusting others and problems with sexuality in such areas as sexual dysphoria, sexual dysfunction, impaired sexual self-esteem, and avoidance of or abstention from sexual activity were also noted. Victims had more marital disruptions, less sexual satisfaction, and lower levels of spirituality than non-victims. Also noted was the fact that these effects are further influenced by factors associated with the abusive acts and events subsequent to the abuse, including duration and frequency of abuse, relationship to the offender, type of sexual act, use of force or aggression, age at onset, sex of the offender, adolescent versus adult offender, telling or not telling, parental reaction, and institutional response.

With regard to male victims, Finkelhor (1990) reports that the effects on men are similar to those on women in the areas of marital disruption, sexual satisfaction, and levels of religiosity. In another study of males and females (Briere, Evans, Runtz, and Wall, 1988), both genders had a statistically

equivalent incidence of suicide attempt, and males were equally as likely as females to experience psychological after effects, such as dissociation, anxiety, depression, anger, sleep disturbance or a hypothesized (by the researchers) post sexual-abuse trauma. In a study of male subjects (Dimock, 1988), three common long term characteristics were reported by victims: sexual compulsiveness, masculine identity confusion, and relationship dysfunction. Other characteristics present included substance abuse, depression, psychosis, and various personality disorders. A study of male psychiatric outpatients indicated that a history of CSA was also prevalent in subjects having major affective illnesses, anxiety or dysthymic disorders, and adjustment disorders (Swett, Surrey, & Cohen, 1990). In addition, Swett et al. reported a tendency toward a higher rate of borderline personality disorder in abused versus non-abused subjects.

In a study of 1,019 consecutive admissions of adult psychiatric inpatients (Brown & Anderson, 1991), those with a history of CSA (n=96) had diagnoses including adjustment disorder, alcohol use disorder, other substance use disorder, major depression, dysthymia, bipolar disorder, anxiety disorder, post-traumatic stress disorder, eating disorder, organic mental disorder, schizophrenia, delusional disorder, psychosexual disorder, and borderline personality disorder.

Chu and Dill (1990) found that dissociative symptoms are much higher in victims of CSA than in non-victims, and multiple personality disorder as been associated with a history of CSA in other studies (Braun, 1989; Baldwin, 1990).

Other adult manifestations of a CSA history include obesity (Bradley, 1985), chronic pelvic pain (Lewis, 1991; Walker et al., 1988), inhibited sexual

desire (Golden, 1988), premenstrual syndrome (Paddison et al., 1990), various sexual dysfunctions (Andron & Ventura, 1987; Feinauer, 1989; Jehu, 1989), bulimia and anorexia nervosa (Hall, Tice, Beresford, Wooley, & Hall, 1989), chronic headache (Domino & Haber, 1987), somatization disorder (Morrison, 1989), and self-mutilation and self-blame (Shapiro, 1987).

The wide range of symptomatology possible for adults presenting with a history of CSA significantly complicates the intake interview and assessment process, and very little information is available to guide this process.

Intake and Assessment Protocols

Seligman (1986, pp. 102-104) identifies five purposes for the intake interview: (1) Determine suitability of client for agency services; (2) Assess and respond to urgency of client's situation; (3) Familiarize client with agency and counseling process; (4) Begin to engender positive client attitudes toward counseling; and, (5) Gather sufficient information on presenting problem, history, and dynamics to allow formulation of diagnosis and treatment plan.

Seligman (1986) also notes that depending on the type of agency and the nature of the clientele, the intake process may take as long as four hours and may involve as many as two or three sessions. The intake interview and assessment of an adult client presenting with a known history of childhood sexual abuse (CSA) is stressful for the client and complex for the intake counselor, so minimizing the duration of this stress on the client is also important.

Purpose of the Study

The purpose of this thesis project was to develop an intake interview and assessment instrument that provides sufficient data for a preliminary DSM-III-R

(American Psychological Association [APA], 1987) diagnosis, treatment plan, and counselor selection or referral in a non-profit public agency using contract counselors. In the agency for which the new intake instrument was being developed, the intake counselor must also provide preliminary DSM-III-R diagnoses for each client, define general long-term treatment goals and objectives with the client, and estimate the time required for completion of treatment.

The primary objectives of this project were to: (1) develop a new intake and assessment instrument that will reduce the discomfort of the client while getting the most essential information in the least amount of time, (2) meet the general objectives of the intake interview as defined by Seligman (1986), and (3) provide sufficient data for diagnostic and treatment planning requirements of the intake counselor.

Current Practice

To understand the current practice within the local community, twenty agencies advertising in a human services directory that they provide services to adults with a CSA history were polled and asked to provide copies of their intake forms and assessment instruments for this population (Appendix B). Two agencies responded with intake instruments designed specifically for this population. Both use the Dissociative Experiences Scale (DES) (Ross, Anderson, Heber & Norton, 1990), which is a 28-item, self-administered questionnaire that screens for dissociative disorders. A client score above a predetermined threshold is highly suggestive of a dissociative disorder.

If a client scores above the DES screening threshold, both agencies then administer a Dissociative Disorders Interview Schedule (DDIS). The DDIS is a

131-item structured interview that allows the rater to make DSM-III-R diagnoses of all the dissociative disorders, somatization disorder, major depressive episode, and borderline personality (Ross, Heber, Norton, & Anderson, 1989). It also inquires about history of substance abuse, childhood physical and sexual abuse, history of sleepwalking, entering trance states, having imaginary playmates, Schneiderian first-rank symptoms of schizophrenia, 16 different extrasensory experiences, and 16 secondary features of multiple personality disorder. Ross et al. (1990) report that the the DDIS has a specificity of 100 percent for the diagnosis of multiple personality disorder. They also say that it takes 30 to 45 minutes to administer.

The agency for which the new intake instrument was targeted is unique in that it has virtually no full-time, salaried counseling staff and employs primarily contract counselors for treatment of its clients. Because of the low fee provided to the contract counselors, and because they are not paid for time spent reading client files in the agency, an additional problem exists in providing the contract counselors adequate documentation of the intake interview, assessment, preliminary diagnosis, and treatment plan for each client. The current process provides a 20 to 40 page client file, which is seldom read, for the agency office and a one page form for the assigned counselor that contains only minimal client data. The client then has to undergo another intake process by the assigned contract counselor which results in additional client expense in terms of money, time, and emotional stress.

Definitions

There is controversy among research professionals in defining the term: childhood sexual abuse (Finkelhor et al., 1990; Friedman, 1990). For the

purposes of this study, the four screening questions used in the 1985 national survey (Finkelhor et al., 1990) will apply. In summary, a CSA history means that when the client was 18 years of age or younger, they experienced anything they now think of as sexual abuse, like: (1) someone trying or succeeding in having any kind of sexual intercourse; or (2) someone trying to touch them sexually, grabbing them, kissing them, or rubbing up against their body either in a public place or private; or (3) someone taking nude photographs or them, or exhibiting parts of their body to them, or performing a sex act in their presence; or (4) someone sodomizing them, or forcing them to give or receive oral sex.

Assumptions

For the purposes of this project, a key assumption made was that the client has a memory, although it may be somewhat vague, of a specific instance of CSA. The importance of this assumption is that often clients reporting to mental health professionals, either individual counselors or in public agencies, present with a variety of symptoms and a total lack of awareness of a CSA history (Shapiro & Dominiak, 1990). The target agency for the new intake and assessment instrument almost entirely deals with clients who are aware of their history, or are being referred by another counselor because of the counselor's suspicion that a CSA history exists.

Summary

This introductory chapter has presented a review of the prevalence of a history of CSA in adults, a summary of the wide variety of possible symptomatology presented by this population, a discussion of intake and assessment protocols available for use with this population, an assessment of

current local intake and assessment practice, and has presented key definitions and assumptions used in controlling the parameters of this project.

CHAPTER 2

LITERATURE REVIEW

This chapter provides a review of literature addressing various aspects of intake, assessment, diagnosis and treatment planning specific for adults with a CSA history. It begins with reviews of literature addressing background information such as prevalence of CSA in adults and the content of intake interviews. This is followed by a discussion of assessment instruments currently being used in diagnosing and treating this population. A discussion of literature regarding specific elements of the intake instrument comes next, including the referral source, past counseling experiences and psychiatric hospitalizations, suicidal ideation and past attempts, presenting problems and symptomatology, developmental history, medical background, and current medications. This is followed by a discussion of literature pertaining to diagnosis, goal setting, treatment planning and documentation.

Background Information

Prevalence of Childhood Sexual Abuse in Adults

Peters et al. (1986) analyzed the research findings in 17 separate studies on the prevalence of CSA in adults. These studies were primarily conducted in local areas, and many differences in sampling techniques were noted. This resulted in a wide range of prevalence of CSA, from 6% to 62% for women and from 3% to 31% for males. Factors accounting for the wide variation of prevalence rates included differences in definitions of sexual abuse, true differences in the populations sampled, and methodological factors. For example, one study asked only to report abuse incidents prior to puberty, and

some studies included noncontact abuse while others did not. In addition, data on the prevalence of CSA in males was nearly nonexistent.

A 1985 nationwide study funded by the National Center on Child Abuse and Neglect and the Los Angeles Poll appears to be the most thorough and demographically representative survey of prevalence of CSA in adults. In this study, 1,145 men and 1,481 women were interviewed (Finkelhor et al., 1990). Within this study, 28% of the women, and 16% of the men reported a history of CSA. In addition, 42% of the men and 33% of the women reporting a history of CSA also reported that they had never disclosed the experience to anyone.

Finkelhor et al. (1990) also analyzed the risk factors for CSA. Several background characteristics were found statistically related to the risk of victimization. Both men and women were likely to have been victimized if they reported that their family life had been unhappy, if one of their natural parents was predominantly absent during their childhood, and, strangely enough, if they were currently living in the Pacific region (California, Oregon, Washington, Alaska, and Hawaii). Men were at higher risk if their family came from English or Scandinavian ancestry. Women were at higher risk if they received an inadequate sex education, and women over 60 years of age were at lower risk compared to younger women.

Bagley (1990) reports that perhaps because of media attention to the problems of CSA, and improved awareness programs in the schools, the prevalence may be decreasing. A survey of 750 young adult women from Calgary, Alberta resulted in prevalence numbers generally decreasing from the older women to the younger women in the study. Prevalence ranged from 36% for women 27 years of age down to 21% at 18 years of age.

Intake and Assessment Protocols

Seligman (1986, pp. 102-104) identifies five purposes for conducting an intake interview before treatment is begun. They are: (1) Determining suitability of the client for the agency's services; (2) Assessing and responding to the urgency of the client's situation; (3) Familiarizing the client with agency and counseling process; (4) Beginning to engender positive client attitudes toward counseling; and (5) Gathering sufficient information on presenting problems, history, and dynamics to allow formulation of diagnosis and treatment planning. She also state that the assessment process can take more than one interview and may last up to four hours.

Cormier and Cormier (1991) identify 11 discussion categories for assessing client problems. They are: purpose of assessment, identification of the range of problems, prioritization and selection of issues and problems, and identification of present problem behaviors, antecedents, consequences, secondary gains, previous solutions, client coping skills, client's perceptions of the problem, and problem intensity. They also go on to point out that a natural sequence of information gathering will evolve in each interview. They also state that the amount of time and number of sessions required to obtain all the information required will vary with each client.

In the only text found by the researcher to deal specifically with sexual trauma assessment (Hindman, 1989), a very detailed and methodical 24-page approach is presented for collecting data from either child or adult survivors of CSA. The five perspectives used by Hindman in her interview approach include: background information, symptomatology, relationships, developmental history, and situational factors. An analysis of a 15-year old boy

is presented as the case example of the technique. The interview time for the example was about six hours.

Kaplan and Sadock (1981) also describe the importance of the mental status examination in assessment. They divide the information into eight categories, which are: overall appearance, sensorium, thought processes, thought content, sensory-motor and perceptual processes, nature and regulation of affect, self-regulation, and bodily functions.

Assessment Instruments

The use of a variety of interview techniques and assessment instruments has been documented in various studies over the past few years. This section will discuss one author's results with an unstructured interview technique and present findings obtained on evaluation of four instruments used with adults having a CSA history.

Ellenson (1985) developed a predictive syndrome based on thought content and perceptual symptoms shared by women survivors of CSA. His research was designed to predict a history of CSA in survivors who had no memory of CSA experience. However, his unstructured method of questioning and his focus on the mental status exam still make it appropriate for consideration as a part of the overall thrust of a new intake interview. It is also notable that the symptoms he defines were universally experienced by all his subjects in the study who had a CSA history, and were not observed in women who did not experience CSA. Thought content disturbances included recurring nightmares, recurring and unsettling intrusive obsessions, recurring dissociation, and persistent phobias. Perceptual disturbances included

recurring illusions, recurring auditory hallucinations, recurring visual hallucinations, and recurring tactile hallucinations.

Four studies using the Trauma Symptom Checklist (TSC-33) were evaluated by Briere and Runtz (1989). The TSC-33 is a 33 item instrument designed to provide a brief, abuse-oriented measure of traumatic impact, most notably in the area of long-term CSA effects. Each of the 33 items is rated for frequency of occurrence on a four-point scale. These items may be read to the client or self-scored by the client. Combinations of the items are summed to produce five symptom subscales (Dissociation, Anxiety, Depression, Post-Sexual Abuse Trauma-hypothesized [PSAT-h], and Sleep Disturbance). As a result of their studies, Briere and Runtz suggest adding another seven symptoms to the list to bolster the reliability of the Sleep Disturbance subscale and form a new Sexual Problems subscale.

The Response to Childhood Incest Questionnaire (RCIQ) is another self-report instrument that assesses a range of commonly reported symptoms experienced by adult survivors of CSA (Edwards & Donaldson, 1989). Edwards and Donaldson (1989) completed a factor analysis of the RCIQ which revealed seven factors which corresponded to hypothesized stress response themes experienced by survivors of traumatic events. These factors included vulnerability and isolation, fear and anxiety, anger and betrayal, reaction to the abuser, sadness and loss, and powerlessness. In addition, four factors corresponded to the DSM-III-R diagnostic criteria for post-traumatic stress disorder, including intrusive thoughts, avoidance and intrusive emotions, detachment, and emotional control and numbness. They also discussed the usefulness of the RCIQ as a pre- and post-treatment measure.

Ross et al. (1989) administered the Dissociative Disorders Interview Schedule (DDIS) to 80 subjects previously diagnosed as having multiple personality disorder, schizophrenia, panic disorder, or eating disorder (n=20, each). The DDIS is 131-item structured interview that is used in determination of DSM-III-R diagnoses of dissociative disorders, somatization disorder, major depressive episode, and borderline personality. It also inquires about history of substance abuse, childhood physical and sexual abuse, history of sleepwalking, entering trance states, having imaginary playmates, Schneiderian first-rank symptoms of schizophrenia, 16 different extra-sensory experiences, and 16 secondary features of multiple personality disorder. Per their report, the DDIS has an overall interrater reliability of 0.76 and a specificity of 100% and a sensitivity of 90% for the diagnosis of multiple personality disorder. Ross et al. also state that the DDIS requires about 30 to 45 minutes to complete.

The Dissociative Experiences Scale (DES) is a 28-item self-report instrument which is a screening instrument for dissociative disorders, not a diagnostic instrument (Ross et al., 1990). This instrument asks subjects to mark along a line ranging from 0 to 100%, with no intermediate graduations, the percentage of time they experience certain dissociative type behaviors. Instructions with the DES state that when the average score is above 30%, as measured by the rater, the presence of a dissociative disorder is indicated. Steinberg, Rounsaville, and Cicchetti (1991) investigated the utility of the DES as a screening instrument for the identification of patients at high risk for dissociative disorders using scores from 45 subjects. They report that the number of false negative diagnoses rises rapidly when a DES cutoff greater

than 20 is used. They recommend a DES cutoff of between 15 and 20 to minimize the risk of false negatives.

