Treating the Long-Term Effects of Childhood Maltreatment: a Brief Overview

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The psychological treatment of abuse effects is likely to be complex and require specialized skills and information. John Briere outlines the central principles of the 'self-trauma model', a therapeutic approach to child abuse-related issues in adults. This perspective calls upon cognitive-behavioral and relational research and theory to address the many cognitive, emotional, behavioral and interpersonal effects of child maltreatment. The critical balance between exposure to traumatic history and the consolidation of safety and stability is explored. Implicit to this model is the importance during trauma processing of internal (or 'self') capacities such as the skills of affect tolerance and affect modulation. Some clients may require extensive 'self-work' before any significant trauma-focused interventions can occur.

Childhood sexual and physical abuse is quite prevalent in Western societies. Retrospective reports by adults in the United States and Canada, for example, suggest that approximately 25-35% of women and 10-20% of men have been sexually abused at some point as children, whereas approximately 10-20% of men and women report experiences congruent with definitions of childhood physical abuse (e.g. Briere & Elliott, 2003; Finkelhor, Hotaling, Lewis, & Smith, 1990).

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

even more salient in work with abuse survivors, since sexual abuse can produce significant boundary confusion, a variety of interpersonal difficulties and greater vulnerability to client-therapist dynamics. In abuse-focused therapy, it is most important that the client be made aware of therapeutic confidentiality (and its limits), the therapist's duty to protect and warn, potential side effects of certain therapeutic interventions (e.g. hypnosis or medications) and the potential for treatment to temporarily exacerbate certain symptoms (e.g. posttraumatic stress or dysphoria). The therapist should be aware of the limits of their expertise in treating abuse survivors, and should seek out consultation, supervision and/or additional training when necessary. Therapeutic interventions should be those accepted by specialists in the field and appropriate to the survivor's specific difficulties.

It is of critical importance that the clinician has sufficient self-awareness, is psychologically healthy and under sufficient self-control that he or she does not act out countertransferential issues on the client (Pearlman & Saakvitne, 1995). Such issues include inappropriate anger, sexual expression or behavior, and physical or psychological boundary violation.

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. Furthermore, the symptom complexity associated with early, especially chronic or severe, child maltreatment may mean that no specific *DSM-IV* (2000) diagnosis accurately captures or describes the range of psychological dysfunction of some survivors (Briere & Spinazzola, in press).

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Psychological testing can provide a rich source of information on the functioning of abuse survivors. Such tests include both generic measures (e.g. the *MMPI-2* (Butcher, Dahlstrom, Graham, Tellegen, & Kaemmer, 1989), *PAI* (Morey, 1991), *Rorschach Inkblot Test* (Rorschach, 1981)) and more abuse- or trauma-specific ones (e.g. the *Trauma Symptom Inventory* (Briere, 1995) and the *Trauma and Attachment Belief Scale* (Pearlman, 2003)). However, generic tests and more abuse-specific measures have strengths and weaknesses that must be taken into account during interpretation (Carlson, 1997). Generic tests may overlook, amplify, or distort abuse-related psychological disturbance, and yet may accurately identify comorbid symptoms or disorders. On the other hand, some abuse-specific tests lack sufficient normative or psychometric data and yet, may provide potentially unique information on abuse-specific psychological disturbance. Fortunately, a number of psychological tests have been developed in the last several years that are sensitive to trauma-specific and/or generic symptoms and possess

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 survive abuse generally works against self-understanding and identity. For this reason the survivor is encouraged to explore his or her own likes and dislikes, views regarding self and other, entitlements and obligations and other aspects of self, in the context of the therapist's support and manifest acceptance. This more broad, less specifically abuse-focused intervention is, in some sense, '*identity-training*' providing the survivor with the opportunity to discover what he or she thinks and feels, above-and-beyond what others think and feel.

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 .

