Further, several recent studies suggest that approximately 35-70% of female mental health patients self-report, if asked, a childhood history of sexual abuse (Briere, 1996). Equally problematic in many cultures is childhood psychological abuse and neglect, although the prevalence of these forms of maltreatment is harder to quantify (Hart, Brassard, Binggeli, & Davidson, 2002; Erickson & Egeland, 2002).

Among the known effects of child maltreatment are:
- anxiety, depression and anger (Briere & Elliott, 2003)
- helplessness, guilt, shame and low self-esteem (Feiring, Taska & Chen, 2002)
- sexual dysfunction (Davis, Petretic-Jackson & Ting, 2001)
- somatization and psychosomatic disorders (Drossman, Lesserman, Nachman, Li, Gluck, Toomey & Mitchell, 1990)
- posttraumatic stress (Kilpatrick & Resnick, 1993) and,
- dissociation (Simeon, Guralnik, Schmeidler, Sirof & Knutelska, 2001).

Abuse survivors are also more prone to:
- drug and alcohol abuse (Briere, Woo, McRae, Foltz & Sitzman, 1997)
- externalizing behaviors such as compulsive and indiscriminate sexual activity (Davis, et al., 2001)
- binging or chronic over-eating (Webster & Palmer, 2000)
- antisocial behavior and aggression (Widom, 1989)
- suicidal behavior (Molnar, Berkman & Buka, 2001) and,
- self-mutilation (Briere & Gil, 1998).

The psychological treatment of abuse effects

As clinicians have become more aware of the range, complexity and potential severity of abuse-related psychological disturbance, various therapeutic approaches for intervention have been developed. A growing body of research and clinical experience suggests that the psychological treatment of abuse effects is likely to be complex and require specialized skills and information. At the same time, the principles of good, generic psychotherapy have direct application to this population. This article outlines a number of central principles relevant to the treatment of abuse-related psychological distress. A more detailed presentation of the therapeutic approach outlined here, known as the self-trauma model, can be found in Briere (2002) and Briere and Scott (in press).

Ethical issues

The ethical issues involved in the treatment of abuse survivors are generally the same as for any client population. However, they may be
Assessment

Child abuse can produce a wide variety of symptoms and disorders and for this reason assessment is especially important when working with abuse survivors (Briere, in press, a). Not only should treatment begin with a psychosocial evaluation, but assessment should be an ongoing component of the treatment process. Symptoms may wax and wane across treatment, or may be effected by initial levels of dissociation and other avoidance responses that decrease as treatment continues - all of which might not be detected if assessment only occurred at the outset of therapy.

When the client is able to tolerate discussion of his or her childhood history, assessment should include a detailed evaluation of the abuse and its characteristics. The presence of other childhood and adult traumas should also be evaluated, since many sexual abuse survivors also experienced psychological abuse, emotional neglect, and physical maltreatment as children, and may also have been revictimized as adults (Classen, Nevo, Koopman, Nevill-Manning, Gore-Felton, Rose & Spiegel, 2002; Edwards, Holden, Felitti, & Anda, 2003). As a result, it should not be assumed that any given symptom is the result of childhood abuse, per se, as opposed to the many other potentially harmful events and processes that the survivor may have experienced.
good psychometric qualities, including reliability, validity, and appropriate normative data (Briere, in press, b; Carlson, 1997; Wilson & Keane, in press).

Amnesia and memory recovery issues

A specific issue related to the assessment of abuse and its effects is that of the validity of abuse-specific recollections. Clinicians in the field have become increasingly aware of the complexity of long-term recall, especially in terms of potential memory distortion effects (Williams & Banyard, 1999). Given our greater understanding of the suggestibility of some survivors, for instance, those with significant dissociative symptoms or impaired self-capacities (Briere & Runtz, 2002), it is suggested that:

• assessment regarding abuse memories be as nondirective as is reasonably possible, such that the client is neither pressured to recall unavailable material, nor discouraged from remembering what it is possible to recall (Courtois, 1999),
• drug-assisted interviews and assessment-focused hypnosis be avoided when possible (Lindsay & Briere, 1997) and,
• amnesia neither be assumed nor prematurely ruled-out (Pope & Brown, 1996).

The process of psychotherapy

Many untreated survivors of severe childhood abuse spend considerable time and energy attempting to counter trauma-related distress and intrusion with avoidance mechanisms such as dissociation, externalization, or substance abuse (van der Kolk, 1996). Such avoidance, although reinforced by its immediate effectiveness in reduction of dysphoria, may prevent adequate exposure to and processing of traumatic material, thereby leaving posttraumatic symptoms relatively undiminished.