Feinauer (1989) and others have used the Derogotis Symptom Checklist-Revised Edition (SCL-90R), which is a 90-item self report symptom inventory designed to reflect nine psychological symptom patterns including somatization, obsessiveness, interpersonal difficulty, anxiety, hostility, phobic anxiety, paranoia, and psychoticism (severe alienation, delusional, or dissociative thought patterns). Each item is rated on a five-point scale of distress ranging from "not at all" to "extremely"

Elements of the Intake Interview

Seligman (1986), and Cormier and Cormier (1991), both provide detailed documentation of a recommended intake format. Seligman (1986) divides the elements of the intake interview into seven categories: identifying information, presenting problem, present difficulties and previous disorders, present life situation, family, developmental history, and medical history.

Cormier and Cormier (1991) choose a different division, and include eight major categories: identifying information, general appearance, presenting problem, past psychiatric/counseling history, educational/job history, health/medical history, social development history, and family, marital, and sexual history.

With regard to the psychodynamics of abuse, McCann, Pearlman, Sakheim, and Abrahamson (1988) suggest that adults with a history of CSA should be assessed within a schema framework. The practical use of their model is to provide a framework for assessing individual response patterns which can then be used for treatment planning. Their premise is that adult

survivors most often come to therapy to deal with schemata that are nonadaptive, or maladaptive, in the context of their current lives. These schema, which may have been adaptive in their childhood experience, are now negative factors in their lives. They analyze five main areas of schemata -- safety, trust, power, esteem, and intimacy -- and they analyze all five with respect to one's self and with respect to others. They recommend that the relations among the sexual abuse, life experiences, and the development of schemata must be explored thoroughly.

Complete assessment includes a detailed history involving the nature of the abuse, the relationship to the perpetrator, and the dynamics of the abuse experience (Gelinas, 1983). These are areas, therefore, that the intake interviewer must be sensitive to throughout the interview because the information may come at various times during the interview.

Past Counseling, Hospitalizations, Suicide Attempts, and Substance Abuse

Sgroi and Bunk (1988) identify two distinct patterns of presentation for adult survivors of CSA -- early presentation and late presentation. It is in this context that getting an accurate history of past counseling, hospitalization, suicides, or other self-destructive behaviors is essential.

Sgroi and Bunk (1988) define early presentation as characterized by an older adolescent or young adult, in their late teens or early twenties. These clients are often coming into the clinic because of symptoms associated with drug or alcohol abuse, acute psychotic reactions, self-mutilating behaviors, eating disorders or suicide attempts. Sometimes there will be a history of two or more of these events. It is common for that person to have experienced multiple modes of abuse and to have been raised by at least one and sometimes two or

more impaired parent figures. Adult survivors of CSA who fit this presentation pattern typically have "a life context of multiple victimization experiences, inconsistent parenting, separation or abandonment, severe physical or mental handicaps, poverty, or social injustice" (p. 150). Clinicians may recognize in this client a damaged goods syndrome with low self-esteem, impaired body image, and a sense of damage and unworthiness, with repeated self-destructive behaviors. Sgroi and Bunk further postulate that only after stabilization of the acute condition can the issues of CSA be addressed in these clients. The presenting symptomatology must be stabilized, and the individual must demonstrate some capacity to impose internal controls before treatment for CSA can usefully begin. This can sometimes take several months or a few years.

On the other hand, the late presentation is characterized by a client in their late twenties or older who appears to others as outwardly well adjusted, competent, and successful (Sgroi & Bunk, 1988). They will also commonly have sought psychotherapy in the past, usually for some other complaint. They may have even disclosed their CSA history to a previous clinician and made an agreement not to pursue the CSA issues at that time. Their previous psychotherapy may have been focused on complaints such as depression, anxiety, multiple somatic complaints, or sexual dysfunction. Despite a past history of competence and apparent success, they may suddenly become symptomatic in a way that can now be perceived as connected to the CSA history (p. 152). Precipitating factors have included: (1) the cooling of a marital relationship, sometimes accompanied by sexual dysfunction, and always accompanied by distancing behavior and intimacy problems; (2) the experience

of genuine intimacy in a relationship, sometimes for the first time in their life, within the marital relationship or an extramarital relationship; (3) the client's child reaching an age or a developmental stage threatening to the client, perhaps around the age of the CSA of the client; (4) a major life change for the survivor; or (5) the client's experience of personally identifying with a victim of CSA, perhaps their own child, the child of a friend, a relative, or attendance at a workshop or watching a movie about CSA (pp. 152-153). Adult survivors manifesting a late presentation pattern may be alarmed by their recent disturbing symptomatology but generally have a past history of good to excellent functioning in their lives and are unlikely to engage in suicide attempts or to experience psychotic breaks as long as there is no past history of the above. It is for this reason that getting an accurate history of previous hospitalizations and suicide attempts or ideation is so critical. Once the clinician is convinced that the adult survivor does not require external controls or psychotropic medication, treatment can begin.

Cormier and Cormier (1991) suggest that the intake interviewer determine the following for each period of previous counseling, psychological or psychiatric treatment: type of treatment, length of treatment, treatment place or person, presenting complaint, outcome of treatment and reason for termination, hospitalization data and drugs prescribed for emotional or psychological problems.

Presenting Problems and Current Symptomatology

Cormier and Cormier (1991) identify several items for exploration of the presenting problem by the interviewer, including: quoting the client's presenting complaint; time of onset; other events occurring at the time;

frequency of occurrence; the thoughts, feelings, and observable behaviors associated with it; where and when it occurs the most, or least; events or persons that precipitate it, make it better, or make it worse; the level at which it interferes with the client's daily functioning; previous solutions or plans have been tried for the problem and with what result; what made the client decide to seek help at this time; or, if referred, what influenced the referring party to refer the client at this time?

Long-term impacts on quality of life. Hawes and Kern (1989), using an Adlerian perspective, identify seven life tasks, or facets of everyday life, into which human energies are directed and from which a persons needs are met. Initially Adlerian therapists considered that satisfaction of almost all conceivable needs depended on the solution of problems of cooperation in the areas of occupation, social relationships, and intimate relationships. Contemporary Adlerian theorists now suggest that in addition to these three major life tasks, there are four minor life tasks: self-worth, meaning in life, nurturing, and leisure.

Hawes and Kern (1989) go on to define occupation task as any kind of work that is useful to the community. Social relationships have to do with membership in the human race, and a sense of community. Fulfillment of the intimate relationship task implies a close union of mind and body and the utmost possible cooperation with a partner. Self-worth is seen as an internal judgment of self-adequacy in relation to a person's perception of the worth of others. Meaning in life has to do with a sense of spirituality, the universe, the existence and nature of God, or a higher power, and how a person relates to these. Nurturing has to do not only with biological reproduction, and parenting of one's own children, but also the teaching and giving of self to the young, the

needy, and to the parenting of one's parents if necessary. Leisure refers to the ability to satisfy one's self in the use of unstructured time. By assessing a client's balance in these seven areas, the interviewer can get an assessment of the client's overall quality of life and can begin to assess the areas of the client's life being effected by the current problems and symptomatology.

Meiselman (1990) lists several general effects of CSA supported empirically in her review of the research. Many of these begin in childhood with the initial incidence of abuse and are carried through to adulthood. Symptoms effecting various aspects of the survivor's quality of life include: guilt, shame, anxiety, fear, anger and hostility, low self-esteem, substance abuse (including food), hysteria, depression and self-destructiveness (including suicide and self-mutilation), distrust, continued revictimization, unstable and stressful relationships.

Other long-term consequences of CSA seen in female survivors (Hall & Lloyd, 1989) include panic attacks, intense reactions to gynecological procedures, fear of men, parenting problems, and compulsive and obsessional problems.

Lew (1990) identified additional long-term consequences frequently reported by male survivors to include: fear of feelings and an accompanying need to control feelings and behavior, their own and others'; compulsive caretaking; sleep disturbances such as nightmares and insomnia; violence or fear of violence; discomfort with being touched; compulsive sexual activity; social alienation; inability to sustain intimacy in relationships or entering abusive relationships; and negative body image.

According to Gil (1990), the intake interviewer must take a detailed history and focus on obtaining descriptions of problem behaviors in order to understand the breadth and depth of the clients presenting problems and recommend appropriate interventions. Gil also presents a detailed set of questions targeted at determining problematic behaviors in many of the areas listed above.

Specific DSM-III-R symptomatology. The preceding section discussed the general effects and long-term consequences of CSA in terms of generalized symptoms and impacts on the survivor's quality of life. Some agencies operate under regulations that require specific DSM-III-R diagnoses in the development of treatment plans and establishment of treatment goals and objectives. DSM-III-R Axis I categories often seen in adult survivors of CSA include: eating disorders, including anorexia nervosa, and bulimia nervosa (Palmer, Oppenheimer, Dignon, Chaloner, & Howells, 1990); gender identity disorders (Gilgun & Reiser, 1990); psychoactive substance use disorders (Rohsenow, Corbett, & Devine, 1988); mood disorders, including bipolar disorders, and depressive disorders (Brown and Anderson, 1991); anxiety disorders, including panic disorder and obsessive compulsive disorder (Bryer, Nelson, Miller, & Krol, 1987), and post-traumatic stress disorder (Greenwald & Leitenberg, 1990); somatization disorder (Morrison, 1989); dissociative disorders, including multiple personality disorder (Coons, Bowman, & Milstein, 1988; Ross, 1991); sexual disorders, including sexual desire disorders , sexual arousal disorders, orgasm disorders , and sexual pain disorders (Jehu, 1989; Tharinger, 1990); sleep disorders (Craine, Henson, Colliver, & MacLean, 1988); and adjustment disorders (Brown and Anderson, 1991). Axis II personality disorders often seen

in adult survivors of CSA include borderline personality disorder (Ogata et al., 1990) and obsessive compulsive personality disorder (Briere & Runtz, 1988). Specific diagnostic criteria for each of these disorders can be found in the DSM-III-R. A summary of the DSM-III-R diagnostic criteria for disorders and conditions commonly observed in adults with a CSA history are provided in Appendix C.

Personal History

Seligman (1986), Hindman (1989), and Cormier and Cormier (1991) all point out the importance of the intake interviewer getting a complete personal history. Seligman separates the developmental history from the family background, while the Cormiers break the client's history into four separate areas: educational and job history; health and medical history; social and developmental history; and family, marital, and sexual history.

Family of origin. In dealing with adult survivors of both intrafamilial and extrafamilial CSA, understanding the dynamics and characteristics of the survivor's family of origin, and the meanings attached to the abuse by the survivor, are critical to understanding the severity of the trauma and the behaviors developed to cope within the family system (Alexander & Lupfer, 1987; Carson, Gertz, Donaldson, & Wonderlich, 1990; Cole & Woolger, 1989; Feinhauer, 1988, 1989; Houck & King, 1989; & Ingram, 1985).

In Carson et al. (1990), a majority of women studied viewed their families of origin as generally unhealthy in terms of autonomy and intimacy, and current relationships with their families of origin were characterized by less intimacy and more intimidation, triangulation, and fusion than a normed group.

As described by McGoldrick and Gerson (1985), one way of quickly understanding and recording family relationships and history is through use of genograms. Genograms provide family information graphically and in a way that provides a quick assessment of complex family patterns and the family constellation, and a tangible representation of relationships within the family, including siblings and other generations and their siblings. They provide a clear view of important life events, such as births, illnesses (psychiatric and medical), deaths (including suicides and homicides), marriages, divorces, vocational choices, family roles and emotional bonds. In addition, they provide a convenient documentation tool for understanding and recording family functioning and dysfunctions, values, abuse patterns (emotional, physical, sexual, and substance), abandonments, communication patterns and parental "tapes", family customs, religion, education, gender role models, and expression and resolution of anger, sadness, and grief.

Molest experience. As discussed by Feinauer (1988, 1989), Finkelhor (1986), and Wyatt and Newcomb (1990), several factors influence the severity of the effects of CSA on adult survivors, and the meaning assigned by survivors to the abuse. These include: the type of abuse (including type of sexual act); location of the abuse; relationship of the offender to the victim; gender of the offender; use of force and aggression; age at onset and age at last incidence; duration of the abuse; telling or not telling as a child; parental reaction; and institutional response. Hindman (1989) also focuses considerable attention on the relationship of the offender to the victim's significant others, and to system participants. In the section of her assessment called Developmental

Perspective, she focuses on the victim's sexuality development before and during the molest period.

Developmental history. Seligman (1986) breaks the developmental history into infancy, early childhood, middle childhood, late childhood/puberty, and adulthood. She also includes in the adulthood portion of the developmental history questions related to the client's educational, vocational, social, relationship, and sexual experiences.

Cormier and Cormier (1991) divide the social/developmental history into preschool, middle childhood, adolescence, young adulthood, middle adulthood, and late adulthood. They also separately cover the client's education, vocation, social, relationship, and sexual history.

Medical history and overall status of current health. This area of the interview will result in an understanding of the significant medical and health issues in the life of the CSA survivor. In their interview format, Cormier and Cormier (1991) include prior significant illnesses and surgeries, current health-related complaints or illnesses, treatment received for current complaints, significant health problems in the client's family of origin, sleep patterns, appetite levels, exercise patterns, current medications (to include recreational drug usage), and allergies.

Diagnosis, Goal Setting, and Treatment Planning

The remaining tasks of the intake counselor are to establish a preliminary diagnosis of the client's disorder(s), to work with the client in establishing long range goals and objectives for recovery, to determine an appropriate initial treatment plan.

Preliminary Diagnosis

Once the client's history is taken, the intake counselor must then convert the anecdotal information obtained into a diagnosis. Cormier and Cormier (1991) use a format for the DSM-III-R diagnoses that would be acceptable to most mental health agencies which require a multiaxial diagnosis. They include the descriptive titles and DSM-III-R codes for Axis I clinical syndromes and Axis II personality disorders. Axis IV psychological stressors are ranked and an overall stressor severity is assigned. For Axis V global assessment of functioning, the DSM-III-R code should be determined for both current functioning as well as highest functioning over the past 12 months (APA, 1987). A summary of definitions and DSM-III-R diagnostic criteria for disorders and conditions commonly associated with adults having a history of CSA is included in Appendix C.

Preliminary Goal Setting

Goals are necessary in order to develop a treatment plan, to assess progress, and to give direction to the counseling process. It is also a mutual process, involving clients and their counselor. The goals should be clear and measurable, with time limits estimated for their completion. They may be long-term or short-term (Seligman, 1986).

The overriding goal of treatment of adult survivors of CSA is typically to repair the client's self-image which is always severely damaged by the abuse (Gil, 1990; Nasjleti, 1980; Rosenthal, 1988). In addition, CSA survivors also must sense empowerment before they can combat their sense of entrapment, despair, helplessness, isolation, or self-blame. Adult survivors must internalize a sense of control of their lives. They must understand that they can change,

and that their efforts need to be focused on those situations which they wish to change. Then they can develop realistic plans for those changes.

Other goals supporting the overall recovery process will typically include instilling hope, resolving specific issues of the trauma and associated memories, grieving, and affiliation (Gil, 1990).

Preliminary Treatment Planning

Treatment phasing, important in working with any client, is critical with adult survivors because of fears and doubts they have about themselves and others. They may have a limited ability to interact and responsd, and their lives are constricted by fear, shame, guilt, longing, and isolation. Counseling must proceed cautiously, with sensitivity and purposefulness. Only after a therapeutic alliance is formed can therapy proceed, and this is done slowly and deliberately. The process includes setting a safe structure, establishing a trusting relationship, validation, allowing denial, and giving the client choices. (Gil, 1990).

