

Treating adult survivors of severe childhood abuse and neglect: Further development of an integrative model

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This chapter outlines an integrated approach to the treatment of adults severely abused or neglected as children. The theory upon which it is based, referred to as the *self-trauma model* (e.g., Briere, 1992, 1996), incorporates aspects of trauma theory, as well as cognitive, behavioral, and self-psychology. Although this perspective is implicitly cognitive-behavioral, it also may be understood as an attempt to rework and reconceptualize psychodynamic therapy to encompass empirically-based principles as they relate to child abuse victims. The current chapter especially expands the cognitive components of self-trauma theory, based on newer ideas in the areas of suppressed or “deep” cognitive activation (e.g., Wegner & Smart, 1997), relational schema (e.g., Baldwin, Fehr, Keedian, Seidel, & Thompson, 1993), and the role of early attachment experiences on thoughts, feelings, and memories (e.g. Simpson & Rholes, 1998). As well, this analysis takes as its basis a growing awareness in cognitive-behavioral circles that implicit memories and processes are – at minimum -- as important as explicit ones, and that emotion is as important as cognition in understanding and treating anxiety-based disorders (Foa & Kozak, 1986; Samoilov & Goldfried, 2000; Westen, 2000) The implications of this model are presented in terms of the specific process, content, and goals of abuse-relevant psychotherapy.

THE PHENOMENOLOGY OF CHILD ABUSE AND NEGLECT AND ITS EFFECTS

As indicated in other chapters of this book, child abuse and neglect are unfortunately prevalent in North America. Beyond the moral and humanitarian objections that must be raised against child maltreatment, it is now becoming clear that childhood victimization is a substantial risk factor for the development of later mental health problems. The specific psychological impacts of early maltreatment experiences vary as a function of a number of variables, including temperament and other biopsychological factors, family environment, security of parent-child attachment, and previous history of support or abuse. In addition, it appears that the specific type of child abuse is, to some extent, related to the form of subsequent psychological distress or disorder.

Abuse Types

For the purposes of discussion here, these various types of maltreatment will be characterized as acts of *omission* and *commission*.

Acts of omission

Most typically, child maltreatment in this category consists of psychological neglect. Psychological neglect of children generally refers to sustained parental nonresponsiveness and psychological or physical unavailability, such that the child is deprived of normal psychological stimulation, soothing, and support. One of the most obvious impacts of child neglect is its tendency to decrease the extent to which secure parent-child attachment can occur. As a result, the neglected child will not be as likely as others to encounter benign interactive experiences that teach

self-awareness, self security, positive views of others, and the development of regulated affective responses to interpersonal challenges.

In addition to the obvious effects of parental nonavailability on intra- and interpersonal learning, psychological neglect is thought to produce acute psychological distress (Bowlby, 1988). Because children are social beings with profound biopsychological needs for contact comfort, nurturance, and love, sustained neglect can result in painful feelings of what appear to be deprivation and abandonment. This acute distress, in turn, may affect the child's development in many of the same ways described below for caretaker acts of commission. Also present, however, may be a growing sense of psychological emptiness and neediness and a general tendency later in life to be especially sensitive to the possibility of abandonment or rejection by others.

Acts of commission

In contrast to acts of omission, acts of commission involve actual abusive behaviors directed toward the child. These acts, whether physical, sexual, or psychological, can produce longstanding interpersonal difficulties, as well as distorted thinking patterns, emotional disturbance, and posttraumatic stress.

When such acts occur early in life, they are especially likely to motivate the development of avoidance strategies that allow the child to function despite inescapable emotional pain (Putnam, 1997). Faced with parental violence, the child may develop a style of relating whereby he or she psychologically attenuates or avoids certain attachment interactions with a given abusive caretaker (Bowlby, 1988). Although this defense protects the child, to some extent, from overwhelming distress and distorted environmental input, it also tends to reduce his or her access to any positive attachment stimuli that might be available in the environment (Briere, 1992). This response, in turn, further deprives the child of normal attachment-related learning and development, reinforces avoidance as a primary response style, and may partially replicate the difficulties associated with neglect-related attachment deprivation.

Together, early acts of omission and commission serve as an etiologic reservoir for the development of later psychological disorder. Some of these responses are the direct result of psychological injury, whereas others appear to represent coping responses to the emotional pain associated with abuse and neglect. Based on the existing literature, recent scientific developments, and clinical experience, a hypothesized series of these traumagenic mechanisms are presented below.

Abuse-related Symptom Development

For the purposes of this chapter, the primary impacts of childhood abuse and neglect on later (i.e., adolescent and adult) psychological functioning can be divided into six areas: (1) negative preverbal assumptions and relational schemata, (2) conditioned emotional responses (CERs) to abuse-related stimuli, (3) implicit/sensory memories of abuse, (4) narrative/autobiographical memories of maltreatment, (5) suppressed or "deep" cognitive structures involving abuse-related material, and (6) inadequately-developed affect regulation skills. There are undoubtedly other major abuse effects, as noted throughout this volume, although many may be secondary to these six.

Preverbal assumptions regarding self and others

One of the earliest impacts of abuse and neglect is thought to be on the child's internal representations of self and other. These representations generally arise in the context of the early parent-child relationship, wherein the child makes inferences based on how he or she is treated by his or her caretakers. In the case of abuse or neglect, these inferences are likely to be negative. For example, the young child who is being maltreated often infers negative self- and other-characteristics from such acts. He or she may conclude that he/she must be intrinsically unacceptable or malignant to deserve such "punishment" or neglect, or may come to see himself or herself as helpless, inadequate, or weak. As well, the abused child may come to view others as inherently dangerous, rejecting, or unavailable.

Although typically considered to be cognitive sequelae, these early inferences and perceptions appear to form basic beliefs that function more as a general model of self and others than as actual thought, per se. Instead, some theorists refer to such intrinsic self-other perceptions as *internal working models* (Bowlby, 1982) or core

relational schemas (Baldwin, 1992), especially when they arise from child-caretaker attachment interactions in the early years of life. This notion of internalized models or schemas emphasizes the structural or organizing aspects of this phenomenon, as opposed to the presence of discrete cognitions or episodic memories. These core beliefs and assumptions are often relatively nonresponsive to superficial verbal reassurance or the expressed alternate views of others later in life, since they are not, in fact, verbally-mediated. For example, the individual who believes, at a basic level, that she is unlikable or unattractive to others, or that others are not to be trusted will not easily change such views based on others' declarations that the person is valued by them or that they can be relied upon.