Because the survivor tends to down-regulate abuse-related dysphoria with avoidance, it is important that psychotherapy proceed carefully and, in some instances, slowly. A primary goal is to avoid overwhelming the client - either by exposing him or her to unacceptable levels of posttraumatic distress, or by inappropriate discouragement of needed avoidance activities (e.g. some level of dissociation). At the same time, however, the clinician must facilitate exposure to traumatic material so that it can be desensitized and integrated. Such interventions challenge and motivate psychological growth, accommodation, and desensitization, but do not overwhelm internal protective systems and motivate unwanted avoidance responses (Briere, 1996).

In addition to balancing challenge with stability, the clinician must work to provide a safe therapeutic environment. Without continual and reliable safety and support during treatment, the survivor is not likely to reduce his or her reliance on avoidance defenses, nor to attempt the necessary work of forming an open relationship with the psychotherapist. As noted later, therapeutic safety may partially extinguish or countercondition anxiety associated with the disclosure (and thus reliving) of traumatic material.

Effective therapeutic responses occur on a continuum, with one end anchored in interventions devoted to greater awareness of potentially threatening, but therapeutically important, material (exploration and exposure), and the other constrained to interventions that support and solidify previous progress, or provide a more secure base from which the survivor can operate without fear (consolidation).

Exploratory interventions invite the client to recollect and examine his or her traumatic history and facilitate emotional and cognitive processing of this material. For example, an exploratory intervention might involve asking the client to describe a specific abuse incident in detail, or to use slightly less avoidance when discussing an abuse-related event. Consolidation, on the other hand, is less concerned with exposure or processing than with safety and foundation, and involves activities that reduce arousal, ‘ground’ the client in the ‘here and now,’ interrupt escalating internal states and increase internal stability.

The decision at any given moment to explore and process or to consolidate reflects the assessment by the therapist of which direction the client’s balance between stresses and resources is tilting. The overwhelmed client typically requires less exploration and more consolidation, whereas the stable client may benefit most from the opposite.

Increasing self functions and affect regulation skills

Implicit in this therapeutic model is the importance of internal (or ‘self’) capacities during trauma processing. In the absence of sufficient affect regulation skills, even small amounts of activated distress or dysphoria may be experienced as overwhelming and thereby motivate avoidance or externalization. Given the importance of self-resources to effective therapeutic intervention, some clients may require extensive ‘self work’ before any significant trauma-focused interventions can occur (Cloitre et al., 2002; Courtois, 1988; Linehan, 1993).

Although a number of self-capacities and functions have been hypothesized (Briere & Runtz, 2002; McCann & Pearlman, 1990; Pearlman, 1998), perhaps most important to the successful processing of traumatic material are the related concepts of affect tolerance and affect modulation - both of which tend to be impaired in survivors of severe childhood maltreatment (Briere & Runtz, 2002; Pearlman, 1998). Affect tolerance refers to the relative ability of the client to feel painful feelings without needing to avoid them through activities such as dissociation, externalization, substance abuse and so on. Affect modulation refers to the ability to alter or reduce painful affects, also without major reliance on avoidance. As noted above, in the absence of such skills, traumatic reexperiencing and dysphoria can easily overwhelm the client.

A programmatic approach to the development of affect regulation is outlined by Linehan (1993). She notes that distress tolerance and affect modulation are both internal behaviors that can be learned during therapy. Among the specific skills taught by Linehan’s treatment model are distraction, self-soothing, and ‘improving the moment’ (e.g. through relaxation). The survivor also learns to identify and label emotions when they occur, reduce vulnerability to hyper-emotionality (i.e. through decreased stress) and develop the ability to experience emotions without judging or rejecting them.

Affect tolerance and modulation is
also learned implicitly during effective therapy. Trauma-focused interventions involve the repeated evocation and processing of distressing, but non-overwhelming, memories and feelings. As a result, such treatment slowly teaches the survivor to become more ‘at home’ with some level of distress, and to develop whatever skills are necessary to de-escalate moderate levels of emotional arousal. This growing ability to move in and out of strong emotional states fosters an increased sense of emotional control and reduced fear of affect.

Another important self-capacity is self-awareness. Although difficult to operationalize, it is likely that a stable, accessible sense of self is an important aspect of good psychosocial functioning (Pearlman, 1998). Unfortunately, self-awareness often was punished by the survivor’s early environment, since an internal focus distracted from needed hypervigilance, and greater internal awareness meant, by definition, access to greater emotional pain. As a result, many untreated survivors of severe abuse are surprisingly unaware of their internal processes and may have less access to a stable sense of personal identity than those with more positive childhoods. (Briere & Runtz, 2002). This may present, for example, as reports of an inability to predict one’s own reactions or behavior in various situations, or problems in self-other boundaries.