Both individual and group therapy techniques have been shown to be effective in treating adult survivors of CSA (Hall, Kassees, & Hoffman, 1986). They also suggest that many group members also undergo individual therapy using each to support the other. Some clinicians (Goodman & Nowak-Scibelli, 1985) require that group members be in concurrent individual therapy. Group therapy is especially effective with adult survivors of CSA working on issues of trust, letting go of shame and guilt, accepting the self as worthwhile and lovable, and confronting powerlessness (Blake-White & Kline, 1985; Wooley & Vigilanti, 1984).

In their review of the literature, Dye and Roth (1991) identified three modalities of treatment of adult survivors of CSA: crisis intervention, psychoanalytic psychotherapy, and cognitive-behavioral therapy. McCarthy (1986) suggests a cognitive-behavioral model for use with survivors of CSA in understanding and modifying the process of victimization, especially in regaining a sense of their sexuality.

Gender issues between clients and individual counselors may be important to the client initially, but there is nothing that fundamentally prevents the possibility of good counseling between clients and counselors of opposite sexes (Westerlund, 1983)

Summary

This chapter provided a review of literature addressing various aspects of intake, assessment, diagnosis and treatment planning specific for adults with a CSA history. There has been very little written specifically dealing with the intake and assessment of this population. The Dissociative Experiences Scale and the Dissociative Disorder Inventory Schedule are two assessment instruments currently being widely used with this population, but they have limited applicability because such a wide variety of symptomatology is commonly seen in assessing this population. The importance of diagnosis, goal setting, and treatment planning for this population was also reviewed.

CHAPTER 3

METHODOLOGY FOR INSTRUMENT DESIGN AND EVALUATION

Chapter 1 posited the need for the development of a new intake instrument for use with adult survivors of CSA who have specific memories of their CSA history. Chapter 2 discussed current literature relevant to content of structured intake interviews and reviewed literature defining areas of assessment interest for this population. This chapter describes the approach used to gather data from which the preliminary list of items was selected, identifies a preliminary list of intake interview items, discusses the method used in establishing counselor ratings of the utility of these interview items, describes the preliminary instrument design selected for field evaluation, and outlines the process used for that evaluation.

Data Gathering

Three areas of interest were explored in developing the list of items for potential inclusion in the preliminary intake instrument. Firstly, common practice was assessed by requesting copies of intake and assessment instruments from 20 mental health providers in the local community who advertise that they provide service to adult survivors of CSA. Two organizations responded with intake and assessment instruments specific to this population. Intake instruments from all other respondees consisted of a generalized form requesting client identification and financial data, some very limited information about the presenting problem, and a simplified symptom checklist consisting of one or two word descriptors. A few agencies responded by saying they had no standardized intake format and that their counselors used their own. Appendix

B provides a list of agencies polled and a sample of the letter sent requesting the information.

Secondly, several contract counselors at the agency for which the new intake and assessment instrument was proposed were polled regarding (1) their use of current intake information, (2) their likes and dislikes about the current intake information, and (3) what changes could be made to current practice in order to improve both the utility of the information and likelihood that they would use it. In addition, intake counselors at the agency were also polled regarding their attitudes, likes and dislikes about the current intake process. Appendix D provides the form used for the survey of the contract counselors' utility of client intake information.

Finally, a thorough review of research literature and published texts on the subject of adult survivors of CSA was conducted, in addition to a review of current counseling texts on the subject of intake interviews, to provide a format and construct basis for developing items for consideration in the preliminary instrument design.

Item Identification: Intake Interview, Assessment, and Diagnosis

This section identifies the items chosen for consideration in the preliminary design of the intake interview and assessment instrument. Items are presented in the order in which they might reasonably appear in an actual structured interview instrument.

Common practice dictates that client identification, financial, and referral information is self-reported on a preprinted form usually administered by a receptionist. The remainder of the items form the basis for the structured interview.

Client Identification, Referral, and Financial Information

1. Client Identification: (Cormier & Cormier, 1991; Seligman, 1986)
    - Name?
    - Address?
    - Home and work telephone numbers?
    - Social security number (common practice)?
    - Date of birth?
    - Gender?
    - Ethnic/cultural affiliation?
    - Marital/relationship status?
    - Other members of the household: names and ages?
        - Spouse or significant other?
        - Children?
        - Other relatives living in the same household?
        - Other biological children, if living elsewhere?
    - Occupation?
    - Employer information (common practice)?
        - Name?
        - Address?
        - Full time or part time?
2. Referral Information (common practice):
    - Name, address of agency?
    - Name of referral source?
    - Appropriate contact information?
    - Reason for referral?

Status of referral documentation?

3. Financial Information (Common Practice):

Name and address of person to be billed if other than client?

Sources and amounts of income?

Medical insurance company?

Counseling coverage?

Funding support from referral agency?

Counseling History, Psychiatric Hospitalizations, Suicide Attempts, and Substance Abuse History

The nature and importance of this section of the intake interview are discussed in Cormier and Cormier (1991) and Sgroi and Bunk (1988).

4. Past Counseling Experiences or Psychological Hospitalizations (for each experience):

Dates of treatment period?

Type of treatment received (inpatient, outpatient, individual or group counseling)?

Reason for treatment (presenting problem)?

Outcome of treatment?

Reason for terminating treatment?

Drugs prescribed for emotional or psychological problems?

5. Current Counseling or Psychological Treatment Relationship:

Name of counselor?

Contact information?

Date begun?

Type of treatment (individual, couple, family, or group)?

Frequency of treatment?

Presenting problem?

Progress?

Drugs currently prescribed (type, name, dosage)?

Intentions for continuation, termination?

6. History of Suicide Attempts (for each attempt):

Date?

Method?

How interrupted?

Current ideation (thought, plan, time, opportunity)?

7. Substance Abuse History (for each substance):

Substance?

Dates of abuse or addiction?

Treatment received (counseling, 12-step, outpatient, inpatient, none)?

How long clean or sober?

Current usage?

Presenting Problems

8. Presenting Problems (Cormier & Cormier, 1991)

(For each problem presented, identify specific DSM-III-R symptomatology for later diagnosis.)

Client's description of current problem?

Time of onset?

Other events occurring at the time?

Frequency of occurrence?

Thoughts, feelings, and behaviors associated with the complaint?

When and where it occurs the most, or least?

Events or persons that precipitate it, make it better or worse?

Previous solutions or plans that have been tried, with what results?

What made the client decide to seek help at this time?

If referred, what precipitated referral at this time?

Personal History

9. Family of Origin (Alexander & Lupfer, 1987;Carson, Gertz, Donaldson, & Wonderlich, 1990; Cole & Woolger, 1989; Feinhauer, 1988, 1989; Houck & King, 1989; & Ingram, 1985; McGoldrick & Gerson,1985) (Use a genogram format to identify and pictorially show the relationship of significant family members.)

   a. Identify family members (include ages of those living, if deceased note age at death, year of death, and cause):

      Parents (including step and adoptive)?

      Siblings (including half-brothers and sisters, and including miscarriages and infant deaths, if known)?

      Children (including adoptions and stepchildren, and those not currently living with you. Also note miscarriages and infant or childhood deaths)?

      Grandchildren, if appropriate?

      Others, if significant, might include aunts, uncles, cousins grandparents, or great-grandparents.

   b. Other information of each family member identified, as known:

      Character?

Notable behaviors?

Role in the family?

Education?

Vocation?

State of health (note major medical or psychological problems)

c. Dates of clients marriages and divorces?

d. Other family marriages and divorces?

e. Emotional bonds or splits of immediate family?

f. Significant family customs, rituals, or ceremonies?

g. Family secrets or myths:

Substance abuse (note for each relevant family member)?

Emotional, physical, or sexual abuse?

h. Family patterns

Gender roles (dominance, submission, power)?

Communications?

Display of affection or sexuality?

Sexual attitudes and values?

Crisis management (death, grief, accidents, birth defects, psychological or medical problems)?

Emotional expression (anger, sadness, joy)?

Approaches to decision making and problem solving?

Significance of religion?

Mobility?

i. Client role models (positive, negative)?

j. Client's perception of inherited traits, if any?

k. Notable ways client is conforming to, or has departed from family patterns?

10. Molest Experience and Sexuality (Feinauer, 1988, 1989; Finkelhor, 1986; & Wyatt & Newcomb, 1990):

a. Molest experience (if only one perpetrator, record first and last incidents, or incidents with most current traumatic memory; for multiple perpetrators, summarize the experience with each perpetrator):

Age (for each event, or age at onset and at termination)?

Name of molester?

Relationship to survivor?

Frequency of molest?

Sexual activity?

Level of force or coercion?

Location?

Others involved?

Sensory memories?

Sexual response?

Childhood disclosure?

Who?

Response?

Legal action?

Adult disclosure?

Who?

Response?

Client's feelings of guilt, or responsibility for the molest?

b. Sexuality assessment:

Sexual identity?

Sexual orientation?

Arousal assessment?

Sexual phobias or obsessions?

Sexual dysfunction?

11. Developmental History (Cormier & Cormier, 1991; Seligman, 1986)

For each of the periods below, discuss significant events, medical or mental issues, discipline, self-esteem, sexuality, significant friendships and relationships, academic, vocation, spirituality):

Early childhood (0 to 5 years)

Middle childhood (6 to 12 years)

Adolescence (13 to 18 years)

Early adulthood (19 to 25 years)

Adulthood (over 25 years to present, with emphasis on current functioning, marriage,divorce, family, vocation, sexuality, and use of leisure time)

12. Medical History and Overall Status of Current Health (Cormier & Cormier, 1991; Seligman, 1986):

Prior significant illnesses, hospitalizations, and surgeries?

Current health related complaints or illnesses?

Onset (acute or chronic)?

Treatment received?

Any history of serious physical symptoms for which doctors could find no explanation?

Sleep patterns?

Appetite levels?

Exercise patterns?

Allergies?

Current medications (name of drug, dosage)?

Assessment

13. Current Effects of Childhood Trauma (Hawes & Kern, 1989)

(Evaluate effects on current functioning in each of the following seven areas as: none, mild, medium, or severe. For each area rated medium or high, give specific examples of currently maladaptive thoughts, feelings, or behaviors.)

Self-worth?

Intimate relationships (including sexuality)?

Nurturing (including parenting, and parenting of parents)?

Social relationships (sense of community, extended family)?

Spirituality?

Occupation?

Leisure?

14. Summarization of Symptomatology Pertaining to DSM-III-R Diagnoses (APA, 1987):

Preliminary Diagnosis

15. Preliminary Multiaxial DSM-III-R Diagnoses (APA, 1987):

Axis I (clinical syndromes, including V-codes):

Names and DSM-II-R codes?

Axis II (personality and specific developmental disorders):

Names and DSM-III-R codes?

Axis III (summary of physical disorders):

Axis IV (assessment of psychological stressors):

List of stressors within past 12 months, ranked in terms of impact.

Overall assessment of stressors?

Axis V (assessment of global functioning):

Current assessment?

Highest level of functioning in past 12 months?

Preliminary Goal Setting and Treatment Planning

The following discussion pertains to Sets 16 and 17 on the counselor questionnaire.

At the agency for which the new intake instrument was targeted, preliminary goals and objectives (Gil, 1990; Nasjleti, 1980; Rosenthal, 1988; Seligman, 1986) are generalized for adult survivors of CSA. Specific goals and objectives for each client are established by the client and the individual or group counselor to whom they are assigned. Progress toward specific goals and objectives are measured, reviewed with the client, and reported every 90 days by individual and group counselors.

Generalized goals include reduction of the effects of the trauma, improvement of associated problems, and resumption of any development arrested by the abuse. Generalized objectives include assessing client defenses and their patterns or rules of maintenance, establishing a therapeutic

relationship with the counselor and group members, replacing self-defeating practices with those that are self-determined and healthy, and beginning the process of self-actualization. These are reviewed with each client at the end of the intake process, along with a discussion of individual and group therapy processes.

Preliminary treatment planning at the agency consists of a determination of the need for individual or group therapy, or both, and the readiness of the client for the group therapy experience. Selection of individual therapy is most often dependent on the client's ability to pay for services. If a client is assessed as being prepared and appropriate for group, and has limited resources, the agency recommends the client enter group therapy because of its therapeutic benefits (Carver, Stalker, Stewart, & Abraham, 1989) in addition to its cost effectiveness.

Counselor Rating of Items

Four contract counselors from the agency for which the new intake interview instrument was intended were each given a set of the intake items and asked to rate the utility of the information provided by the interview. Counselors who participated in the rating were selected by consultation with the treatment coordinator for the agency.

Only item sets 4 through 17, described in the previous section, were rated because item sets one through three are primarily administrative in nature and are mandated by current practice in most agencies. The counselors were asked to rate both the utility of each of the 14 sets of items as a set and the utility of each of the items within the set. Appendix E provides instructions and a copy of the forms used for counselor evaluation of item sets and items.

A five-point scale was used for rating individual sets and items within the set. Counselors rated the utility according to the following terms: "leave out", "seldom useful", "sometimes useful", "often useful", and "must have".

Results of this counselor evaluation of instrument item sets and modification to the sets based on this evaluation are summarized in Chapter 4.

Preliminary Instrument Design

Based on an assessment of initial counselor input regarding the utility of the current intake instrument, information gained from review of the literature, and counselor input regarding utility of the various item sets and items within the set, a preliminary instrument was designed for field evaluation. A copy of this instrument is included in Appendix F: Preliminary Intake Interview and Assessment Instrument Designed for Field Evaluation.

Field Evaluation of Preliminary Instrument

All five counselors who conduct intake interviews of adults with a history of CSA at the agency for which the interview and assessment instrument is being targeted were used in the field evaluation. They were given a questionnaire to use after completion of the intake interview to rate various aspects of the instrument. Although the intake instrument is similar in content to the existing instrument at the agency, it is vastly different in terms of organization, style, prompting of the interviewer, and detail. Each evaluator was asked to evaluate the instrument with a minimum of two intakes. Appendix G provides the questionnaire used for counselor evaluation of the preliminary intake and assessment instrument.

Summary

The methodology used in designing and evaluating the intake and assessment instrument included: (1) a review of current local practice; (2) a review of the literature; (3) a preliminary selection of item sets and items; (4) a review of these item sets and items by counselors in the field; (5) a preliminary design of an intake and assessment instrument for field evaluation; and (6) a field evaluation of that instrument by counselors conducting intakes on adults presenting with a history of CSA.

CHAPTER 4

RESULTS

This chapter presents the results of the four main phases of this project. It begins with a discussion of the counselor feedback received on the utility of information supplied by the current intake process. This is followed by a discussion of the counselor ratings of the candidate items and item sets on the new intake and assessment instrument. Then, there is a discussion of the modifications of the items and items sets and the format used in the preliminary instrument designed for field evaluation. Finally, there is a discussion of the feedback received from intake counselors who evaluated the preliminary intake interview and assessment instrument.

Utility of Information Currently Provided by Intake Process

The questionnaire used in this phase is presented in Appendix D. Eleven counselors were given questionnaires. Five counselors responded with completed questionnaires.

The number of individual clients currently being served by the respondents ranged from 8 to 15, and the number served during the past year ranged from 12 to 35. In terms of group clients, the number currently being served ranged from zero to 24, with the approximate number served during the past year ranging from 15 to 40.

Two of the counselors responded that they review the client intake information only about two percent of the time. One counselor indicated that she reviews intakes for all of her clients. The others indicated that they reviewed the intake data about 33 to 50 percent of the time.