The quality and valence of these core schemas intrinsically affect the individual's later capacity to form and maintain meaningful attachments with other people. Such individuals may find themselves in conflictual or chaotic relationships later in life, may have problems with forming intimate adult attachments, and may engage in behaviors that are likely to threaten or disrupt close relationships with others (Collins & Read, 1990; Levy & Davis, 1988; Simpson, 1990). Generally, early childhood abuse and neglect has been associated with insecure attachment styles in adulthood (Alexander, 1992; Coe, Dalenberg, Aransky, & Reto, 1995; Styron & Janoff-Bulman, 1997). Insecure attachment, in turn, can be divided into three types: Fearful (involving a high need for interpersonal acceptance and affirmation and, yet, avoidance of intimacy), Preoccupied (involving similar high needs for validation and acceptance, but with a tendency to be preoccupied with attaining such affirmation through relationships), and Avoidant/Dismissing (involving avoidance of interpersonal attachments and high needs for self-reliance). These patterns of relating are likely to represent, at least in part, behavioral outcomes of the implicit relational schemas or structures described earlier, wherein early life experiences (including child abuse and neglect) produce expectations about self and others that are played out in the interpersonal sphere (Baldwin, et al., 1993). Interestingly, it appears that many individuals have different attachment styles in different situations, partially depending on what relational memories or schemata are cued or "primed" at any given period of time (Baldwin, Keelan, Fehr, Enns, & Koh-Rangarajoo, 1996).

In addition to attachment-style-related schema, it is clear that abuse and neglect early in life can produce more general relational disturbance. Pearlman & Saakvitne (1995), for example, suggest that trauma during the early years can result in chronic, negative expectations and perceptions around issues of safety, trust, esteem, intimacy, and control. These negative schema, in turn, may be easily activated by interpersonal stimuli in the current environment, as noted above.

Because such disturbance is typically at the implicit, nonverbal level, and is primarily based in safety and attachment needs, these relational schemas may not be evident except in negative or potentially threatening interactions with others, at which time these underlying cognitive cognitions may be triggered with resultant interpersonal difficulties (Simpson & Rholes, 1994). For example, an individual who -- by virtue of early parental abandonment and rejection -- has developed a preoccupied attachment style may relate relatively well in a given occupational or intimate context until he or she encounters stimuli that suggest some level of rejection or abandonment. At this point he or she may respond in the context of an activated gestalt of archaic emotional responses and cognitive structures that, although excessive in the immediate context, are appropriate to the feelings and thoughts of an abused or neglected child. This gestalt, in turn, may motivate behavior that, although intended to ensure proximity and maintain the relationship, is so "primitive" (i.e., characterized by child-level responses and demands) and affectively-laden that it challenges or even destroys that relationship.

Conditioned associations between abuse stimuli and emotional distress

Perhaps the most basic learning that occurs during child maltreatment is that of classically conditioned associations between abuse stimuli and negative emotions. Children who are beaten, repetitively screamed at, sexually abused, or abandoned typically will come to associate aspects of the abuser (e.g., his or her sex, age, physical characteristics, or escalating behaviors) with fear and other emotional distress. These conditioned emotional responses (CERs) may be embedded in generalized "fear structures" (Foa & Kozak, 1986), leading the child to experience distress in response to seeing any male, authority figure, angry person, etc. In some cases, this generalization will result in negative CERs to a variety of potential interpersonal relationships, especially those involving intimacy, closeness, or vulnerability.

These classically conditioned responses are not encoded as autobiographical memories, but rather as simple associations between certain stimuli (e.g., the sudden raising of a hand) and certain responses (e.g., fear, leading to flinching). As a result, they are not "remembered," per se, but rather are evoked or triggered by events that are

similar to the original abuse context including, as it turns out, sensory or autobiographical memories of that abuse. Later in life, exposure to such abuse-reminiscent stimuli and memories may produce strong, seemingly inappropriate or “out of the blue” negative affects that, given the nonverbal nature of the conditioning, may not even be understandable to the former victim, let alone others in his or her environment. When triggered CERs occur in the obvious context of a traumatic stressor (e.g., sudden fear when seeing a car similar to the vehicle that hit one in an accident), they are considered to be one of the “B” (reliving) criteria of PTSD. In other cases, however, the conditioned negative affect will be to early relational events that might not be definable as traumatic stressors, per se.

Implicit/sensory memories

Frequently, memories of especially traumatic events, including severe child abuse, are reexperienced later in life on a sensory level, for example as “flashbacks.” This is thought to be due, in part, to the fact that those brain and psychological systems responsible for directing the encoding and early organization and processing of explicit, narrative memory material may be flooded (or at least bypassed) by overwhelming emotional input during severe abuse or trauma -- resulting in less integrated, primarily sensory (as opposed to verbally/autobiographically-mediated) recollections upon exposure to trauma-reminiscent stimuli (Metcalf & Jacobs, 1996; Siegel, 1999; van der Kolk, McFarlane, & Weisaeth, 1996). In addition, traumatic experiences that occurred prior to the child’s acquisition of language necessarily will be nonnarrative, typically sensorimotor in nature.

As opposed to narrative memories, implicit, sensory recollection is generally devoid of autobiographic material, and is often experienced as an intrusion of unexpected sensation (e.g., sights or sounds of an event) rather than of remembering, per se. Although sensory reexperiencing is often accompanied by the associated emotions that were involved at the time of the abuse, the sensory memory of the maltreatment experience and the affects conditioned to the memory (i.e., CERs) are likely to be separate phenomena (Davis, 1992; LeDoux, 1995). In many cases, sensory memories become the stimuli that release strong CERs, which can, in turn, reinstate enough of the context of the original abuse to trigger additional reexperiencing. As will be described below, the combination of triggered sensory memories and associated negative affects is often characteristic of posttraumatic stress.