Cognitive and affective processing of posttraumatic stress

Assuming the client has sufficient self skills, or that these self functions have been strengthened beforehand, the treatment of trauma symptoms is relatively straightforward. There are at least three major steps in this process, although they may occur in different orders at various points in treatment:

- identification of traumatic abuse-related events,
- gradual re-exposure to the affect and stimuli associated with a memory of the abuse, and
- cognitive/affective processing.

For traumatic material to be processed in treatment, it must be identified as traumatic material. Although this seems an obvious step, it is more difficult to implement in some cases than might be expected. The survivor's avoidance of abuse-related material may lead either 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 transferential 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

questions about the specifics of the abuse experience, what the survivor recalls of his or her responses at the time and so on. *Implicit memories*, on the other hand, are often triggered either by the rendition of explicit memories (e.g. sensory reexperiencing of an abuse experience upon describing it), or by aspects of the therapeutic process (e.g. the developing attachment of the client to the therapist activates early, and therefore nonverbal, relational memories).

For abuse-focused therapy to work well, there should be as little avoidance as possible during the session. The client should be encouraged to stay as 'present' as he or she can during the detailed recall of abuse memories, so that exposure, per se, is maximized. In this regard, the very dissociated survivor may have little true exposure to abuse material during treatment, despite what may be detailed verbal renditions of a given memory.

Effective therapy also capitalizes on the effects of emotional expression and therapeutic connection during the desensitization process. The positive feelings associated with emotional release, such as crying, may countercondition the distress initially associated with the trauma, just as traditional systematic desensitization pairs a formerly distressing stimulus to a relaxed (anxiety-incompatible) state. Similarly, the experience of describing and reexperiencing painful abuse events may be counterconditioned, to some extent, in the context of positive feelings engendered by therapeutic support, validation and caring (Briere, 2002).

The therapeutic relationship not only serves to countercondition painful abuse memories, it also is a form of exposure itself. To the extent that childhood abuse has caused the survivor to fear or distrust relationships, the development of a relationship with the therapist both activates these beliefs and feelings, and provides an alternative (i.e. safety, reliability and caring) that may extinguish old associations and result in new learning.

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.

References

American Psychiatric Association (2000). *Diagnostic and Statistical Manual of Mental Disorders* (4th ed., Text Revision). Washington, D.C.

Briere, J. (1995). *Trauma Symptom Inventory*. Odessa, FL: Psychological Assessment Resources.

Briere, J. (1996). 'Treating adults who were sexually abused as children: Central principles'. *PTSD Clinical Quarterly*, 6, 29, 31-33. (Publication of the National Center for PTSD, Dept. of Veterans Affairs, U.S. Government).

Briere, J. (2002). 'Treating adult survivors of severe childhood abuse and neglect: Further development of an integrative model.' In J.E.B. Myers, L. Berliner, J. Briere, C.T. Hendrix, T. Reid, & C. Jenny (Eds.). *The APSAC Handbook on Child Maltreatment*, 2nd Edition. (pp. 175-202). Newbury Park, CA: Sage Publications.

Briere, J. (in press, a). 'Psychological assessment of child abuse effects in adults.' In J.P. Wilson & T.M. Keane (Eds.), *Assessing Psychological Trauma and PTSD: A Handbook for Practitioners*, 2nd Edition. NY: Guilford.

Briere, J. (in press, b). *Psychological Assessment of Adult Posttraumatic States: Phenomenology, Diagnosis, and Measurement*, 2nd edition. Washington, D.C.: American Psychological Association.

Briere, J. (1996). *Therapy for Adults Molested as Children*, 2nd edition. New York: Springer Publishing Co.

Briere, J., & Elliott, D.M. (2003). Prevalence and symptomatic sequelae of self-reported childhood physical and sexual abuse in a general population sample of men,*Child Abuse & Neglect*, 27, 1205-1222.

Briere, J., & Gil, E.(1998). 'Self-mutilation in clinical and general population samples: Prevalence, correlates, and functions'. *American Journal of Orthopsychiatry*, 68, 609-620.