Several reasons were given for not reviewing the files. These are included in the list below with the ones given most frequently listed first:

Not paid for time spent reading files (4)

Time consuming, and little available time (3)

Difficulty in finding relevant material in poorly organized files (2)

"Need for one-page summary sheet"

"Must be read at agency"

"Files locked at night"

The respondents were fairly uniform on their assessment of the utility of the various aspects of the current intake. One of the counselors who only reviews two percent of her client's intakes marked everything "seldom used", but indicated that she thought the agency should continue to provide all the various items. For the other respondents, everything was marked either "often used" or "always used" except as shown in Table 1.

When asked to describe the things they like about the current client intake information, the responses were as follows:

"Verbal reports from the intake workers."

"I like it all."

"Like question about guilt for molest."

"Like the DDI."

"Good questions."

"Need the background and developmental history."

Statements regarding dislikes included the following:

"I would like a summary page."(followed by a list of what it was to include).

"I have not been briefed on how to interpret the DDIS results."

"It should be xeroxed and placed in our boxes when client assigned to make it expedient. We could read it at our own convenience and return it or destroy it or keep it until client leaves. Surely we can be trusted for this."

"Info-history-broken down into age, is still overwhelming, hard to process"

Table 1. Number of Counselors Rating Current Intake Items as "Sometimes Useful" or "Seldom Useful"

Item	Number of Counselors	
	Sometimes Useful	Seldom Useful
Intake Treatment Plan	1	
Referral Information	1	1
Client's Situation	1	
Victim's Significant Others/Offender Relationships	1	
Victim/Victim's Significant Others Relationships	1	
Drug Prescription History		1
Medical Information		1
Current Medications		1
DDIS Raw Score Data		1

The only change recommended was made by two of the respondents. Their suggestion to make the intake shorter and more concise, short enough so they could automatically be given a copy of it.

Intake workers responsible for conducting the intake interviews at the agency were also interviewed about problems they have in administering the current intake. Their comments included the following:

"On several occasions I've had to use three sessions to finish it."

"It's just too long."

"It's no wonder our files are so stuffed. A 24-page, 4-hour intake is ridiculous."

"There's so much of it I usually leave blank, or that has only one or two words on it. It's wasteful."

The results of this part of the project would indicated that even though the intake is not used uniformly by all counselors, there is a general acceptance of the need for the information provided. People are also in general agreement that it is too long, and should be shorter to reduce stress on the client and to make it more affordable to provide the counselors their own copy.

Counselor Rating of Items and Item Sets

Four counselors were given the opportunity to rate the candidate items and item sets. Appendix E provides a copy of their instructions and the rating forms. Two counselors rated item sets only. Two counselors rated both item sets and individual items. There was notable consistency in ratings of the items and item sets among all four counselors.

Except for item sets shown in Table 2, item sets received either "often useful" or "must have" ratings.

Table 2. Number of Counselors Rating Item Sets as "Sometimes Useful" or "Seldom Useful"

		Number of Counselors	
		Sometimes	Seldom
Set No.	Description	Useful	Useful
11	Development History	1	
12	Medical History	2	
14	DSM-III-R Symptomatology	2	
15	Preliminary Multiaxial Diagnosis	2	
16	Preliminary Goals & Objectives	3	1
17	Preliminary Treatment Plan	3	1

In addition, only one item set in particular seemed to generate a diversity of opinion: Item Set 8, Presenting Problems. Because of the anonymity of the evaluators, all four were contacted to discuss their opinions about the presenting problem. Two counselors offered that the presenting problem was a history of CSA, and that all they really needed was the symptomatology associated with their current way of life. The other two, upon further discussion, agreed that most of the essential information was contained elsewhere in the intake. Also, one of the counselors noted that the presenting problem for adults with a CSA history changes rapidly and that the initial counseling focus is one of crisis management.

Modification of Items Sets for Use in the Preliminary Instrument

As noted in the previous section, only one item set was identified as potentially unnecessary in the intake instrument. For the design of the preliminary instrument, Item Set 8, Presenting Problems, was omitted. The preliminary instrument designed for field evaluation is presented in Appendix F.

This six page format replaced, during the evaluation, a thirteen page format. Major differences include: (1) addition of a genogram format with which to gather family constellation data, discuss individual family members, and note intergenerational personal characteristics; (2) a Family Characteristics section, following the development of the genogram, with which to develop an understanding of family patterns, family secrets, and the clients identification of role models and inherited traits; (3) a section for evaluating current effects of childhood trauma in seven Adlerian-based aspects of life, by identifying current examples of maladaptive behaviors, thoughts, or feelings; and (4), a Summary of DSM-III-R Symptomatology for collecting major symptoms for use in subsequent diagnoses.

Field Evaluation of Preliminary Instrument

Twenty copies of the field version of the preliminary instrument were printed for use at the agency, with counselor evaluation sheets attached. The evaluation sheet is provided in Appendix G.

Four intake counselors were briefed on the new form by the researcher. During the briefings, two concerns emerged. The first was that because of the shortening of the form, and collapsing of the some of the lines, there wasn't as much room to write as on the previous form. The second was that only two of the five intake counselors (including the researcher) had had formal training in

developing family histories using the genogram technique. A short training session was then conducted on the development of genograms.

One other factor impacted the field evaluation, although minimally. Because the form was experimental, agency management decided that the form would not be used with certain clients. During the field evaluation period, there were only three clients for whom the experimental intake instrument was not used.

A total of 12 critique forms were collected from four intake counselors. All concerns have been focused on the same two issues that were identified at the outset, during training: discomfort with use of the genogram and inadequate writing space.

Positive responses have included the following:

> It's much easier because of the new formatting of information.
>
> I've been able to complete an entire intake in one session.
>
> I really like the section where we assess the trauma on current functioning.

No areas have been suggested for improvement except for the writing area, and no one has reported any area of their client's life that were not covered by the intake instrument.

Summary

Results of four phases of the project were reported. In the first phase, five counselors rated the utility of information found on a current intake instrument and provided information on how often they used the intake files for their clients. They indicated that when they used the files, they found most of the information useful. They also suggested changes that would increase their utility of the

information. In the second phase, four counselors rated 17 item sets proposed for the new intake instrument, and found the proposed information generally useful. A preliminary intake and assessment instrument was designed for field evaluation based on the literature review and the feedback from the first two phases of counselor input. Results of the use of the preliminary instrument by intake counselors were reported and were generally satisfactory.

CHAPTER 5

SUMMARY, DISCUSSION, AND RECOMMENDATIONS

Summary

The prevalence of adults having a history of childhood sexual abuse (CSA) is estimated to be approximately 28% for females and about 16% for males. Since the mid-1980s several programs have been developed for treatment of this population. Much has been written to guide therapists who are trying to detect this history in clients who have repressed or suppressed the abuse. However, little research has been done in the area of interview and assessment of that portion of this population that presents with a known history of CSA. This project used counselor and research input to develop an instrument that is thorough, yet reduces interview time, and that offers the potential of greater use by counselors to whom clients with known CSA histories are referred. A field test of the preliminary instrument was conducted and a copy of the intake used for that field evaluation is included.

Discussion

This thesis project resulted in an intake interview and assessment instrument that is useful with adults presenting with a history of CSA. It is well formatted and is shorter in both document length and time to administer than existing intake instruments for the same population. It provides information deemed necessary by counselors to whom clients from this population are being referred. Minor revisions in writing space allotted to different sections of the instrument may make it more useful. In addition, more training on the development and use of genogram techniques would be required to fully implement the new instrument.

For the agency within which the field evaluation was conducted, because of the reduced time to administer the instrument, it also offers the potential for reduced waiting time between the time the client calls for an appointment and the time they can schedule their first session with an intake counselor. It also, therefore, is likely to result in that client being assigned a counselor or a group in a shorter time than they currently experience.

Recommendations for Future Research

Instrument for Assessing Functioning in Each of Seven Adlerian-based Life Tasks

The seven Adlerian-based life tasks (Hawes & Kern, 1989) provide a potentially broad foundation upon which to base several studies.

The first task would be to develop an instrument specifically for the purpose of evaluating functioning of adults in the seven Adlerian life task areas. Because this instrument would have the potential for use as a basic data collection method for research studies, in addition to intake assessment and progress evaluation, it would be very important to establish high confidence in its validity and reliability. Very closely controlled studies would have to be conducted using a variety of validation techniques, and its reliability would have to be carefully assessed.

A set of questions pertaining to each of the seven areas would be developed. Individual items would be developed to evaluate subelements of each of the seven areas. In order to get a quantitative assessment of each of the seven areas, one would probably want to have several items for each area with a Likert-type response scale which would allow the respondent to choose along a continuum of possible responses. Assessments of each area would be

provided when scored, along with a composite assessment of overall functioning. A quantitative composite assessment comparable to the DSM-III-R (APA, 1987) Global Assessment of Functioning would be useful because that scale is familiar to most counselors.

Once the instrument had demonstrated validity and reliability, it could be used for several purposes. Two purposes for which it would seem ideally suited are (1) client assessment and evaluation, and (2) as a research instrument.

Client assessment and progress evaluation. The concept of this instrument seems particularly appropriate for use with the population of adults having CSA histories, because its purpose is to assess functioning, not to diagnose. Adults with CSA histories often present with complex symptomatology, which defies DSM-III-R diagnosis. Counselors are most typically faced with a client who wants to improve their functioning in various areas, and DSM-III-R diagnoses, supplied by existing instruments used with this population, are not usually helpful to either the counselor or the client. Use of this instrument would tend to depathologize the clients by steering away from the medical model imposed by the DSM-III-R. In addition, it would: (1) provide significant guidance at intake in assessing specific areas of low, or maladaptive, functioning; (2) provide a means of prioritizing the client's work in a way that is meaningful to the client; (3) provide a means of monitoring shifts in functioning, and assessing balance; and (4) provide a means of monitoring overall progress.

The instrument could be used at intake for establishing baseline assessment of functioning in each of the seven areas as well as assessing the client's overall functioning. It could then also be used periodically to measure

progress of each client during group or individual therapy. Results could be compared to previous assessments to see which areas were improving, regressing, or remaining the same.

Research instrument. Several areas of research could be pursued with such an instrument. One study that would seem particularly useful would be a comparison study of the functioning (both compositely, and for the individual seven areas) of adults with a CSA history and that of those without. It would also be useful to evaluate functioning in the seven areas, and compositely, as a function of several variables traditionally studied in CSA research, such as: duration of abuse, level of force, age at onset, age at termination, type of activity, gender of abuser, relationship to abuser, intrafamilial vs extrafamilial, frequency of occurrence, education level of victim, socioeconomic variables, geographic area of current residence, family-of-origin factors, and religious background.

Focusing the Dissociative Experiences Scale (DES)

During this study, it was noted that the DES is used frequently as a screening instrument for dissociative disorders. Typically, if a client scores above 30-35% on the DES, intake counselors administer the Dissociative Disorders Inventory Schedule. Currently, clients complete each item on the DES by making a mark somewhere along an ungraduated scale (marked 0% on the left, and 100% on the right) indicating the percentage of time they experience the particular phenomenon indicated by the question. It is then up to the interpreter to assign a number to that mark, between 0 and 100, for each of the 28 questions of the DES.

The problem arises when the DDIS is administered upon assessment of an average score of higher than 30%. The DDIS is a 133-item instrument that

assesses a very broad set of dissociative disorders as well as other conditions. When administering the DDIS, it is quite common that only a portion of the DDIS is appropriate for that client. If the DES could be improved in the manner in which it is scored, so that the results could identify which areas in the DDIS should be administered, considerable savings in time and client discomfort could be achieved.

The research project would be to determine a way to modify the DES items and scoring process so that the DES could provide a better mapping into the DDIS for the purposes of assessing dissociative disorders.

Use of Genograms

Another area of research indicated by this project is the further development of genogram techniques specifically for this population. A project characterizing various aspects of the genograms of CSA survivors, such as patterns, gender roles, mental or emotional disorders, communication, and dysfunctions, would be useful. It appears that the genogram would also be a useful tool for gathering research data, perhaps more qualitative, in understanding the family dynamics of CSA survivors.

Final Thoughts

The research shows that approximately 27% of adult females, and 16% of adult males in the United States report a history of CSA, and the annual incidence of sexual abuse of children seems to be on the rise. Most of the abusers report that they were also abused, either sexually, physically, or emotionally, often in all three ways. The professional community needs to do everything possible to make it easier, and quicker, for these CSA survivors to get into treatment, and to make the treatment as effective as humanly possible.

Good intake interviewing and assessment tools for the intake counselors in mental health agencies, methods that provide therapists treating these CSA survivors ways of prioritizing treatment, and new techniques for getting at the root cause of the CSA survivors maladaptive functioning are essential. Only by effectively treating the abused, can the cycle of abuse be broken.

APPENDIX A.

HUMAN SUBJECTS COMMITTEE APPROVAL

Human Subjects Committee

THE UNIVERSITY OF
ARIZONA
HEALTH SCIENCES CENTER

65

1690 N. Warren (Bldg. 526B)
Tucson, Arizona 85724
(602) 626-6721 or 626-7575

December 2, 1991

James Otis Crabb
Department of Counseling and Guidance
Education Building, Room 218
Main Campus

RE: AN INTAKE INTERVIEW AND ASSESSMENT INSTRUMENT FOR ADULTS PRESENTING WITH A HISTORY OF CHILDHOOD SEXUAL ABUSE

Dear Mr. Crabb:

We received documents concerning your above cited project. Regulations published by the U.S. Department of Health and Human Services [45 CFR Part 46.101(b)(5)] exempt this type of research from review by our Committee.

Please be advised that approval for this project and the requirement of a subject's consent form is to be determined by your department.

Thank you for informing us of your work. If you have any questions concerning the above, please contact this office.

Sincerely yours,

WF Denny

William F. Denny, M.D.
Chairman,
Human Subjects Committee

WFD:sj

cc: Departmental/College Review Committee

APPENDIX B.

REQUEST FOR CURRENT PRACTICE FROM LOCAL AGENCIES

September 7, 1991

Kevin Thorson
Arizona Counseling and Therapy, Inc.
4550 E. 5th St.
Tucson, AZ 85711

Subject: Request for Information on Intake and Assessment Procedures

Dear Dr. Thorson,

I am a Master's-level graduate student in the University of Arizona's Counseling and Guidance program. During the past year, I have worked at the Rape Crisis Center and at Las Familias focusing my professional development in the area of adults having a history of childhood sexual abuse. My responsibilities have included conducting intakes, individual counseling, and group counseling with this population.

For my thesis, I am designing and evaluating a research-based intake instrument specifically for assessing adults with a history of childhood sexual abuse, and developing treatment plans. The purpose of this letter is to ask your support of this project by providing me with a copy of your intake instrument or procedure specific to this population so that I can begin with a documentation of that which constitutes current, or common, practice. In the absence of documentation specific to this population, I would also gladly accept documentation of a generalized instrument or procedure that you are willing to share.

I have enclosed a stamped self-addressed envelope for your convenience. Also, in exchange for your participation and support, I will be more than happy to send you a copy of the results of this project.

Because of the schedule of this project, your expeditious response will be greatly appreciated. If you have any questions, please feel free to call me at 323-1801.

Thank you very much.