Narrative/autobiographical memories

Memories of abuse and trauma also may be encoded at the explicit, autobiographical level. In this instance, autobiographical memories and negative cognitions can be triggered by similar stimuli in the environment which, in turn, then activate negative emotional responses associated with the memory. Thus, for example, a man may be criticized by his employer in an way that triggers autobiographical memories of similar verbal abuse by his father when he was a child. These memories, in turn, may activate (a) anger and fear that remains conditioned to reminders of being repeatedly berated, as well as (b) broader negative self-perceptions and cognitions associated with these stimuli (e.g., of being bad or inadequate), and (c) intrusive sensory/implicit recollections of aspects of the abuse experiences (e.g., his father’s rageful face). These additional associations and responses may serve to reinstate the cognitive-emotional context of the original abuse, thereby providing additional stimuli that, in turn, activate additional autobiographical, sensory, and cognitive reactions, each with their associated CERs.

Clinical experience suggests that, for those with significant childhood trauma, autobiographically-encoded memories are distressing primarily for their ability to activate related implicit memory intrusions, relational schema, and CERs, as described above. In other words, explicit, verbally-mediated memory material may be most aversive for its ability to activate associated nonverbal feelings, implicit/sensory memories, and abuse-related schema. Although this is distressing for the child abuse survivor, it will be suggested later in this chapter that the therapist can use this very phenomenon to activate otherwise less-available implicit and schematic childhood memories during treatment.

Suppressed or “deep” cognitive structures

Even some autobiographical, narrative memories may not be available to the survivor's surface awareness, however. In this regard, recent work in cognitive experimental psychology indicates that some verbally-mediated, otherwise normally-available cognitive material can be excluded from everyday, "surface" thinking, instead operating at "deep" (i.e., nonconscious) levels (Wegner & Erber, 1992). These cognitions usually are negative and distress-producing, and are thought to be actively suppressed as a way to reduce dysphoria (Wegner & Smart,

1997). When suppressed thoughts are triggered, such that they influence other thoughts or motivate behavior, the phenomenon is referred to as *deep cognitive activation*. For the purposes of this chapter, these suppressed but still influential thoughts, many of which appear to form associational networks and, upon activation, trigger associated emotional responses (Wenzlaff, Wegner, & Klein, 1991), will be referred to here as *deep cognitive structures*.

Thought suppression is a more difficult task than otherwise might be assumed, however. By virtue of what are called ironic processes (the mind's monitoring of whether it has successfully suppressed material ironically defeats suppression by keeping the material in mind), deep cognitive material typically presses for returned awareness (Wegner, 1994). It appears, however, that individuals with a history of continued avoidance (e.g., some abuse survivors) are able to suppress material for considerably longer periods of time (Kelly & Kahn, 1994; Wegner & Gold, 1995), probably through the use of distraction and -- although not considered as such in the cognitive literature -- dissociative compartmentalization of unwanted cognitive material. Even the defensive strategies of "expert" suppressors, however, can be relatively easily overwhelmed by exposure to stimuli in the environment that are reminiscent in some way of the suppressed material. This may be especially true for thoughts and memories of prior painful interpersonal experiences (i.e., those especially distressing to the individual, and thus more likely to be suppressed) that are triggered by later, similar stimuli in the interpersonal domain. For example, an individual whose parents were dismissing and discounting of him or her, may have deep (not consciously perceived in their untriggered state) cognitive structures/memories of painful rejection experiences which, in turn, may be stimulated later in life by perceptions (real or otherwise) of criticism by significant others.

Because both tend to operate outside of conscious awareness, deep cognitive structures and the previously-described relational schemata may appear similar. However, relational schema are generally acquired much earlier in childhood, typically during the period of greatest parent-child attachment sensitivity, and involves memory that is intrinsically nonverbal, whereas deep cognitive structures are generally later, autobiographical memories that are actively suppressed for defensive reasons. Nevertheless, both operate as unconscious processes, and both can be triggered by environmental (typically relational) stimuli that are in some way similar to the original abusive context.

Interference in development of affect regulation/tolerance skills.

A final impact of severe childhood maltreatment appears to be that of insufficiently-developed affect regulation (Pearlman, 1998). This concept refers to the individual's capacity to control and tolerate strong (especially negative) affect, without resorting to avoidance strategies such as dissociation, substance abuse, or external tension-reducing behavior (Briere, 1992). This capacity is thought to develop in the early years of life (Bowlby, 1988), although it usually continues to develop thereafter. The normal development of affect regulation capacities is briefly described here, so that its mis-development in the severely abused can be more clearly appreciated. As well, it will be suggested later in this chapter that affect regulation skills can be learned later in life, generally in ways parallel to their development in a healthy, normal childhood environment.

The child who develops in a generally positive environment is, nevertheless, likely to encounter a variety of surmountable obstacles or challenges, ranging from small frustrations and minor discomfort to momentarily unavailable caretakers. In the context of sustained external security, the well cared-for child is thought to learn to deal with the associated uncomfortable (but not overwhelming) internal states through trial and error, slowly building a progressively more sophisticated repertoire of internal coping strategies as he or she confronts increasingly more challenging and stressful experiences (Briere, 1996). At the same time, since the associated discomfort does not exceed the child's growing internal resources, he or she is able to become increasingly more at home with some level of distress and is able to tolerate greater levels of emotional pain. This process appears to be self-sustaining: as the individual becomes better able to modulate and tolerate distress or dysphoria, such discomfort becomes less de-stabilizing and the individual is able to seek more challenging and complex interactions with the environment without being derailed by concomitant increases in stress and anxiety.

In contrast to those with good affect regulation skills, however, severely abused or neglected children have been exposed to *insurmountable* affective obstacles, such as extreme neglect, emotionally intolerable physical or sexual abuse, or chronic, invasive psychological maltreatment. In such instances, affect regulation skills are less likely to develop, given the danger and ongoing emotional pain that overwhelms and precludes trial-and-error skills development. Instead, as noted later, the abuse victim may become expert at using more powerful (but generally more primitive) dissociation, thought suppression, distraction, or other avoidance strategies that allow continued

functioning in the face of otherwise potentially overwhelming distress. Unfortunately, however, these same defenses, by virtue of their effectiveness, further preclude the development of more sophisticated regulation capacities.