Briere, J., & Runtz, M.R.(2002). 'The Inventory of Altered Self-Capacities (IASC):A standardized measure of identity, affect regulation, and relationship disturbance.' *Assessment*, 9, 230-239.

Briere, J., & Scott, C. (in press). *Principles of Trauma Therapy: A Guide to Symptoms, Evaluation and Treatment.* Thousand Oaks, CA: Sage.

Briere, J., & Spinazzola, J. (in press). 'Phenomenology and psychological assessment of complex posttraumatic states'. Special Issue, *Journal of Traumatic Stress.*

Briere, J., Woo, R., McRae, B., Foltz, J., & Sitzman, R.(1997). 'Lifetime victimization history, demographics, and clinical status in female psychiatric emergency room patients'. *Journal of Nervous and Mental Disease*, 185, 95-101.

Butcher, J.N., Dahlstrom, W.G., Graham, J.R., Tellegen, A., & Kaemmer, B. (1989). *Minnesota Multiphasic Personality Inventory (MMPI-2). Manual for administration and scoring.* Minneapolis: University of Minnesota Press.

Carlson, E.B. (1997). *Trauma Assessments: A Clinician's Guide*. New York: Guilford.

Classen, C.C., Nevo, R., Koopman, C., Nevill-Manning, K., Gore-Felton, C.,Rose, D.S., & Spiegel, D. (2002). 'Recent stressful life events, sexual revictimization, and their relationship with traumatic stress symptoms among women sexually abused in childhood.' *Journal of Interpersonal Violence*, 17, 1274-1290.

Cloitre, M., Koenen, K.C., Cohen, L.R., & Han, H. (2002). 'Skills training in affective and interpersonal regulation followed by exposure: a phase-based treatment for PTSD related to childhood abuse.' *Journal of Consulting and Clinical Psychology*, 70, 1067-1074.

Courtois, C. (1999). *Recollections of Sexual Abuse: Treatment Principles and Guidelines.* New York: Norton.

Davis, J.L., Petretic-Jackson, P.A., & Ting, L. (2001). 'Intimacy dysfunction and trauma symptomatology: long-term correlates of different types of child abuse.' *Journal of Traumatic Stress*, 14, 63-79.

Drossman, D.A., Lesserman, J., Nachman, G, Li, Z., Gluck, H., Toomey, T.C., & Mitchell, C.M. (1990). 'Sexual and physical abuse in women with functional or organic gastrointestinal disorders.' *Annuals of Internal Medicine*, 113, 828-833.

Edwards, V.J., Holden, G.W., Felitti, V.J., & Anda, R.F. (2003). 'Relationship between multiple forms of childhood maltreatment and adult mental health in community respondents: results from the Adverse Childhood Experiences Study'. *American Journal of Psychiatry*, 160, 1453-1460.

Erickson, M.F., & Egeland, B. (2002). 'Child neglect'. In J.E.B. Myers, L. Berliner, J. Briere, C.T. Hendrix, C. Jenny & T.A. Reid (Eds.), *The APSAC Handbook on Child Maltreatment,* 2nd Ed. Thousand Oaks, CA: Sage.

Feiring, C., Taska, L.S., & Chen, K. (2002). 'Trying to understand why horrible things happen:attribution, shame, and symptom development following sexual abuse.' *Child Maltreatment*, 7, 26-41.

Finkelhor, D., Hotaling, G., Lewis, I.A., & Smith, C. (1990). 'Sexual abuse in a national survey of adult men and women: prevalence, characteristics, and risk factors.' *Child Abuse and Neglect*, 14, 19-28.

Hart, S.N., Brassard, M.R., Binggeli, N.J., & Davidson, H.A. (2002). 'Psychological maltreatment.' In J.E.B. Myers, L. Berliner, J. Briere, C.T. Hendrix, C. Jenny, & T.A. Reid (Eds.), *The APSAC Handbook on Child Maltreatment*, 2nd Edition (pp. 79-104). Thousand Oaks, CA: Sage.