Jimmy Crabb
4201 E. Monte Vista Dr., Apt. C102
Tucson, AZ 85712

Major Mental Health Service Providers Serving
Adults Molested as Children
Tucson, AZ

Source: Information & Referral Services, Inc
Directory of Human Services (2nd Edition)

Arizona Counseling and Therapy, Inc
4550 E. 5th St.
Tucson, AZ 85711
325-5196

Catholic Social Service
P.O.Box 5746
155 W. Helen St.
Tucson, AZ 85705
623-0344

Center for Family and Individual Counseling
430 N. Tucson Blvd.
Tucson, AZ 85716
325-4837

Cottonwood de Tucson
P.O. Box 5087
4110 Sweetwater Dr.
Tucson, AZ 85703
743-0411

Department of Veterans Affairs Medical Center
3601 S. 6th Ave.
Tucson, AZ 85723
792-1450

Eastside Counseling Center
601 N. Wilmot, #30
Tucson, AZ 85711
745-8791

El Dorado Psychological Associates
1200 N. El Dorado Place
Building F, Suite 640
Tucson, AZ 85715
298-9746

Family Counseling Agency
209 S. Tucson Blvd., #F
Tucson, AZ 85716
327-4583

La Frontera Center
502 W. 29th St.
Tucson, AZ 85713
884-9920

Las Familias
3618 E. Pima
Tucson, AZ 85716
327-7122

The Mark
4653 E. Pima
Tucson, AZ 85712
326-6182

Palo Verde Mental Health Services
P.O.Box 40030
2695 N. Craycroft Rd.
Tucson, AZ 85712
795-4357

Sierra Tucson
16500 N. Lago del Oro Parkway
Tucson, AZ 85737
624-4000

Sonora Desert Hospital
1920 W. Rudasill Rd.
Tucson, AZ 85704
297-5500

Southern Arizona Mental Health Center
1930 E. 6th St.
Tucson, AZ 85719
628-5221

Tucson Psychiatric Institute
355 N. Wilmot Rd.
Tucson, AZ 85711
745-5100

Southern Arizona Center Against Sexual Assault
P.O.Box 40306
639 E. Speedway Blvd.
Tucson, AZ 85717
624-7273

Westcenter
3838 N. Campbell Ave.
Tucson, AZ 85719
795-0952

University of Arizona
Student Health Center
North Cherry
Tucson, AZ 85721
621-3334

University of Arizona
Student Counseling and Testing Service
Old Main, Room #200W
Tucson, AZ 85721
621-7591

APPENDIX E.

DEFINITIONS AND DSM-III-R DIAGNOSTIC CRITERIA FOR DISORDERS COMMONLY SEEN IN ADULTS WITH A CSA HISTORY

This appendix contains the definitions and diagnostic criteria for a number of disorders sometimes associated with a history of CSA. The source of these definitions and diagnostic criteria is the DSM-III-R (APA, 1987), which should be referred to for a complete description of the disorder prior to making a final diagnosis.

Adjustment Disorder

Definition:

This diagnosis is used to identify a maladaptive reaction to an identifiable psychosocial stressor, or stressors that occurs within three months after onset of the stressor, and has persisted for no longer than six months. In cases of adults with a history of CSA, the stressor could consist of memory of the CSA, flashbacks, etc. Specific manifestations must also be specified (Adjustment Disorder With...e.g., Withdrawal).

Diagnostic Criteria:

A. A reaction to an identifiable psychosocial stressor, or stressors, occurring within three months of onset of the stressor(s).
B. The maladaptive nature of the reaction is indicated by either (1) impairment in occupational or academic functioning or in usual social activities or relationships, or (2) symptoms in excess of normal and expectable reaction to the stressor(s)
C. Disturbances are more than one instance of a pattern of overreaction to stress or an exacerbation of a disorder previously described.
D. The maladaptive reaction has lasted for no longer than six months.
E. The disturbance doesn't meet criteria for other specified disorders.

Adjustment Disorder With...

Anxious Mood, 309.24
Use: Predominant manifestations include nervousness, worry, and jitteriness.

Depressed Mood, 309.00
Use: Predominant manifestations include depressed mood, tearfulness, and feelings of hopelessness.

Mixed Emotional Features, 309.28
Use: Predominant manifestations include a mixture of depressed moods and anxious moods.

Physical Complaints, 309.82
Use: Predominant manifestations include physical symptoms that are not diagnosable as a specific Axis III physical disorder or condition.

Withdrawal, 309.83
Use: Predominant manifestation is social withdrawal without depressed or anxious mood.

Work (or Academic) Inhibition, 309.23
Use: Predominant manifestation is an inhibition in work or academic functioning when previous work or academic performance as been adequate. There may also be an accompanying mixture of anxiety and depression.

Adjustment Disorder NOS, 309.90
Use: Where predominant manifestation is not classifiable as a specific type of Adjustment Disorder.

Anxiety Disorders

Post-traumatic Stress Disorder, 309.89
Definition:

PTSD is typified by development of characteristic symptoms following a psychologically distressing event outside the range of usual human experience, such as CSA. Onset may be delayed by up to several years following the event.

Diagnostic Criteria:

A. A history of one or more traumatic childhood sexual abuse incidents.
B. Reexperience of the event(s) in one of the following ways.
   (1) recurrent and intrusive distressing recollections of the event.
   (2) recurrent distressing dreams of the event
   (3) sudden acting or feeling as if the event were recurring (including a sense of reliving the event, illusions, hallucinations, or dissociative [flashback] episodes)
   (4) intense distress when exposed to events symbolizing or resembling an aspect of the event.
C. Persistent avoidance of stimuli associated with the event or numbing of general responsiveness, as indicated by at least three of the following:
   (1) efforts to avoid thoughts or feelings associated with the trauma
   (2) efforts to avoid activities or situations that arouse recollections of the event
   (3) inability to recall an important aspect of the trauma (psychogenic amnesia)
   (4) diminished interest in significant activities
   (5) feeling of detachment or estrangement from others
   (6) restricted range of affect
   (7) sense of foreshortened future
D. Persistent symptoms of increased arousal as indicated by at least two of the following:
   (1) difficulty falling or staying asleep
   (2) irritability or outbursts of anger
   (3) difficulty concentrating
   (4) hypervigilance
   (5) exaggerated startle response
   (6) physiologic reaction when exposed to events symbolizing or resembling an aspect of the event.
E. Duration of the disturbances (symptoms B., C., and D.) of at least one month

Obsessive Compulsive Disorder, 300.30
Definition:

This disorder is characterized by recurrent obsessions or compulsions sufficiently sever to cause marked distress, be time-consuming, or significantly interfere with the person's normal routine, occupational functioning, or usual social activities or relationships.

Diagnostic Criteria:

A. Either obsessions or compulsions.

To qualify as an obsession, all of the following criteria must be met:

(1) recurrent and persistent ideas, thoughts, impulses, or images that are experienced as intrusive and senseless
(2) the person attempts to ignore or suppress such thoughts or impulses or to neutralize them with some other thought or action
(3) the person recognizes that the obsessions are the product of his or her own mind, not imposed from without
(4) the content of the obsession is unrelated to another (present) Axis I disorder

To qualify as a compulsion, all of the following criteria must be met:

(1) repetitive, purposeful, and intentional behaviors that are performed in response to an obsession, or according to certain rules, or in a stereotyped fashion
(2) the behavior is designed to neutralize or to prevent discomfort or some dreaded event or situation; however, either the activity is not connected in a realistic way with what is designed to neutralize or prevent, or it is clearly excessive
(3) the person recognizes that their behavior is excessive or unreasonable

B. The obsessions or compulsions cause marked distress, are time-consuming (more than one hour per day), or significantly interfere with the person's normal routine, occupational or academic functioning, or usual social activities or relationships.

Panic Disorder, Without Agoraphobia, 300.01

Definition:

Panic disorders are typified by discrete periods of intense fear or discomfort, called panic attacks.

Diagnostic Criteria:

A. One or more panic attacks have occurred that were (1) unexpected and (2) not triggered by situations in which the person was the focus of others' attention.
B. Either four attacks defined in A have occurred within a four-week period, or one or more attacks have been followed by a period of at least a month of persistent fear of having another attack.
C. At least four of the following symptoms developed during at least one of the attacks:
   (1) shortness of breath or smothering sensations
   (2) dizziness, unsteady feelings, or faintness
   (3) palpitations or accelerated heart rate
   (4) trembling or shaking
   (5) sweating
   (6) choking
   (7) nausea or abdominal distress
   (8) depersonalization or derealization
   (9) numbness or tingling sensations
   (10) flushes (hot flashes) or chills
   (11) chest pain or discomfort
   (12) fear of dying
   (13) fear of going crazy or of doing something uncontrolled

D. During at least some of the attacks, at least four of the C symptoms developed suddenly and increased in intensity within ten minutes of the beginning of the first C symptom noted in the attack.
E. It cannot be established that an organic factor initiated and maintained the disturbance.
F. Absence of Agoraphobia.

The current severity of panic attacks must also be specified.

Mild: During the past month, either all attacks have been limited symptom attacks (fewer than four symptoms listed in C.), or there has been no more than one panic attack.

Severe: During the past month, there have been at least eight panic attacks.

Moderate: During the past month attacks have been between mild and severe.

In Full Remission: No panic or limited symptom attacks during the past six months.

In Partial Remission: Condition intermediate between Mild and In Full Remission.

Depressive, Hypomanic, and Manic Episodes

Note: These definitions and diagnostic criteria are used in various Mood Disorder diagnoses, including Bipolar Disorders and Depressive Disorders commonly found in adult survivors of CSA.

Major Depressive Episode (MDE)

Definition:

The essential feature of a MDE is either depressed mood or loss of interest or pleasure in activities, in addition to other symptoms, for a period of at least two weeks.

Diagnostic Criteria:

A. At least five of the following symptoms have been present during a two week period, and represent a change from previous functioning, and, at least one of the symptoms is either (1) depressed mood, or (2) loss of interest or pleasure.
   (1) depressed mood most of the day, nearly every day, as indicated by self-report or observation by others
   (2) significantly diminished interest or pleasure in all, or nearly all, activities most of the day, nearly every day, as indicated by self-report or observation by others
   (3) significant weight loss or weight gain when not dieting (e.g., more than 5% body weight change in one month), or decrease or increase in appetite nearly every day
   (4) insomnia or hypersomnia nearly every day
   (5) psychomotor agitation or retardation nearly every day observable by others
   (6) fatigue or loss of energy nearly every day
   (7) feelings of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly every day
   (8) diminished ability to think or concentrate, or indecisiveness nearly every day, either by self-report or observed by others
   (9) recurrent thoughts of death, recurrent suicidal ideation, without a specific plan, or a suicide attempt, or a specific plan for committing suicide
B. (1) no organic factor associated with initiation or maintenance of the depressed mood, and
   (2) not a normal reaction to death of a loved one (Uncomplicated Bereavement)

C. No period of delusions or hallucinations as long as two weeks during the absence of prominent mood symptoms.
D. Not superimposed on Schizophrenia, Schizophreniform Disorder, Delusional Disorder, or Psychotic Disorder NOS.

Severity of current state:
1 - Mild: few, if any, symptoms in excess of the minimum required to make the diagnosis and only minor impairment in occupational, academic, or social activities or relationships
2 - Moderate: functional impairment between Mild and Severe
3 - Severe (without psychotic features): several symptoms in excess of those required to make the diagnosis and symptoms significantly impair occupational, academic, or social activities or relationships
4 - Severe (with psychotic features): delusions or hallucinations
mood-congruent psychotic features -- delusions or hallucinations whose content is consistent with typical depressive themes
mood-incongruent psychotic features -- delusions or hallucinations whose content does not involve typical depressive themes. Included might be persecutory delusion, thought insertion, thought broadcasting, and delusions of control.
5 - In Partial Remission: in-between Mild and In Full Remission, and no previous Dysthymia
6 - In Full Remission: no significant signs or symptoms of disturbance in past six months
0 - Unspecified

Chronic: if current episode has lasted two consecutive years without a period of two months or longer during which there were no significant depressive symptoms

Melancholic Type: presence of at least five of the following:
(1) loss of interest or pleasure in nearly all activities
(2) lack of reactivity to usually pleasurable stimuli
(3) depression regularly worse in the morning
(4) early morning awakening
(5) psychomotor retardation or agitation
(6) significant anorexia or weight loss
(7) no significant personality disturbance before first MDE
(8) one or more previous MDEs followed by complete, or nearly complete, recovery
(9) previous good response to specific and adequate somatic antidepressant therapy (tricyclics, ECT, MAOI, Lithium)

Manic Episode (ME)

Definition:

The essential feature of a ME is a distinct period during which the predominant mood is either elevated, expansive, or irritable, plus associated symptoms.

Diagnostic Criteria:
A. A distinct period of abnormally and persistently elevated, expansive, or irritable mood.
B. During the period of mood disturbance, at least three of the following symptoms (or four if the mood is only irritable) have been present to a significant degree.
(1) inflated self esteem or grandiosity
(2) decreased need for sleep

(3) more talkative than usual
(4) flight of ideas, or subjective experience that thoughts are racing
(5) distractibility to unimportant or irrelevant external stimuli
(6) increase in goal-directed activity or psychomotor agitation
(7) excessive involvement in pleasurable activities that have high potential for painful consequences

C. Mood disturbance sufficiently severe to cause marked impairment in occupational, academic, or social activities or relationships, or to necessitate hospitalization to prevent harm to self or others.
D. No period of delusions or hallucinations as long as two weeks during the absence of prominent mood symptoms.
E. Not superimposed on Schizophrenia, Schizophreniform Disorder, Delusional Disorder, or Psychotic Disorder NOS.
F. No organic factor associated with initiation or maintenance of the elevated, expansive or irritable mood.

Severity of Current State:

See Major Depressive Episode. Note: for a diagnosis of mood-congruent psychotic features, typical manic themes include inflated worth, power, knowledge, identity, or special relationship with a deity or famous person; for a diagnosis of mood-incongruent features, include catatonic symptoms such as stupor, mutism, negativism, and posturing.

Hypomanic Episode (HME)

Definition:

An HME is similar to a manic episode except the disturbance is not severe enough to cause an impairment in occupational, academic, or social functioning, or to cause hospitalization. Delusions are never present.

Diagnostic Criteria:

Diagnostic criteria for an HME are the same as categories A and B of the ME criteria. (Criterion C of the ME criteria does not apply.)

Depressive Disorders

Note: Use the fifth digit, and the codes for Severity of Current Episode indicated for MDEs, to classify current severity.

Major Depression, Single Episode, 296.2x

Diagnostic Criteria:

A. A single MDE.
B. Has never had an ME or an HME.

Major Depression, Recurrent, 296.3x

Diagnostic Criteria:

A. Two or more MDEs, each separated by at least two months of return to usual functioning.
B. Has never had an ME or an HME.

Dysthymia, 300.40

Definition:

Dysthymia involves a chronic disturbance of mood involving depressed mood for most of the day, more days than not, for at least two years.

Diagnostic Criteria:

A. Depressed mood for most of the day, more days than not, as indicated by self-report or by observations of others, for at least two years.
B. Presence, while depressed, of at least two of the following:
   (1) poor appetite or overeating
   (2) insomnia or hypersomnia
   (3) low energy or fatigue
   (4) low self-esteem
   (5) poor concentration or difficulty making decisions
   (6) feelings of hopelessness
C. Never without the symptoms in A and B for more than two months in a two-year period of the disturbance.
D. No evidence of an MDE during the first two years of the disturbance.
E. Has never had an ME or an HME.
F. Not superimposed on a chronic psychotic disorder.
G. No organic factor initiated or maintained disturbance.

Type:

Primary: mood disturbance not related to preexisting chronic, nonmood Axis I or Axis III disorder.

Secondary: mood disturbance apparently related to a preexisting chronic, nonmood Axis I or Axis III disorder.

Specify **Early Onset** if onset before age 21; **Late Onset** if after the age of 21.

Depressive Disorder NOS, 311.00

Definition:

Depressive features that do not meet specific criteria for a Depressive Disorder diagnosis or a diagnosis of Adjustment Disorder With Depressive Mood.