As a result of inadequate opportunities to develop affect regulation skills, the formerly abused adult may be subject to affective instability, problems in inhibiting the expression of strong affect, and may have difficulty terminating dysphoric states without externalization or avoidance. Because the individual is unable to adequately modulate his or her emotions, he or she may be seen as moody and emotionally hyperresponsive, and as tending to overreact to negative or stressful events in his or her life. In the absence of sufficient internal affect regulation skills, the individual may respond to painful affect and activated negative cognitions with external behaviors that distract, soothe, numb, or otherwise reduce painful internal states, such as substance abuse, inappropriate or excessive sexual behavior, aggression, bingeing or purging, or even self-injury (Briere, 1992; Briere & Gil, 1998; McCann & Pearlman, 1990). In this regard, the survivor of extreme abuse and neglect may have to deal with two interacting sets of difficulties: the triggering of sudden abuse-related memories, cognitions, and painful affects in the interpersonal world, and the relative absence of affect regulation capacities that might otherwise allow regulation and resolution of these triggered responses.

Posttraumatic stress

The various cognitive, memory, and self-related difficulties noted above can contribute to the development of posttraumatic stress disorder (PTSD) in a significant proportion of those with severe child maltreatment histories. The major symptoms associated with abuse-related posttraumatic stress are (a) intrusive reliving experiences, such as sensory flashbacks, intrusive thoughts, and (autobiographical) memories of the abuse, nightmares, and heightened emotional reactions to events reminiscent of maltreatment stimuli, (b) avoidance and numbing, for example attempts to avoid people, places and situations associated with the abuse, as well as reduced or constricted emotionality, and (c) autonomic hyperarousal, involving chronic activation of the sympathetic nervous system, with resultant heightened startle responses, sleep disturbance, muscle tension, irritability, etc (American Psychiatric Association, 1994).

Not all people exposed to abuse or other upsetting events develop PTSD, however, nor do they necessarily exhibit significant posttraumatic symptoms short of PTSD (Blank, 1993). Various authors suggest that the extent to which a given event produces major posttraumatic stress is a function of a variety of pre-trauma variables, such as temperament and biologically-based vulnerability to stress, the presence of preexisting psychological difficulties that reduce stress tolerance, exposure to previous traumatic events, the memory of which may be triggered by current trauma exposure to produce even more posttraumatic distress, and the individual's ability to regulate negative affect, as described above (Briere, 1997; March, 1993; Yehuda & McFarlane, 1995). Apropos of the last point, the self-trauma model suggests that a significant aspect of one's response to a potential trauma is the degree to which the stressor overwhelms one's capacity to "handle" its effects through self capacities, especially affect regulation.

The relative mismatch between especially overwhelming trauma (i.e., severe child abuse) and inadequate affect regulation -- whether by virtue of insufficient affective development or because the trauma was so severe that even normal affective capacities would fall short -- is thought to produce extreme distress which, in turn, is classically conditioned to those stimuli present at the time of the trauma. As a result, phenomena that are reminiscent of the original traumatic event can trigger sensory or narrative memories that, in turn, activate negative emotional responses. When this memory is primarily sensory (e.g., suddenly seeing or hearing aspects of a childhood rape), it may be described as a flashback. When the triggered memory is more autobiographical (e.g., a less sensory, more narrative recollection of the rape), it is often referred to as a restimulated memory, *per se*. Finally, although not typically understood as such in this context, the activation of deep/unmonitored, abuse-related relational memories and deep cognitive structures by reminiscent stimuli in interpersonal interactions can also be viewed as posttraumatic, as will be suggested later in this chapter. In many cases, different aspects of a memory (i.e., its sensory, narrative, emotional, and relational components) are triggered simultaneously, leading to an especially powerful reexperiencing of the original traumatic event. It is important to reiterate at this point that there appear to be two separate components of triggered memory: the memory itself, whether sensory or autobiographical, and the negative affective responses at the time of the abuse that are classically conditioned to the

memory.

As a result of painful affects linked to trauma-related memory, remembering abuse (whether via a trigger or narrative recall) often is upsetting. In response, as noted earlier, many individuals engage in at least some level of avoidance when faced with a triggered feeling, memory, or cognition. This avoidance may be of one's thoughts, for example, by actively suppressing awareness of upsetting cognitions and memories of the trauma. Or, avoidance may be focused on reducing one's activated emotional responses to the memory of the trauma, for example by numbing one's feelings with drugs, alcohol, or by separating oneself from one's emotional experience through dissociation. Finally, avoidance may be of the triggers themselves, for example by avoiding people, places, or situations that otherwise might trigger a traumatic memory, or, in some cases, by dissociating awareness of environmental stimuli that might otherwise serve as triggers. Such responses are superficially adaptive at the time they occur. However, avoidance also may disrupt normal psychological functioning, and, as will be described later, can interfere with psychological recovery from traumatic events.

The intrusive and avoidant experiences associated with posttraumatic stress frequently interact with one another. For example, as described above, an abused or otherwise traumatized person may have flashbacks or intrusive cognitions that are triggered by a reminiscent event, and then may try to suppress these thoughts and memories in order to avoid the associated conditioned responses. Such avoidance may involve distraction or other attempts to not think about or feel anything related to the traumatic event. However, also as noted earlier, suppression of thoughts or feelings is harder than it might seem – a number of researchers have found, for example, that trying not to think about something often results in a rebound effect; after initial suppression, the thought or feeling intrudes all the more (Wegner, 1994). In fact, it is likely that an important initiator of intrusive trauma-related thoughts is the very act of attempted suppression (Shipherd & Beck, 1999). As a result, although the original thought or memory might be triggered by an environmental stimulus and then suppressed, the subsequent re-intrusion of the thought or memory may be due to, among other things, its unsuccessful continued suppression or avoidance.

Although these various intrusive experiences and avoidance responses are common in PTSD, they also may occur in people who have been traumatized but do not present with all the diagnostic criteria for this disorder. In contradistinction to more classical pathology models, the self-trauma model suggests that posttraumatic responses are not merely symptoms of dysfunction, but rather often are intrinsic mechanisms that serve an important psychological function -- that of repetitive reactivation and processing of traumatic memories to the point that they lose their distress-producing characteristics and can be accommodated by existing self capacities.