By facilitating self-exploration and self-reference (as opposed to defining the self primarily in terms of others’ expectations or reactions), abuse-focused therapy allows the survivor to gain a greater sense of personal identity. Increased self-awareness may especially be fostered when the client is asked about his internal experience throughout the course of treatment. This might include multiple, gentle inquiries about the client’s early perceptions and experiences, his or her feelings and reactions during and after victimization experiences, and what his or her thoughts and conclusions are regarding the ongoing process of treatment.

Equally important, however, is the need for the client to discover literally what he or she feels about current things, both abuse-related and otherwise. The external-directedness required to explicitly about the client’s early perceptions and might include multiple, gentle inquiries throughout the course of treatment. This especially be fostered when the client identity. Increased self-awareness may to gain a greater sense of personal focused therapy allows the survivor expectations or reactions), abuse-focused intervention in treatment, it must be identified as traumatic material. Although this seems to conscious reluctance to think about or speak of upsetting abuse incidents, or to less conscious dissociation of such events. Since such responses are avoidance defenses, they should not be punished or unduly confronted, nor should the survivor be pushed to access more painful material than he or she can tolerate. On the other hand, interventions focused on increasing perceived safety and/or developing better affect regulation may eventually increase the amount of distress the client can ‘handle,’ and thus decrease the need for such avoidance.

If, at some point, there is sufficient abuse material available to the treatment process, the next step in the treatment of abuse-related trauma is that of careful, graduated exposure to various aspects of the abuse memory. In this regard, the survivor is asked to recall non-overwhelming, but painful abuse-specific experiences in the context of a safe therapeutic environment. Exposure is graduated according to the intensity of the recalled abuse, with less upsetting memories often being recalled, verbalized and desensitized before more upsetting ones are considered (Briere, 2002). In contrast to more strictly behavioral interventions, however, this approach does not adhere to a strict, pre-planned series of exposure activities. This is because the survivor’s self-capacities may be compromised, and his or her tolerance for exposure may vary considerably from session to session as a function of outside life stressors, support from friends, relatives, and others, and shifting transferenceal dynamics.

Exposure to abuse memories is complicated by the fact that there are probably at least two different memory systems to address: explicit and implicit (Riviere, 1996; Siegel, 1999). The former is more narrative and autobiographical, whereas the latter involves the encoding and recovery of nonverbal, more experiential memories. Typically, material from both systems must be processed - the first by repeatedly exploring the factual aspects of the event (e.g. who, what, where, and when), and the second by activating recollections of the images, sensations, and emotions associated with the abuse. Explicit memory material is usually activated by
Trauma work with the abuse survivor involves not only the processing of emotions, but also more direct cognitive interventions. For example, the client might explore the circumstances of the abuse, the basis for his or her reactions, and the dynamics operating in the abuser. In such a way, the client may come to reconsider, in the context of adult awareness and feedback from the therapist, negative assumptions and beliefs about self and others that he or she formed at the time of the abuse. Abuse-related trauma work offers many opportunities for the reworking of harsh self-judgements (e.g. of having caused, encouraged or deserved the abuse), as well as those broader self-esteem problems typically associated with child maltreatment. By exploring with the survivor the inadequate information and misinterpretations associated with such beliefs, the therapist can assist in the development of a more positive model of self and others.

Conclusion

Taken together, the approach outlined here allows the therapist to address the impaired self-functioning, cognitive distortions and posttraumatic stress found in some adults who were sexually abused as children. The serial desensitization of painful memories, both explicit and implicit, is likely to slowly reduce the survivor’s overall level of posttraumatic stress, a process that eventually lessens the general level of dissociation and avoidance required by the survivor for internal stability. This process also increases self-resources. Progressive exposure to nonoverwhelming distress is likely to increase affect regulation skills and affect tolerance. As a result, successful ongoing treatment allows the survivor to confront and process increasingly more painful abuse-related material without exceeding the survivor’s (now greater) self-capacities. This process, under optimal conditions, may continue until substantial symptom resolution has occurred. At the same time, the exploration and processing of abuse memories allows the client to reconsider early abuse-related cognitions and beliefs in the context of adult, contemporaneous awareness and, potentially, new information provided by the therapist. Throughout this process, the therapeutic relationship remains a central component, involved in both the activation and processing of childhood relational memories and associated distress, as well as serving as a model for more positive relationships in the future.

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NOTE: Portions of this article were adapted from Briere (1996).

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