Bipolar Disorders

Definition:

Bipolar disorders usually include one or more Manic Episodes accompanied by one or more Major Depressive Episodes. The fourth digit classifies the disorder as mixed, manic, or depressive depending on the clinical features of the current episode. The fifth digit classifies the current state.

Bipolar Disorder, Mixed, 296.6x

Diagnostic Criteria:

A. Current or most recent episode involves a full symptomatic picture of both ME and MDE (except for the two-week duration requirement) intermixed or rapidly alternating every few days.
B. Prominent depressive symptoms lasting at least a full day.

Note: Use ME criteria to describe current state (fifth digit).

Bipolar Disorder, Manic, 296.4x

Diagnostic Criteria:

A. Currently in ME.

Note: Use ME criteria to describe current state (fifth digit).

Bipolar Disorder, Depressive, 296.5x

Diagnostic Criteria:

A. Has had one or more MEs.
B. Currently or most recently in MDE.

Note: Use MDE criteria to describe current state (fifth digit).

Cyclothymia, 301.13

Definition:

Cyclothymia is typified by chronic mood disturbance of at least two years' duration involving Hypomanic Episodes and numerous periods of depressed mood or loss of interest in pleasure of insufficient severity or duration to meet the criteria for an MDE or an ME.

Diagnostic Criteria:

A. A period of at least two years in which there has been the presence of numerous HEs and periods with depressed mood or loss of interest or pleasure that do not meet the criteria for MDE.
B. Never a period of more than two months in which there are no hypomanic or depressive symptoms.
C. No clear evidence of an MDE or ME during the first two years of the disturbance.
D. Not superimposed on a chronic psychotic disorder.
E. No organic factor evident in initiation or maintenance of the disturbance.

Bipolar Disorder NOS, 296.70

Definition:

Disorders with manic or hypomanic features that do not meet the criteria for any specific bipolar disorder.

Dissociative Disorders

Depersonalization Disorder, 300.60

Definition:

Depersonalization involves an alteration in the perception or experience of self in which the usual sense of one's own reality is temporarily lost or changed, as manifested by a feeling of detachment from self or feeling like an automaton, or as if living in a dream.

Diagnostic Criteria:

A. Persistent or recurrent experiences of depersonalization as indicated by either
   (1) an experience of feeling detached from, and as if one is an outside observer of, one's mental processes or body, or
   (2) an experience of feeling like an automaton or as if in a dream.
B. Reality testing remains intact during the experience(s).
C. The experience is sufficiently severe and persistent to cause marked distress.
D. The depersonalization experience is the predominant disturbance and is not a symptom of another disorder.

Multiple Personality Disorder (MPD), 300.14

Definition:

The existence within the person of two or more personalities or personality states.

Diagnostic Criteria:

A. Existence within the persona of two or more distinct personalities or personality states, each having its own relatively enduring patterns of perceiving, relating to, and thinking about the environment and self.
B. At least two of these personalities or personality states recurrently take full control of the person's behavior.

Psychogenic Fugue, 300.13

Diagnostic Criteria:

A. Sudden, unexpected travel away from home or one's customary place of work, with inability to recall one's past.
B. Assumption of a new identity (partial or complete)
C. Disturbance not due to MPD or to an Organic Mental Disorder.

Psychogenic Amnesia, 300.12

Diagnostic Criteria:

A. An episode of sudden inability to recall important personal information or events that is too extensive to be explained by ordinary forgetfulness.
B. Disturbance not due to MPD or to an Organic Mental Disorder.

Dissociation Disorder NOS, 311.00

Definition:

A disorder in which the predominant feature is a dissociative symptom that does not meet the criteria for a specific Dissociative Disorder.

Sleep Disorders

Primary Insomnia, 307.42

Diagnostic Criteria:

A. Predominant complaint is difficulty in initiating or maintaining sleep, or nonrestorative sleep (adequate in amount, but leaving an unrested feeling).
B. The disturbance in A occurs at least three times a week for at least one month, and is sufficiently severe to result in either a complaint of daytime fatigue or the observation by others of symptoms attributable to the sleep disturbance.
C. Occurrence not exclusively during the course of Sleep-Wake Schedule Disorder or a Parasomnia.
D. Not maintained by another mental disorder or organic factor.

Dream Anxiety Disorder (Nightmare Disorder), 307.47

Diagnostic Criteria:

A. Repeated awakenings from the major sleep period or naps with detailed recall of extended and extremely frightening dreams, usually involving threats to survival, security, or self-esteem. The awakenings generally occur during the second half of the sleep period.
B. On awakening from the frightening dreams, the person rapidly becomes oriented and alert (in contrast to confusion and disorientation seen in Sleep Terror Disorder and some forms of epilepsy).
C. The dream experience or the sleep disturbance resulting from the awakenings causes significant distress.
D. No organic factor responsible for initiation or maintenance of the disturbance. (Note: Certain drugs associated with treatment of other disorders commonly seen in adults with a history of CSA have been reported to occasionally cause nightmares. These include reserpine, thioridazine, mesoridazine, tricyclic antidepressants, and benzodiazepines.)

Dyssomnia NOS, 307.40

Definition:

A disturbance in the amount, quality, or timing of sleep that cannot be classified into the categories of insomnia, hypersomnia (abnormal need for day-time sleep), or sleep-wake schedule disturbances.

Parasomnia NOS, 307.40

Definition:

Disturbances during sleep that cannot be classified in any specific parasomnia category, such as nightmares apparently caused by having taken or withdrawn from certain drugs.

Eating Disorders

Anorexia Nervosa, 307.10

Definition:

The essential features of this disorder include a distorted body image, intense fear of gaining weight or becoming fat, refusal to maintain body weight over a minimal normal range for the person's height and age, and amenorrhea in females.

Diagnostic Criteria:

A. Refusal to maintain body weight over a minimal normal weight for age and height.
B. Intense fear of gaining weight or becoming fat, even though underweight.
C. Disturbance in the way in which one's body weight, size, or shape is experienced.
D. In females, absence of at least three consecutive menstrual cycles when otherwise expected to occur.

Bulemia Nervosa, 307.51

Definition:

This disorder features recurrent episodes of binge eating, feelings of lack of control over eating behavior, self-induced vomiting, use of laxatives or diuretics, strict dieting or fasting or obsessive exercise, and persistent concern with body shape and weight.

Diagnostic Criteria:

A. Recurrent episodes of binge eating (rapid consumption of a large amount of food in a discrete period of time).
B. A feeling of lack of control over eating behavior during the eating binges.
C. The person regularly engages in either self-induced vomiting, use of laxatives or diuretics, strict dieting or fasting, or vigorous exercise in order to prevent weight gain.
D. A minimum average of two binge eating episodes a week for at least three months.
E. Persistent overconcern with body shape and weight.

Eating Disorder NOS, 307.50

Definition:

Disorders of eating that do not meet the diagnostic criteria for specific eating disorders.

Gender Identity Disorders

Definition:

The essential features of these disorders include a persistent or recurrent discomfort and sense of inappropriateness about one's assigned sex.

Transsexualism, 302.50

Diagnostic Criteria:

A. Persistent discomfort and sense of inappropriateness about one's assigned sex.
B. Persistent preoccupation for at least two years with getting rid of one's primary and secondary sex characteristics and acquiring the sex characteristics of the other sex.
C. The person has reached puberty.

Gender Identity Disorder of Adolescence or Adulthood, Nontransexual Type (GIDAANT), 302.85

Diagnostic Criteria:

A. Persistent or recurrent discomfort and sense of inappropriateness about one's assigned sex.
B. Persistent or recurrent cross-dressing in the role of the other sex, either in fantasy or actuality, but not for the purpose of sexual excitement (as in Transvestic Fetishism).
C. No persistent preoccupation (for at least two years) with getting rid of one's primary and secondary sex characteristics and acquiring the sex characteristics of the other sex (as in Transsexualism).
D. The person has reached puberty.

Note: For both Transsexualism, 302.50, and GIDAANT, 302.85, **specify** history of sexual orientation: **asexual, homosexual, heterosexual,** or **unspecified.**

Personality Disorders (Axis II), Cluster B

Borderline Personality Disorder (BPD), 301.83

Diagnostic Criteria:

A pervasive pattern if instability of mood, interpersonal relationships, and self-image, beginning by early adulthood and present in a variety of contexts, as indicated by at least five of the following:

(1) a pattern of unstable and intense interpersonal relationships characterized by alternating between extremes of overidealization and devaluation
(2) impulsiveness in at least two potentially self-damaging areas such as spending, sex, substance use, shoplifting, reckless driving, or binge eating (not including suicidal or self-mutilating behavior covered in (5)
(3) affective instability, manifested in marked shifts from baseline mood to depression, irritability, or anxiety, usually lasting a few hours and only rarely more than a few days
(4) inappropriate, intense anger, or lack of control of anger, including physical fights
(5) recurrent suicidal threats, gestures, or behavior (attempts), or self-mutilating behavior
(6) marked and persistent identity disturbance as evidenced by uncertainty about at least two of the following: self-image, sexual orientation, long-term goals or career choice, type of friends desired, or preferred values.
(7) chronic feelings of emptiness or boredom
(8) frantic efforts to avoid real or imagined abandonment, not including suicidal or self-mutilating behavior covered in (5)

Histrionic Personality Disorder, 301.50

Diagnostic Criteria:

A pervasive pattern of excessive emotionality and attention-seeking, beginning by early adulthood and present in a variety of contexts, as indicated by at least four of the following:

(1) constantly seeks or demands reassurance, approval, or praise
(2) is inappropriately sexually seductive in appearance or behavior
(3) is overly concerned with physical attractiveness
(4) expresses emotion with inappropriate exaggeration
(5) is uncomfortable in situations in which he or she is not the center of attention
(6) displays rapidly shifting and shallow expression of emotions
(7) is self-centered, actions being directed toward obtaining immediate satisfaction; has no tolerance for frustration associated with delayed gratification
(8) has a style of speech that is excessively impressionistic and lacking in detail

Narcissistic Personality Disorder, 301.81

Diagnostic Criteria:

A pervasive pattern of grandiosity, lack of empathy, and hypersensitivity to the evaluation of others, beginning by early adulthood and present in a variety of contexts, as indicated by at least five of the following:

(1) reacts to criticism with feelings of rage, shame, or humiliation (even if not expressed)
(2) is interpersonally exploitative by taking advantage of others to achieve his or her own ends
(3) has a grandiose sense of self-importance
(4) believes that his or her problems are unique and can be understood only by other special people
(5) is preoccupied with fantasies of unlimited success, power, brilliance, beauty or ideal love
(6) has a sense of entitlement evidenced by unreasonable expectation of especially favorable treatment
(7) requires constant attention and admiration; fishing for compliments
(8) lack of empathy shown by inability to recognize and experience how others feel, e.g., annoyance or surprise when an ill friend cancels and engagement
(9) is preoccupied with feelings of envy

Personality Disorders, Cluster C

Avoidant Personality Disorder, 301.82

Diagnostic Criteria:

A pervasive pattern of social discomfort, fear of negative evaluation, and timidity, beginning by early adulthood and present in a variety of contexts, as indicated by at least four of the following:

(1) is easily hurt by criticism or disapproval
(2) has no close friends or confidants (or only one) other than first-degree relatives
(3) is unwilling to get involved with people unless certain of being liked
(4) avoids social or occupational activities that involve significant interpersonal contact
(5) is reticent in social situations because of a fear of saying something inappropriate or foolish, or of being unable to answer a question

(6) fears being embarrassed by blushing, crying, or showing signs of anxiety in front of other people
(7) exaggerates the potential difficulties, physical dangers, or risks involved in doing something ordinary but outside his or her usual routine

Dependent Personality Disorder, 301.60

Diagnostic Criteria:

A pervasive pattern of dependent and submissive behavior, beginning by early adulthood and resent in a variety of contexts, as indicated by at least five of the following:

(1) is unable to make everyday decisions without an excessive amount of advice or reassurance from others
(2) allows others to make most of his or her important decisions
(3) agrees with people even when he or she believes they are wrong because of fear of being rejected
(4) has difficulty initiating projects or doing things on his or her own
(5) volunteers to do things that are unpleasant or demeaning in order to get other people to like him or her
(6) feels uncomfortable or helpless when alone, or goes to great lengths to avoid being alone
(7) feels devastated or helpless when close relationships end
(8) is frequently preoccupied with fears of being abandoned
(9) is easily hurt by criticism or disapproval

Obsessive Compulsive Personality Disorder, 301.40

Diagnostic Criteria:

A pervasive pattern of perfectionism and inflexibility, beginning by early adulthood and present in a variety of contexts, as indicated by at least five of the following:

(1) perfectionism that interferes with task completion
(2) preoccupation with details, rules, lists, order, organization, or schedules to the extent that the major point of the activity is lost
(3) unreasonable insistence that others submit to exactly his or her way of doing things, or unreasonable reluctance to allow others to do things because of the conviction that they will not do them correctly
(4) excessive devotion to work and productivity to the exclusion of leisure activities and friendships (not justified by obvious economic need)
(5) indecisiveness manifested by avoidance, postponement or protracted decision making (not as a result of need for advice or reassurance)
(6) overconscientiousness, scrupulousness, and inflexibility about matters of morality, ethics, or values (not specifically related to religious or cultural values)
(7) restricted expression of affection
(8) lack of generosity in giving time, money, or gifts when no personal gain is likely to result
(9) inability to discard worn-out or worthless objects even when they have no sentimental value

Passive Aggressive Personality Disorder, 301.84

Diagnostic Criteria:

A pervasive pattern of passive resistance to demands for adequate social and occupational performance, beginning by early adulthood and present in a variety of contexts, as indicated by at least five of the following:

(1) procrastinates to the point that deadlines are not met
(2) becomes sulky, irritable, or argumentative when asked to do something he or she doesn't want to do

(3) seems to work deliberately slowly or to do a bad job on tasks that he or she really does not want to do
(4) protests, without justification, that others make unreasonable demands on him or her
(5) avoids obligations by claiming to have forgotten
(6) believes that he or she is doing a much better job than others think he or she is doing
(7) resents useful suggestions from others concerning how he or she could be more productive
(8) obstructs the efforts of others by failing to do his or her share of the work
(9) unreasonably criticizes or scorns people in positions of authority

Personality Disorder NOS, 301.90

Definition:

This applies to disorders of personality functioning that are not classifiable as a specific Personality Disorder, and would specifically apply to the case wherein there are features of more than one specific Personality Disorder that do not meet the full criteria for one diagnosis but cause significant impairment in social or occupational functioning, or subjective distress. Other uncoded Personality Disorders sometimes seen in adults who have a history of CSA may be assigned to this diagnosis, such as Sadistic Personality Disorder or Self-defeating Personality Disorder.

Sexual Dysfunctions

Definition:

Sexual Dysfunction Disorders are typified by inhibition, disruption, or anomalies in the sexual response cycle, or painful intercourse. Symptoms associated with these disorders are often reported by adults having a CSA history.

Note: Also specify Sexual Dysfunction Disorders according to the following:
psychogenic only, or **psychogenic and biogenic** (dysfunctions that are biogenic only should be coded on Axis III)
lifelong or **acquired**
generalized or **situational**

Hypoactive Sexual Desire Disorder, 302.71

Diagnostic Criteria:

A. Persistently or recurrently deficient or absent sexual fantasies and desire for sexual activity. The judgment of deficiency or absence is made by the clinician, taking into account factors that affect sexual functioning, such as age, gender, and context of the person's life.
B. Occurrence not exclusively during the course of another Axis I disorder other than a Sexual Dysfunction.