Intrusive Sensory and Cognitive Symptoms as Memory Processing

Given that overwhelming childhood maltreatment commonly produce repetitive and intrusive cognitive, sensory, and emotional experiences later in time, usually preceded and followed by avoidance activities, an important question is what psychological purpose, if any, such phenomena might serve. In other words, although it may be possible to establish that reexperiencing symptoms such as flashbacks, nightmares, or triggered trauma-related thoughts and feelings arise from triggered implicit or suppressed memories, an interesting question emerges: could the cycles of intrusion and avoidance experienced by those exposed to traumatic events (e.g., child abuse) represent something more than just reciprocal effects? Could it be that posttraumatic intrusion represents an inherent tendency to *process* suppressed or intrinsic memory material, and could concomitant or subsequent avoidance activities represent the control or titration of this exposure function?

Apropos of this, and integrating Horowitz's (1976, 1986) ideas with behavioral exposure models (e.g., Foa & Rothbaum, 1998) and with Rachman's (1980) and others' notion of emotional processing, the self-trauma model suggests that posttraumatic intrusion and avoidance may be, in fact, an inborn self-healing activity. Specifically, "symptoms" such as flashbacks, intrusive cognitions, and nightmare may represent the mind's automatic attempt to desensitize affectively-laden memories by repeatedly exposing itself to small "chunks" of such material in a safe environment. In this regard, similar to what may be the critical elements of cognitive-behavioral treatment for traumatic stress (see the treatment section of this chapter), the ameliorative components of posttraumatic stress responses may be (a) *exposure* (i.e., to the triggered memory), (b) *activation* (i.e., of cognitive and emotional responses, as well as larger cognitive-emotional gestalts or structures), (c) *disparity* (i.e., the fact that reliving the memory means reliving danger and trauma, whereas, in reality, the current environment is not dangerous or

traumatic), and (d) *processing* (habituation/extinction/counterconditioning in the case of conditioned emotional responses to the memory, and restructuring/reconsideration of meaning in the case of negative cognitive schemas).

Thus, the repeated evocation (via internal or external triggers) of traumatic memory in the immediate absence of threat or danger may serve to habituate or extinguish conditioned emotional responses and/or prompt reconsideration of abuse/trauma-related cognitive structures, since these responses are no longer accurate in the current, non-dangerous environment. The avoidant symptoms of posttraumatic stress, on the other hand, may serve to regulate or control the impact of intrusive cognitive-emotional memories by decreasing contact with posttraumatic triggers through dissociation of environmental stimuli and by reducing awareness of activated CERs. This avoidance mechanism would be most important in instances when early childhood maltreatment had precluded the development of sufficient affect regulation capacities, such that "normal" reexperiencing of memory would exceed the survivor's ability to regulate painful material, producing extreme distress and, ironically, eliminating the disparity requirement by making the current environment painful and subjectively dangerous.

From this perspective, the individual who was traumatized in the context of an otherwise relatively positive childhood history (for example, in cases of isolated extrafamilial abuse, or when the trauma occurred later in life) will have, on average, better affect regulation capacities than those with significant, ongoing childhood maltreatment (Briere, 2000; Elliott, 1994), and thus will need less avoidance of triggered traumatic memories. In such individuals, activated cognitive and emotional memories/schemas allow relatively rapid exposure, processing, and habituation/extinction of painful affects that were conditioned to the memory, leading to a more rapid resolution of posttraumatic distress¹. In this regard, the CERs associated with the traumatic memory extinguish as they are repeatedly activated but not reinforced by current danger or pain. As, over time, the CERs become less susceptible to activation, the traumatic memory becomes less distress-producing. As well, the diminution of abuse-era emotional responses means that the original abuse context is less fully reinstated, and thereby is less able to activate additional sensory and autobiographical memories, leading to less reexperiencing.

Individuals from abusive or neglecting environments, however, have fewer affect regulation skills and thus are more easily overwhelmed by reexperienced traumatic memories, and therefore require more avoidance to downregulate their distress to acceptable levels. The unfortunate but unavoidable result of this more extreme titration requirement, however, is less self-exposure and less activation – leading to a more delayed recovery. In the extreme case, very low affect regulation capacities in the face of especially painful childhood memories may result in chronic and extreme avoidance strategies (e.g., substance addiction, dissociative disorders) that, in fact, nullify the effects of intrusion and block recovery entirely.

From this perspective, flashbacks and related intrusive experiences, as well as avoidant symptoms such as numbing and cognitive disengagement, represent the mind's desensitization and processing activities more than they reflect underlying pathology, per se. This view of repetitive memory intrusion as a desensitization device is in some ways similar to Horowitz's (1976, 1986) cognitive stress response theory. Horowitz, however, suggests that posttraumatic intrusions represent the mind's ongoing attempt to integrate traumatic material into a pre-existing cognitive schemata that did not include the trauma or its implications. Horowitz hypothesizes that the traumatized individual automatically cycles through periods of intrusion and avoidance in an attempt to cognitively process and accommodate new, trauma-related material.

While acknowledging the importance of reconfiguring cognitively unacceptable material via reexperiencing in a disparate environment (a concept similar - but not equivalent - to Horowitz's model -- see Foa and Rothbaum [1998] for a critique of Horowitz's hypothesis), self-trauma theory suggests that these cycles also represent (perhaps more directly) the stepwise exposure and consolidation associated with an inborn form of systematic desensitization of *affect*. In this regard, many traumatic memories appear to be too anxiety-producing to be cognitively processed prior to some reduction in their stress-producing capacity (Foa & Riggs, 1993), and therefore must be at least partially desensitized before equally important cognitive processes can occur.