Janoff-Bulman, B. (1992). *Shattered Assumptions: Towards a New Psychology of Trauma*. NY: Free Press.

Kilpatrick, D., G., & Resnick, H.S. (1993). 'Posttraumatic stress disorder associated with exposure to criminal victimization in clinical and community populations.' In J.R.T. Davidson and E.B. Foa (Eds), *Posttraumatic Stress Disorder: DSM-IV and Beyond.* Washington, D.C: American Psychiatric Press.

Lindsay, D.S., & Briere, J. (1997). 'The controversy regarding recovered memories of childhood sexual abuse: Pitfalls, bridges, and future directions.' (Invited commentary). *Journal of Interpersonal Violence*, 12, 631-647.

Linehan, M. M. (1993). *Cognitive-Behavioral Treatment of Borderline Personality Disorder*. NY:Guilford.

McCann, I.L., & Pearlman, L.A. (1990). *Psychological Trauma and the Adult Survivor: Theory, Therapy, and Transformation*. NY: Brunner/Mazel.

Molnar, B.E., Berkman, L.F., & Buka, S.L. (2001). 'Psychopathology, childhood sexual abuse and other childhood adversities: relative links to subsequent suicidal behaviour in the US.' *Psychological Medicine*, 31, 965-977.

Morey, L.C. (1991). *Personality Assessment Inventory: Professional Manual.* Odessa, FL: Psychological Assessment Resources.

Pearlman, L. (1998). 'Trauma and the self: A theoretical and clinical perspective.' *Journal of Emotional Abuse*, 1, 7-25.

Pearlman, L.A., & Saakvitne, K.W. (1995). *Trauma and the Therapist: Countertransference and Vicarious Traumatization in Psychotherapy with Incest Survivors*. NY: W.W. Norton.

Pope, K. S., & Brown, L. S. (1996). *Recovered Memories of Abuse: Assessment, Therapy, Forensics*. Washington, DC:American Psychological Association.

Reviere, S. L. (1996). *Memory of Childhood Trauma: A Clinician's Guide to the Literature.* New York: Guilford.

Rorschach, H.(1981). *Psychodiagnostics: A diagnostic test based upon perception.* (P. Lemkau & B. Kronemberg, Eds. & Trans.,: 9th ed.). New York: Grune & Stratton. (Original work published in 1921)

Siegel, D.J. (1999). *The Developing Mind: Toward a Neurobiology of Interpersonal Experience*. NY:Guilford.

Simeon, D., Guralnik, O., Schmeidler, J., Sirof, B., Knutelska, M. (2001). 'The role of childhood interpersonal trauma in depersonalization disorder.' *American Journal of Psychiatry*, 158, 1027-1033.

van der Kolk, B.A. (1996). 'The complexity of adaptation to trauma: self-regulation, stimulus discrimination, and characterological development.' In B.A. van der Kolk, A.C. McFarlane, & L. Weisaeth (Eds.). *Traumatic Stress: the Effects of Overwhelming Experience on Mind, Body and Society*, (pp.182-213). New York: Guilford Press.

Webster, J.J., & Palmer, R.L. (2000). 'The childhood and family background of women with clinical eating disorders: a comparison with women with major depression and women without psychiatric disorder.' *Psychological Medicine*, 30, 53-60.

Widom, C.S. (1989). 'The cycle of violence.' *Science*, 244, 160-166.

Williams, L.M., & Banyard, V.L. (Ed). (1999). *Trauma and Memory*. Thousand Oaks, CA: Sage.

Wilson, J.P., & Keane, T.M. (Eds.) (in press). *Assessing Psychological Trauma and PTSD: A Handbook for Practitioners*, 2nd Edition. NY: Guilford.

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

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