Sexual Aversion Disorder, 302.79

Diagnostic Criteria:

A. Persistent or recurrent extreme aversion to, and avoidance of, all or almost all, genital sexual contact with a sexual partner.
B. Occurrence not exclusively during the course of another Axis I disorder other than a Sexual Dysfunction.

Female Sexual Arousal Disorder, 302.72

Diagnostic Criteria:

A. Either
   (1) persistent or recurrent partial or complete failure to attain or maintain the lubrication-swelling response of sexual excitement until the completion of the sexual activity, or
   (2) persistent or recurrent lack of a subjective sense of sexual excitement and pleasure in a female during sexual activity
B. Occurrence not exclusively during the course of another Axis I disorder other than a Sexual Dysfunction.

Male Erectile Disorder, 302.72

Diagnostic Criteria:

A. Either
   (1) persistent or recurrent partial or complete failure in a male to attain or maintain erection until the completion of the sexual activity, or
   (2) persistent or recurrent lack of a subjective sense of sexual excitement and pleasure in a male during sexual activity
B. Occurrence not exclusively during the course of another Axis I disorder other than a Sexual Dysfunction.

Inhibited Female Orgasm, 302.73

Diagnostic Criteria:

A. Persistent or recurrent delay in, or absence or, orgasm in a female following a normal sexual excitement phase during sexual activity that the clinician judges to be adequate in focus, intensity, and duration.
B. Occurrence not exclusively during the course of another Axis I disorder other than a Sexual Dysfunction.

Inhibited Male Orgasm, 302.74

Diagnostic Criteria:

A. Persistent or recurrent delay in, or absence or, orgasm in a male following a normal sexual excitement phase during sexual activity that the clinician, taking into account the person's age, judges to be adequate in focus, intensity, and duration. (Note: For this diagnosis,judgement of failure to achieve orgasm is usually restricted to an inability to reach orgasm in the vagina, with orgasm possible with other types of stimulation, such as masturbation.)
B. Occurrence not exclusively during the course of another Axis I disorder other than a Sexual Dysfunction.

Premature Ejaculation, 302.75

Diagnostic Criteria:

Persistent or recurrent ejaculation with minimal sexual stimulation or before, upon, or shortly after penetration and before the person wishes it. The clinician must take into account factors that affect duration of the excitement phase, such as age, novelty of the sexual partner or situation, and frequency of sexual activity.

Dyspareunia, 302.76

Diagnostic Criteria:

A. Recurrent or persistent genital pain in either a male or female before, during or after sexual intercourse.
B. The disturbance is not caused exclusively by lack of lubrication or by Vaginismus.

Vaginismus, 306.51

Diagnostic Criteria:

A. Recurrent or persistent involuntary spasm of the muscles in the outer third of the vagina that interferes with coitus.
B. The disturbance is not caused exclusively by a physical disorder, and is not due to another Axis I disorder.

Sexual Dysfunction NOS, 302.70

Definition:

Sexual Dysfunctions that do not meet the criteria for any of the specific Sexual Dysfunctions.

Sexual Disorder NOS, 302.90

Definition:

Sexual Disorders not classifiable in any of the previous categories.

Somatoform Disorders

Somatization Disorder, 300.81

Definition:

Typified by recurrent and multiple somatic complaints, for several years beginning prior to the age of 30, for which medical attention has been sought but for which no physical reason can be found for the symptom(s).

Diagnostic Criteria:

A. A history of many physical complaints or a belief that one is sickly, beginning before the age of 30 and persisting for several years.
B. At least 13 symptoms from the list below. To count a symptom as significant, all three of the following criteria must be met:
   (1) no organic pathology accounts for the symptom, or the social or occupational impairment is grossly in excess of that normally expected from the pathology
   (2) has occurred at times other than during a panic attack
   (3) has caused the person to see a doctor, take prescription medication, or alter life-style

   Note: Items marked with an asterisk (*) can be used to screen for this disorder. Presence of two or more suggests a high likelihood of the disorder.

Gastrointestinal symptoms:

*(1) vomiting (other than during pregnancy)
(2) abdominal pain (other than when menstruating)
(3) nausea (other than motion sickness)
(4) bloating (gassy)
(5) diarrhea
(6) intolerance of (gets sick from) several different foods

Pain symptoms:

*(7) pain in extremities
(8) back pain
(9) joint pain
(10) pain during urination
(11) other pain (excluding headaches)

Cardiopulmonary symptoms:

*(12) shortness of breath when not exerting oneself
(13) palpitations

(14) chest pain
(15) dizziness

Conversion or pseudoneurologic symptoms:
*(16) amnesia
*(17) difficulty swallowing
(18) loss of voice
(19) deafness
(20) double vision
(21) blurred vision
(22) blindness
(23) fainting or loss of consciousness
(24) seizure or convulsion
(25) trouble walking
(26) paralysis or muscle weakness
(27) urinary retention, or difficulty urinating

Sexual symptoms:
*(28) burning sensation in sexual organs or rectum (other than during intercourse)
(29) sexual indifference
(30) pain during intercourse
(31) impotence

Female reproductive symptoms (judged to occur more frequently, or more severely, than normal:
*(32) painful menstruation
(33) irregular menstrual periods
(34) excessive menstrual bleeding
(35) vomiting throughout pregnancy

Somatoform Pain Disorder, 307.80

Diagnostic Criteria:

A. Preoccupation with pain for at least six months.
B. Either
   (1) appropriate evaluation uncovers no organic pathology or pathophysiologic mechanism, or
   (2) when there is related organic pathology, the complaint of pain or resulting social or occupational impairment is grossly in excess of what would be expected from the physical findings.

Somatoform Disorder NOS, 300.70

Definition:

Disorders with somatoform symptoms that do not meet the criteria for any specific Somatoform Disorder or Adjustment Disorder with Physical Complaints.

V-Code Conditions

Definition:

V-Codes are provided for conditions that are a focus of attention or treatment but are not attributable to any of specific mental disorders. The V-Codes listed below are those that may occasionally be used for preliminary diagnoses of symptoms presented by adults with a CSA history.

Marital Problem, V61.10
Use: When the focus of attention or treatment is a marital problem that is apparently not due to a mental disorder, such as conflict related to estrangement or divorce.

Occupational Problem, V62.20
Use: When the focus of attention or treatment is an occupational problem that is apparently not due to a mental disorder, such as job dissatisfaction or uncertainty about career choices.

Parent-Child Problem, V61.20
Use: For either a parent or a child when the focus of attention or treatment is a parent-child problem that is apparently not due to a mental disorder of the person being evaluated.

Other Interpersonal Problem, V62.81
Use: When the focus of attention or treatment is an interpersonal problem (other than marital or parent-child) that is apparently not due to a mental disorder of the person being evaluated.

Other Specified Family Circumstances, V61.80
Use: When the focus of attention or treatment is a family circumstance other than marital or parent-child) that is apparently not due to a mental disorder of the person being evaluated.

Phase of Life Problem, or Other Life Circumstance Problem, V62.89
Use: When the focus of attention or treatment is a problem associated with a particular developmental phase or some other life circumstance that is apparently not due to a mental disorder.

No Diagnosis on Axis I, or No Diagnosis on Axis II, V71.09
Use: When no Axis I or Axis II diagnosis or condition, including other V-Code conditions, is present.

Diagnosis Deferred on Axis I, or Diagnosis Deferred on Axis II, V799.90
Use: When there is insufficient information to make any diagnostic judgment about an Axis I or Axis II diagnosis.

APPENDIX D.

SURVEY OF UTILITY OF CLIENT INTAKE INFORMATION

The following survey was given to all contract counselors (n=11) from the agency for which the intake is being designed who counsel adults with a history of CSA.

Survey on Utility of Client Intake Information

I am a Master's-level graduate student in the University of Arizona's Counseling and Guidance program. For my thesis, I am designing and evaluating an intake instrument specifically for assessing adults with a known history of childhood sexual abuse.

A goal of my project is to arrive at a combination of content and format that will be useful to this agency. Your assistance is being solicited so that I can make a determination of three major factors: (1) your use of current intake information, (2) your likes and dislikes about the current intake information, and (3) what changes could be made to the current intake content and format in order to improve both the utility of the information and likelihood that you would use it. Results of this survey will be integrated into the final design of the intake instrument.

This survey is completely anonymous. Please place in my box when you've completed it. I need your feedback by October 25th. Your cooperation in completing this survey is greatly appreciated. Thanks.

Jimmy Crabb

A. General background Information

1. Approximately how many individual clients and group clients from this agency are you currently serving?

   Individual Clients:
   Number being currently served____
   Approximate number served during the past year____

   Group Clients:
   Number being served____
   Approximate number served during the past year____

2. For approximately what percentage of the clients from this agency served by you during the past year have you reviewed the client's intake file?____

3. Please indicate up to three reasons that might tend to keep you from reviewing the client's intake file.

   a._____

   b._____

   c._____

B. Please indicate your use of information supplied on the current intake report. Place a √ in the appropriate box. If you do not use the client intake information for some reason, such as those you may have stated above, but think the information is useful and should continue to be provided, please place an X on the line just to the right of the "always used" box.

	never used 1	seldom used 2	sometimes used 3	often used 4	always used 5
Client Identification/Household Information	[ ]	[ ]	[ ]	[ ]	[ ]__
Dissociation Experience Scale Results	[ ]	[ ]	[ ]	[ ]	[ ]__
Intake Treatment Plan	[ ]	[ ]	[ ]	[ ]	[ ]__
Referral Information	[ ]	[ ]	[ ]	[ ]	[ ]__
Background Information (Family of Origin)	[ ]	[ ]	[ ]	[ ]	[ ]__
Client's Situation (Developmental Background)	[ ]	[ ]	[ ]	[ ]	[ ]__
Developmental Perspective (Sexuality Background)	[ ]	[ ]	[ ]	[ ]	[ ]__
Offender/Victim Relationship Information	[ ]	[ ]	[ ]	[ ]	[ ]__
Victim's Significant Others/Offender Relationship Information	[ ]	[ ]	[ ]	[ ]	[ ]__
Victim/Victim's Significant Others Relationship Information	[ ]	[ ]	[ ]	[ ]	[ ]__
Evaluation: Perception of guilt, responsibility, abuser as offender	[ ]	[ ]	[ ]	[ ]	[ ]__
Sexual Abuse - Environment (Molest Details)	[ ]	[ ]	[ ]	[ ]	[ ]__
Supernatural/Possession/ESP Experience/Cults (from DDIS)	[ ]	[ ]	[ ]	[ ]	[ ]__
Substance Abuse History	[ ]	[ ]	[ ]	[ ]	[ ]__
Suicidal Assessment (Event/Ideation History)	[ ]	[ ]	[ ]	[ ]	[ ]__
Drug Prescription History	[ ]	[ ]	[ ]	[ ]	[ ]__
Medical Information	[ ]	[ ]	[ ]	[ ]	[ ]__
Current Medications	[ ]	[ ]	[ ]	[ ]	[ ]__
Dissociation Disorder Interview Schedule (DDIS) Results (when appropriate)					
DDIS Raw Data	[ ]	[ ]	[ ]	[ ]	[ ]__
DDI Summary Report	[ ]	[ ]	[ ]	[ ]	[ ]__

C. Please describe those things you like, and the things you don't like, about the current client intake information.

Likes:

Dislikes:

D. Please describe changes you would recommend in the client intake process that would make the client intake information more useful to you and improve the possibility that you would use it.

APPENDIX E.

INSTRUCTIONS AND FORMS FOR COUNSELOR EVALUATION OF ITEMS AND ITEM SETS

Instructions for Completing Attached Forms:
Counselor Rating of Item Sets and Items

The attached forms are being used to determine counselor ratings of various items that might be used in an intake interview and assessment instrument for adults presenting with a history of childhood sexual abuse.

You are being asked to rate each item within the sets of items according to your assessment of its usefulness. You are also being asked to rate your overall assessment of each set of items, into which the items are grouped. The possible responses include: leave out, seldom useful, sometimes useful, often useful, and must have.

Some items have more than one element included. For your response in these cases, please consider the overall use of the elements in total.

With regard to rating an individual set, if you feel that all the items within the set should get the same rating, it is OK to rate the set, and leave the ratings of the individual items blank.

This is my last survey!! Your prompt response will be greatly appreciated. If at all possible, please return your completed forms to my box when you come in next week to do your groups.

Thanks A Bunch!!

Jimmy Crabb

Instructions:	Please be sure to make an overall evaluation as to the usefulness of the entire item set (e.g., Set 1, Set 2, etc.) in addition to making an evaluation of each item within the set.	Counselor Rating of Sets and Items				
		leave out	seldom useful	sometimes useful	often useful	must have
		1	2	3	4	5

A. Client Identification, Referral, and Financial Information

Please Place a √ in the Appropriate Box

Set1.	Client Identification:	set				
	name					
	address					
	home and work telephone numbers					
	social security number					
	date of birth					
	gender					
	ethnic/cultural affiliation					
	marital/relationship status					
	other members of the household (names and ages):					
	spouse or significant other					
	children					
	other relatives living in the same household					
	other biological children, if living elsewhere					
	occupation					
	employer information					
	name					
	address					
	full time or part time					
Set 2.	Referral Information	set				
	name, address of agency					
	name of referral source (individual)					
	appropriate contact information					
	reason for referral					
	status of referral documentation					
Set 3.	Financial Information	set				
	name,address, and phone no. of person to be billed (if other than client)					
	sources and amounts of income					
	medical insurance company					
	counseling coverage					
	funding support from referral agency					

B. Counseling History, Psychiatric Hospitalizations, Suicide Attempts, and Substance Abuse History

Set 4.	Past Counseling Experiences or Psychological Hospitalizations	set				
	dates of treatment period					
	type of treatment received (inpatient, outpatient, individual or group counseling)					
	reason for treatment (presenting problem)					
	outcome of treatment					
	reason for terminating treatment					
	drugs prescribed for emotional or psychological problems					

Instructions:	Please be sure to make an overall evaluation as to the usefulness of the entire item set (e.g., Set 1, Set 2, etc.) in addition to making an evaluation of each item within the set.	Counselor Rating of Sets and Items				
		leave out	seldom useful	sometimes useful	often useful	must have
		1	2	3	4	5

Set 5.	Current Counseling or Psychological Treatment Relationship	set					
	name of counselor						
	contact information (address, phone)						
	date begun						
	type of treatment (individual, couple, family, or group)						
	frequency of treatment						
	presenting problem						
	progress						
	intentions for continuation, termination						
	drugs currently prescribed (type, name, dosage)						
Set 6.	History of Suicide Attempts (for each attempt)	set					
	date						
	method						
	how interrupted						
	current ideation (thought, plan, means, time)						
Set 7.	Substance Abuse History (for each substance)	set					
	substance						
	dates of abuse or addiction						
	treatment received (counseling, 12-step, outpatient, inpatient, none)						
	how long clean or sober						
	current usage						

C. Presenting Problems

Set 8.	Presenting Problems (for each problem)	set					
	client's description of current problem						
	time of onset						
	other events occurring at the time						
	frequency of occurrence						
	thoughts, feelings, and behaviors associated with the complaint						
	when and where it occurs the most, or least						
	events or persons that precipitate it, make it better or worse						
	previous solutions or plans that have been tried, with what results						
	what made the client decide to seek help at this time						
	if referred, what precipitated referral at this time						

Instructions:	Please be sure to make an overall evaluation as to the usefulness of the entire item set (e.g., Set 1, Set 2, etc.) in addition to making an evaluation of each item within the set.	Counselor Rating of Sets and Items				
		leave out	seldom useful	sometimes useful	often useful	must have
		1	2	3	4	5