Unfortunately, as noted above, some survivors of severe child maltreatment (and later adult traumas) are not able to fully desensitize and accommodate trauma through intrusive re-experiencing of affects, memories, or cognitions alone, and hence present with chronic posttraumatic stress. This may occur because the severity of the trauma (or, perhaps more typically, the extent of impaired self capacities) motivates excessive use of cognitive and

¹ The actual recovery time is likely to vary considerably, according to the severity of the trauma and the presence of other predisposing factors.

emotional avoidance strategies. The presence of excessive dissociation or other avoidance responses lessens the survivor's self-exposure to traumatic material -- and the availability of the associated emotional responses to habituation or extinction -- and thus reduces the efficacy of the intrusion-desensitization process. In support of this notion, it appears that individuals who tend to avoid internal access to traumatic material, either through cognitive avoidance or dissociation, suffer more psychological distress than do those with less avoidant tendencies (e.g., Burt & Katz, 1987; Holen, 1993; Koopman, Classen, & Spiegel, 1994; Wirtz & Harrell, 1987). In contrast, even superficial exploration (exposure) and emotional expression (activation) of previous traumatic events in safe environments has been shown to significantly decrease psychological symptoms, as well as increasing indices of physical health (Murray & Segal, 1994; Pennebaker, Kiecolt-Glaser, & Glaser, 1988; Petrie, Booth, Pennebaker, Davison, & Thomas, 1995). This seeming competition between two relatively automatic trauma-related processes, intrusion and avoidance, will be considered in the upcoming treatment section.

Borderline Personality Disorder Reconsidered

If one considers posttraumatic stress to consist, in part, of intrusive feelings, thoughts, and memories that are triggered by some sort of reminiscent stimulus, often followed by attempts by the affected individual to avoid such triggers or their emotional effects, then a close cousin of PTSD may be borderline personality disorder. In addition to problems with identity and self-other boundaries, those diagnosed as borderline are often characterized as prone to sudden emotional outbursts, self-defeating cognitions, feelings of emptiness and intense dysphoria, and impulsive, tension-reducing behavior that are triggered by perceptions of having been abandoned, rejected, or maltreated by another person (American Psychiatric Association, 1994). The "borderline" person is often viewed as having problems in impulse control, such that he or she is seen as emotionally overreactive to perceived losses or maltreatment, responding with angry affect and sudden, ill-considered behavior.

As with PTSD, many severely abused people have a number of "borderline traits," but fail to meet all the diagnostic criteria for the disorder. And, as per PTSD, the self-trauma model holds that a fair portion of what is considered borderline behavior and symptomatology can be seen, instead, as triggered implicit memories, schemas, and feelings associated with early (in this instance relational) traumas (e.g., abuse, abandonment, rejection, or lack of parental responsiveness/attunement) that the individual, in turn, tries to avoid via "dysfunctional" activities such as substance abuse, inappropriate proximity-seeking, or involvement in distracting, tension-reducing behaviors (e.g., dramatic actions, sexual behaviors, or aggression). In this way, the "impulsive," "acting-out" behavior of "borderline" individuals parallels the experience of the PTSD individual, except that in the former the triggers for reexperiencing are usually within some sort of relationship, the activated memories are often implicit, preverbal, and imbedded in attachment disturbance, and the reactions to the activated memories are often more relational and seemingly more primitive since they involve the reliving of unprocessed childhood-era events (see Jacobs & Nadel, 1985, re the "infantile" effects of some activated early childhood memories).

In a comparative example, a Vietnam veteran with PTSD might have intrusive sensory reexperiences of a combat scenario after being triggered by the sound of an automobile backfire, and, upon experiencing the Vietnam-era fear associated with the combat memory, engage in attempts to find safety. An individual with borderline personality disorder, after being triggered by a perceived slight in an intimate relationship, on the other hand, might experience sudden, intrusive thoughts and feelings of abandonment and betrayal associated with childhood maltreatment, and reexperience abuse-era desperation and anger associated with that memory. The individual might then engage in dramatic negative tension-reducing or proximity-seeking behavior in the context of that relationship. Both are having posttraumatic reactions that involve reliving a previously traumatic event, although the relational components of the latter are often seen, instead, as evidence of a personality disorder.

Summary of the self-trauma Model

The self-trauma model suggests that, beyond its initial negative effects, early and severe child maltreatment interrupts normal child development, conditions negative affect to abuse-related stimuli, and interferes with the usual acquisition of self capacities -- perhaps especially the development of affect regulation skills. This reduced affect regulation places the individual at risk for being more easily overwhelmed by emotional distress associated with memories of the abuse/trauma, thereby motivating the use of dissociation and other methods of avoidance in

adolescence and adulthood. In this way, impaired self capacities lead to reliance on avoidance strategies, which, in turn, further preclude the development of self capacities. This negative cycle is exacerbated by the concomitant need of the traumatized individual to process conditioned emotional responses and distorted cognitive schema by repetitively re-experiencing cognitive-emotional memories of the original traumatic event -- a process that can further overwhelm self-capacities and produce distress.

Unfortunately, if the individual is sufficiently dissociated or otherwise avoidant, the intrusion-desensitization process will not include enough direct exposure to upsetting material to significantly reduce the survivor's underlying conditioned emotional distress. As a result, the individual will continue to have flashbacks and other intrusive symptoms indefinitely, and will continue to rely on avoidance responses such as dissociation, tension reduction, or substance abuse to deal with the negative emotions arising from such reexperiencing. This process may lead the abuse survivor in therapy to present as chronically dissociated, besieged by overwhelming yet unending intrusive symptomatology, and as having "characterologic" difficulties associated with identity, relational, and affect regulation difficulties.

TREATMENT IMPLICATIONS OF THE SELF-TRAUMA MODEL

The model outlined above has a number of implications for the treatment of adults severely abused as children. These include suggestions regarding (a) the correct focus, pace, and intensity of psychotherapy, (b) how one might intervene in the self and cognitive difficulties of abuse survivors, and (c) possible approaches to the resolution of the chronic posttraumatic symptomatology often found in this population.

Treatment Process Issues and the Therapeutic Window

A major implication of the self-trauma model is that many adult survivors of severe childhood abuse expend considerable energy addressing trauma-related distress and insufficient self capacities with avoidance mechanisms. In other words, the survivor whose reexperienced CERs to traumatic memories generally exceeds his or her internal affect regulation capacities is forced to continually invoke dissociation, substance abuse, thought suppression, and other avoidance responses to maintain internal equilibrium. These avoidance strategies are used at several levels: (a) to reduce awareness of (and therefore susceptibility to) potential environmental triggers, (b) to lessen awareness of memories once they are triggered, and (c) to reduce cognitive and emotional activation once CERs to these memories are evoked. In the absence of such protective mechanisms, the individual is likely to become overwhelmed by anxiety and other negative affects on a regular basis -- especially when exposed to triggers of traumatic memory in the environment. As a result, avoidance defenses are viewed as necessary survival responses by some survivors, and overly enthusiastic or heavy-handed attempts by a therapist to remove such "resistance," "denial," or "dissociative symptoms" may be seen as potential threats to the client's internal equilibrium. For this reason, the psychotherapeutic process must proceed carefully to avoid overwhelming the client and reinforcing the use of additional avoidance responses that otherwise would further impede therapeutic progress.