D. Personal History

Set 9. Family of Origin (Use a genogram format to identify and pictorially show the relationship of significant family members.) **set**

a. identify family members (include year of birth or age of those living, if deceased note age at death, year of death, and cause)
   - parents (including step and adoptive)
   - siblings (including half-brothers and sisters, and including miscarriages and infant deaths, if known)
   - children (including adoptions and step children, and not currently living with you, also note miscarriages and infantor childhood deaths)
   - grandchildren, if appropriate
   - others, if significant, might include
     - aunts, uncles, cousins
     - grandparents
     - great-grandparents

b. other information of each family member identified, as known
   - character
   - notable behaviors
   - role in the family
   - education
   - vocation
   - state of health (note major medical or psychological problems)

c. dates of client's marriages and divorces

d. other family marriages and divorces

e. emotional bonds or splits of immediate family

f. significant family customs, rituals, or ceremonies

g. family secrets or myths
   - substance abuse (note for each relevant family member)
   - emotional, physical, or sexual abuse

h. family patterns
   - gender roles (dominance, submission, power)
   - communications
   - display of affection or sexuality
   - sexual attitudes and values
   - crisis management (death, grief, accidents, birth defects, psychological or medical problems)
   - emotional expression (anger, sadness, joy)
   - approaches to decision making and problem solving
   - significance of religion
   - mobility

i. client role models (positive, negative)

j. client's perception of inherited traits, if any

k. notable ways client is conforming to, or has departed from family patterns

Instructions:	Please be sure to make an overall evaluation as to the usefulness of the entire item set (e.g., Set 1, Set 2, etc.) in addition to making an evaluation of each item within the set.	Counselor Rating of Sets and Items				
		leave out	seldom useful	sometimes useful	often useful	must have
		1	2	3	4	5

Set 10. Molest Experience and Sexuality — set

a. molest experience (if only one perpetrator, record first and last incidents, or incidents with most current traumatic memory; for multiple perpetrators, summarize the experience with each perpetrator)
- age (for each event, or age at onset and at termination)
- name of molester
- relationship to survivor
- frequency of molest
- sexual activity
- level of force or coercion
- location
- others involved
- sensory memories
- sexual response
- childhood disclosure
  - who
  - response
  - legal action
- adult disclosure
  - who
  - response
- client's feelings of guilt, or responsibility for the molest

b. sexuality assessment
- sexual identity
- sexual orientation
- arousal assessment
- sexual phobias or obsessions
- sexual dysfunction
- sexual arousal toward children

Set 11. Developmental History (For each of the periods below, discuss significant events, medical or mental issues, discipline, self-esteem, sexuality, significant friendships and relationships, academic, vocation, spirituality) — set

- early childhood (0 to 5 years)
- middle childhood (6 to 12 years)
- adolescence (13 to 18 years)
- early adulthood (19 to 25 years)
- adulthood (over 25 years to present, with emphasis on current functioning, marriage,divorce, family, vocation, sexuality, and use of leisure time)

Set 12. Medical History and Overall Status of Current Health — set

- prior significant illnesses, hospitalizations, and surgeries
- current health related complaints or illnesses
  - onset
  - acute or chronic
  - treatment received
- any history of serious physical symptoms for which doctors could find no explanation
- sleep patterns
- appetite levels
- exercise patterns
- allergies
- current medications (name of drug, dosage)

Instructions:	Please be sure to make an overall evaluation as to the usefulness of the entire item set (e.g., Set 1, Set 2, etc.) in addition to making an evaluation of each item within the set.	Counselor Rating of Sets and Items				
		leave out	seldom useful	sometimes useful	often useful	must have
		1	2	3	4	5

E. Assessment

Set 13.	Current Effects of Childhood Trauma (Evaluate effects on current functioning in each of the following seven areas as: none, mild, medium, or severe. For each area rated medium or high, give specific examples of currently maladaptive thoughts, feelings, or behaviors.)	set					
	self-worth						
	intimate relationships (including sexuality)						
	nurturing (including parenting)						
	social relationships (sense of community, extended family)						
	spirituality						
	occupation						
	leisure						
Set 14.	Summarization of Symptomatology Pertaining to DSM-III-I Diagnoses	set					

F. Preliminary Diagnosis

Set 15.	Preliminary Multiaxial DSM-III-R Diagnoses	set					
	Axis I (clinical syndromes, including V-codes) names and DSM-II-R codes						
	Axis II (personality and specific developmental disorders) names and DSM-III-R codes						
	Axis III (summary of physical disorders)						
	Axis IV (assessment of psychological stressors)						
	list of stressors within past 12 months, ranked in terms of impact						
	overall assessment of stressors						
	Axis V (assessment of global functioning)						
	current assessment						
	highest level of functioning in past 12 months						

G. Preliminary Goal Setting and Treatment Planning

Set 16.	Preliminary Goals and Objectives (general for adults presenting with a known history of CSA)	set					
Set 17.	Preliminary Treatment Plan	set					
	orientation, individual, group						
	frequency recommended						
	estimated time of completion						

APPENDIX F.

PRELIMINARY INSTRUMENT USED FOR FIELD EVALUATION

This is the preliminary instrument used for field evaluation. It has been reduced in size to comply with thesis format requirements.

Client Identification:

Name _____ Home Address

Social Security No. _____ Street _____

Date of Birth _____ Apartment, Trailer, or Lot No. _____

[ ] Female [ ] Male City _____ State _____ Zip _____

Phone No. (Home) _____

Ethnic Background _____ (Work) _____

Marital Status: [ ] Single [ ] Married [ ] Divorced [ ] Separated

Other Members of the Household: Total Number in Household _____

Spouse/Significant Other: Name _____ Age ____

Children: Name _____ Age _____ Name _____ Age ____

Name _____ Age _____ Name _____ Age ____

Relatives Living in Household: Name _____ Age ____ Relationship _____

Name _____ Age ____ Relationship _____

Other Children Living Elsewhere: Name _____ Age ____ Location _____

Name _____ Age ____ Location _____

Employment Information: [ ] Unemployed

Occupation _____ Employer: Name _____

[ ] Full Time [ ] Part Time Street _____

City _____ State _____ Zip _____

Referral Information:

Referred By: _____ Agency Name: _____

Reason For Referral _____ Street _____

_____ City _____ State _____ Zip _____

Funding Support? [ ] Yes [ ] No Phone No. _____

Referral Documentation [ ] None [ ] Supplied [ ] In Process

Financial Information: Sources/Amounts of Monthly Income:

If someone other than the client is to be billed, please complete.

Name _____

Street _____

City _____ State _____ Zip _____

Phone No. (Home) _____ (Work) _____

Client's Medical Insurance Company/HMO _____

Counseling Coverage? [ ] Yes [ ] No

1. Household Income _____
2. General Assistance _____
3. Aid Dep. Child. (AFDC) _____
4. Soc. Sec. Supp. (SSI) _____
5. Soc. Sec. Dis. (SSDI) _____
6. Child Support _____
7. Pension/Retirement _____
8. Other _____

Total Monthly Income _____

Total Annual Income _____

Signature: _____ Date _____

Client's Name: _____ Intake Counselor: _____ Date: _____

Past Counseling Experiences or Psychological Hospitalizations

	Experience No. 1	Experience No. 2	Experience No. 3
Dates of Treatment Period (Inclusive)			
Location (Local Facility or City/State)			
Name of Counselor/Psychologist/Psychiatrist			
Reason for Treatment (Presenting Problem)			
Type of Treatment Received			
Outcome of Treatment			
Reason for Terminating Treatment			
Drugs Prescribed During/After Treatment			

Current Counseling/Psychological Treatment Relationship

Name of Therapist _____ Date Treatment Began _____

Contact Information: Phone No. _____ Type of Treatment _____

Address _____ Frequency _____

City _____ State _____ Zip _____

Presenting Problem(s) _____

Progress To Date _____

Intentions for Continuation/Termination [ ] will continue [ ] Will Terminate (Date) _____

Drugs Currently Prescribed: Type _____ Name _____ DailyDosage _____

Type _____ Name _____ DailyDosage _____

Type _____ Name _____ DailyDosage _____

History of Suicide Attempts (For Each Attempt, or Three Most Recent)

	Attempt No. 1	Attempt No. 2	Attempt No. 3
Date			
Method			
How Interrupted			

Current Ideation: Thoughts _____ Plan _____

Means _____ Opportunity _____

What would keep client from further attempts? _____

Sources of Support _____

Substance Abuse History

Have you ever had a substance abuse problem? [ ] Yes [ ] No [ ] Not Sure

Alcohol? [ ]Yes [ ]No Street Drugs? [ ]Yes [ ]No Intravenous User? [ ]Yes [ ]No

Complete the following information for each substance addicted to or abused.

	Substance No. 1	Substance No. 2	Substance No. 3
Substance Name			
Dates of Abuse/Addiction			
Treatment Received			
How Long Clean and Sober			
Current Usage			

Family-of-Origin Genogram

(Use a genogram format here to develop concept of family constellation and to note other significant information.)

Identify Key Family Members (Parents, Siblings, Spouses, Children, Grandchildren, Aunts, Uncles, etc.)

Include year or birth or age of those living, if deceased note age at death, year of death, and cause.

Include step and adoptive relatives, half-brothers and sisters, and miscarriages and infant deaths, if known.

For significant family members, note character, notable behaviors, family roles, education, vocation, major medical or psychological problems, and substance abuse history, if known.

Note dates of client's marriages and divorces, and other key family marriages and divorces.

Identify key emotional bonds or splits of immediate family.

Family Characteristics

Discussion of Client's Family of Origin (See Genogram on Previous Page)

How does the client characterize key family patterns?

Gender Roles _____

Communications _____

Display of Affection or Sexuality _____

Sexual Attitudes and Values _____

Decision Making, Problem Solving _____

Crisis Management _____

Emotional Expression _____

Significance of Religion _____

Mobility _____

What were the key family secrets or myths?

Substance Abuse _____

Emotional, Physical or Sexual Abuse _____

What were the significant family customs, rituals, or ceremonies? _____

_____

Who were client's role models, both positive and negative? _____

What are client's perception of inherited traits, if any? _____

_____

Note ways client is conforming to, or has departed from family patterns. _____

_____

Developmental History

For each period indicated, summarize significant or traumatic events, medical or mental issues, self-esteem, sexuality development, academic performance, spirituality, etc.

Early Childhood (0-5 years) _____

_____

_____

_____

_____

Middle Childhood (6 to 12 years) _____

_____

_____

_____

_____

Adolescence (13 to 18 years) _____

_____

_____

_____

_____

Early Adulthood (19 to 25 years) _____

_____

_____

_____

_____

Adulthood (over 25 years to present; emphasis on current functioning, self-esteem, relationships, family, sexuality vocation, spirituality, and use of leisure time) _____

_____

_____

_____

_____

Client's Current Family Relationships

With Mother (or Primary Female Parenting Figure) _____

With Father (or Primary Male Parenting Figure) _____

With Siblings _____

With Extended Family _____

Molest Experience

Complete the following. If only one perpetrator, record first and last incidents, or incidents with most current traumatic memory; for multiple perpetrators, summarize the experience with each perpetrator. Regarding age, note for each event, or age at onset and at termination.

	First Incident (or Perpetrator No. 1)	Last Incident (or Perpetrator No. 2)
Age		
Name of Molester		
Relationship to Survivor		
Frequency of Molest		
Sexual Activity		
Level of Force/Coercion		
Location		
Others Involved		
Sensory Memories		
Sexual Response		
Childhood Disclosure?		
To Whom?		
Response		
Legal Action		
Adult Disclosure?		
To Whom?		
Response?		

Client's feelings of guilt, or responsibility for the molest? _____

Sexuality Assessment

Sexual Identity _____

Sexual Orientation _____

Arousal Assessment _____

Sexual Phobias or Obsessions _____

Sexual Dysfunctions _____

Sexual Arousal Toward Children _____

Medical History and Overall Status of Current Health

Prior Significant Illnesses, Hospitalizations, and Surgeries _____

_____

Current Health Related Complaints or Illnesses

Onset(#1)_____ Acute or Chronic_____ Treatment Received_____

Onset(#2)_____ Acute or Chronic_____ Treatment Received_____

Is there any history of serious physical symptoms for which doctors could find no explanation? [ ] Yes [ ] No

Sleep Patterns _____

Appetite Levels _____

Exercise Patterns _____

Allergies _____

Current Medications_____

Assessment: Current Effects of Childhood Trauma

(Evaluate negative effects on current functioning in following areas. For each area rated medium or high, give examples of currently maladaptive thoughts, feelings, or behaviors.)

	Impact on Quality of Life			
	None	Low	Medium	High
Self-Worth	[ ]	[ ]	[ ]	[ ]
Examples of Current Functioning _____				
Intimate Relationships (including sexuality)	[ ]	[ ]	[ ]	[ ]
Examples of Current Functioning _____				
Nurturing (including parenting)	[ ]	[ ]	[ ]	[ ]
Examples of Current Functioning _____				
Social Relationships (community, extended family)	[ ]	[ ]	[ ]	[ ]
Examples of Current Functioning _____				
Spirituality	[ ]	[ ]	[ ]	[ ]
Examples of Current Functioning _____				
Occupation	[ ]	[ ]	[ ]	[ ]
Examples of Current Functioning _____				
Leisure	[ ]	[ ]	[ ]	[ ]
Examples of Current Functioning _____				

Assessment: Dissociative Disorders

DES Total Score: _____ ÷ 28 = _____ % avg. DDIS Administered? [ ]No [ ]Yes, Date:_____

DDIS Diagnoses _____

Summary of DSM-III-R Symptomatology

_____

_____

_____

_____

_____

_____

_____

_____

Preliminary Multiaxial DSM-III-R Diagnoses

	Code	Name
Axis I (Clinical Syndromes, Including V-Codes)		
Axis II (Personality and Specific Developmental Disorders)		
Axis III (Medical Problems)		

Axis IV

Rank Top 4 Psychological Stressors Within Past 12 Months

1_____ 2_____ 3_____ 4_____

Overall Assessment of Stressor Severity

1	2	3	4	5	6	7
None	Minimal	Mild	Moderate	Severe	Extreme	Catastrophic

Axis V (Global Assessment of Functioning)

Current:	1 - 10	11 - 20	21-30	31-40	41-50	51-60	61-70	71-80	81-90
Highest Level of Functioning in Past 12 Months	1 - 10	11 - 20	21-30	31-40	41-50	51-60	61-70	71-80	81-90

Preliminary Treatment Plan

Goals: 1_____

2_____

3_____

4_____

Objective: 1_____

2_____

3_____

4_____

Mode of Counseling [ ] Individual [ ] Group

Frequency _____

Estimated Duration of Treatment _____

Client's Signature _____ Date_____

Intake Counselor's Signature _____ Date_____

APPENDIX G.

QUESTIONNAIRE FOR INTAKE COUNSELOR EVALUATION OF PRELIMINARY INSTRUMENT

Note: Reduced in size to comply with thesis format requirements.

Experimental Intake Instrument: Counselor Critique Sheet

(Please make your comments at the end of each intake session, and return to Jimmy Crabb at the completion of the entire intake)

Counselor:_____ Intake Dates: 1st Session_____ 2nd Session _____

Duration of Sessions: 1st Session_____ 2nd Session _____

Please indicate on which page, and on which item you ended the first sessior Page_____

Item_____

If there were particular aspects of this client's history that were difficult to document because of the questions or formatting of this intake questionnaire, please indicate the nature of the difficulties below.

Page No.	Area or Item	What difficulty was encountered?

If you have suggested improvements for individual areas or items, please indicate below:

Page No.	Area or Item	Suggestions for improvement

If there were important areas of this client's history that were not covered by the intake questionnaire, please note below:

Other Comments:

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