The process of effective psychotherapy may be conceptualized, in part, as taking place in the context of a *therapeutic window*. (Briere, 1996). This window refers to that psychological location between overwhelming exposure and excessive avoidance wherein therapeutic interventions are most helpful. Such interventions are neither so nondemanding as to provide inadequate exposure and processing, nor so evocative or powerful that the client's delicate balance between trauma activation and self capacity is tipped toward the former. In other words, interventions that take the therapeutic window into account are those that challenge and motivate psychological growth, desensitization, and cognitive processing, but do not overwhelm internal protective systems and thereby retraumatize and motivate unwanted avoidance responses.

Interventions that undershoot the therapeutic window are those that either (a) completely and consistently avoid traumatic material, including any exploration of childhood abuse, or (b) are focused primarily on support and validation in a client who could, in fact, tolerate greater exposure and processing of traumatic material. Undershooting interventions are rarely dangerous; they can, however, waste time and resources at times when more effective therapeutic interventions might be possible.

Overshooting the window occurs when interventions provide too much exposure intensity or focus on material that requires additional work before it can be safely addressed. In addition, interventions that are too fast-paced may overshoot the window because they do not allow the client to adequately accommodate and otherwise process previously activated material before adding new stressful stimuli. When therapy consistently overshoots the window, the survivor must engage in avoidance maneuvers in order to keep from being overwhelmed by the therapy process. Most often, the client will increase his or her level of dissociation during the session or will interrupt the focus or pace of therapy through arguments, "not getting" obvious therapeutic points, or changing the subject to something less threatening. Although these behaviors may be seen as "resistance" by the therapist, they are often appropriate protective responses to, among other things, therapist process errors. Unfortunately, the client's need for such avoidance strategies can easily impede therapy by decreasing her or his exposure to effective treatment components.

In the worst situation, therapeutic interventions that consistently exceed the window can harm the survivor. This occurs when the process errors are too numerous and severe to be balanced or neutralized by client avoidance, or when the client is so impaired in the self domain or intimidated by the therapist that he or she cannot adequately utilize self-protective defenses. In such instances, the survivor may become flooded with intrusive stimuli, may "fragment" to the point that his or her thinking is less organized or coherent, or may become sufficiently overwhelmed that more extreme dissociative behaviors emerge. Further, in an attempt to restore a self-trauma equilibrium, she or he may have to engage in avoidance activities such as self-mutilation or substance abuse after an overstimulating session. Although these states and responses may not be permanent, they are stigmatizing or disheartening for many clients, and may lead them to terminate treatment or become especially avoidant during subsequent sessions.

In contrast, effective therapy provides sufficient safety and containment that the client does not have to over-rely on avoidance strategies. By carefully titrating therapeutic exposure so that the attendant emotional/CER activation does not exceed the survivor's internal affect regulation capacities, treatment in the therapeutic window allows the client to go where he or she may not have gone before without being retraumatized in the process. As is described below under "Intervening in abuse-related trauma symptoms," this sense of safety and concomitant lower level of avoidance is a major prerequisite to the successful processing of posttraumatic stress in many individuals.

Clinical experience suggests that, at minimum, three aspects of therapeutic process should be considered in effective (window-centered) abuse-focused psychotherapy. These are: (1) exploration versus consolidation, (2) intensity control, and (3) goal sequence. Each represents the therapist's attempt to find the appropriate point between safety and processing, with the assumption that, when in doubt, the former is always more important than the latter.

Exploration versus consolidation

This aspect of the therapeutic process occurs on a continuum, with one end anchored in interventions devoted to greater exposure to traumatic material, with subsequent nonoverwhelming activation of abuse-related CERs, and the other constrained to interventions that support and solidify previous progress and provide a secure base from which the survivor can operate without fear.

Exploratory interventions typically invite the client to verbally examine (and thereby implicitly re-experience) material related to his or her traumatic history. For example, an exploratory intervention might involve asking the client to approach the possibility of using slightly less cognitive avoidance (e.g., denial) or dissociative disengagement when describing a previously described painful subject. Or, the client may be asked about something that, although somewhat threatening or distress-producing, is within his or her capacity to address. The key here is that the survivor -- in the context of relative safety -- attempts to do something new, whether it be thinking of something previously not completely considered, or feeling something previously not fully experienced.

Consolidation, on the other hand, is less concerned with exposure or processing than it is with safety and foundation. Consolidative interventions may focus the client on potential imbalances between trauma-related activation and self-capacities at a given moment, and invite the client to shore up the latter. Or, the therapist may choose to validate, sooth, or support the client at a point where he or she is experiencing significant distress. An important issue here is that the survivor is not being asked to avoid existing traumatic states, but rather to more fully anchor himself or herself in such a way as to strengthen challenged self capacities. Interventions in this

domain may involve, in one instance, working to keep the agitated client from exceeding the therapeutic window. In another, it may involve reminding the client who is attempting to move too fast of how far he or she has come and of the need to honor his or her needs for safety and stability.

The decision to explore or consolidate at any given moment reflects the therapist's assessment of which direction the client's balance between stress and resources is tilting. The overwhelmed client, for example, typically requires less exposure and more consolidation, whereas the stable client may benefit most from the opposite. Further, this assessment of the client's internal state may vary from moment to moment: at one point exploration and exposure may be indicated, whereas at another consolidation may be required.

Intensity control

Intensity control refers to the therapist's awareness and relative control of the level of activation occurring within the session. Most generally, it is recommended that -- especially for those with impaired self-capacities -- emotional intensity be highest at around mid session, whereas the beginning and end of the session should be at the lowest intensity. At the onset of the session, the therapist should encourage the client to gradually enter the therapeutic domain of trauma and self work, whereas by the end of the session the clinician seeks to insure that the client is sufficiently de-aroused and has sufficient closure that she or he can re-enter the outside world without needing later tension-reduction activities. In addition, the relative safety of the session may encourage some clients to become more affectively aroused than they normally would outside of the therapeutic environment. As a result, it is the therapist's responsibility to leave the client in as calm an affective state as is possible -- ideally no more than the arousal level present initially -- lest the client be left with more affective distress than he or she can reasonably tolerate upon the session's end and termination of therapeutic support.

From the perspective offered in this chapter, intense affect during treatment may push the survivor toward the outer edge of the window, whereas less intensity (or a more "surface" cognitive focus) will represent movement toward the inner (safer) edge. The need for the client, at some point, to experience seemingly dangerous feelings and to think potentially distress-producing thoughts -- not to dissociate them -- during abuse-focused treatment requires that the therapist carefully titrate the level of affective activation the client experiences, at least to the extent this is under the therapist's control. The goal is for the client to neither feel too little (i.e., dissociate or otherwise avoid to the point that abuse-related CERs and cognitions cannot be processed) nor feel too much (become so flooded with previously avoided affect that he or she overwhelms available self resources and is retraumatized).

Goal sequence

As noted by various authors (Courtois, 1991; Linehan, 1993; McCann & Pearlman, 1990; van der Hart, Steele, Boon, & Brown, 1993), therapy for severe abuse-related difficulties should generally proceed in a step-wise fashion, with early therapeutic attention paid more to the assessment and development of self resources and coping skills than to trauma per se. This notion of "self before trauma" takes into account the fact that those interventions most helpful in working through major traumatic stress (i.e., exposure and activation) may overwhelm the client who lacks sufficient internal resources (Linehan, 1993). Specifically, the process of accessing and affectively processing traumatic memories requires basic levels of affect tolerance and regulation skills. In the relative absence of such self resources, exposure to traumatic material can easily exceed the therapeutic window and lead to fragmentation, increased dissociation, involvement in later tension-reduction activities, and, potentially, therapy drop-out.

Because of the need for adequate self skills prior to intensive trauma work, the choice of therapeutic goals for a client must rely on detailed psychological assessment (Briere, 1997). Whether done with the assistance of psychological tests that tap self and trauma domains, or solely through careful attention to self and trauma dynamics during early sessions, the therapist must determine if a given client has sufficient self-functioning to tolerate relatively quick progression to trauma-focused interventions, or whether she or he requires extended therapeutic attention to identity, boundary, and affect regulation before significant trauma work can be undertaken (Linehan, 1993).

Due to the complex relationship between self capacities and traumatic stress, however, assessment of readiness to do trauma work cannot be determined solely at one point in time and then assumed thereafter. Indeed, a client's affect regulation capacities may appear sufficient early in treatment, only to emerge as far less substantial later in therapy. For example, as therapy successfully reduces dissociative symptomatology, it may become clear that what originally appeared to be good affect regulation actually represents the effects of dissociative avoidance of painful affect and/or continued suppression of traumatic memories. Alternatively, a client who initially had superficially intact self-functioning may later experience a reduction in self capacities as he or she addresses especially traumatic material or as the deepening therapeutic relationship triggers early attachment-related schema. Although some of this fragmentation may be amenable to careful attention to the therapeutic window, it is also true that intense re-experiencing of traumatic events can temporarily reduce self functioning (Linehan, 1993). Given these potential scenarios, it is strongly recommended that the therapist continue to evaluate the client's current affect regulation capacities and trauma level throughout treatment, so that he or she can adjust the type, focus, or intensity of intervention when necessary.

Intervening in Impaired Self-functioning

As noted above, the availability and quality of self resources are typically major determinants of level of symptomatology and response to treatment. So important are such capacities to traumatic stress and therapeutic intervention that, as mentioned, some clients may require more "self work" than trauma exposure early in treatment, although, as will be considered below, these two activities sometimes may be quite similar, or even equivalent. For others, there may be sufficient self skills available to allow some trauma-based interventions, yet continued attention to the development of further self capacities will be required. Finally, for some clinical abuse survivors, self issues may not require any significant intervention, and desensitization of traumatic material may occur relatively quickly (Linehan, 1993). Even in the latter case, however, it is possible for processing of especially painful traumatic memory to briefly overwhelm normally sufficient self capacities, thereby requiring some (typically temporary) self-level interventions.

Although the primary self resource or capacity stressed thus far has been affect regulation, the survivor's ability to maintain a coherent sense of self is also important. Because early traumatic abuse typically pulls the child's attention away from internal experience and towards the external environment (where danger exists and must be assessed), the maltreated child may grow to become primarily "other-directed" (Briere, 1992, 1996). Although this adaptation is well-suited for the hypervigilance required of endangered beings, it can easily interfere with optimal psychological functioning in later instances where self-awareness, internal security, and independence or self-directedness are necessary. Most relevant to this chapter, effective psychotherapy, abuse-oriented or otherwise, requires that the client be able to attend to internal processes and dynamics, and to develop a relationship to self -- above-and-beyond his or her relationship with the therapist. For this reason, the self-trauma model attends not only to affect regulation, but also to identity issues when working with maltreatment effects.

Safety and support

Because, for many survivors, an early hazard to the development of self resources was the experience of danger and lack of support or protection, thereby motivating hypervigilance and other-directness, these issues must receive continuing attention in abuse-focused psychotherapy. In the absence of continual and reliable safety and support during treatment, the survivor is unlikely to reduce his or her reliance on avoidance defenses, nor to attempt the necessary work of forming a relatively open relationship with the psychotherapist. Because early neglect and/or abuse may have led to the development of an ambivalent or avoidant attachment pattern (Alexander, 1992), the client is, in some sense, being asked to go against lifelong learning and become dangerously vulnerable to a powerful relational figure. That he or she is willing to do so at all in such cases is testament to the investment and bravery that many abuse survivors bring to therapy.

Given the above, the clinician must work hard to provide an environment where the survivor can experience therapeutic nurturance and support. Just as the chronically avoidant, formerly-abused child may reject a loving foster parent, the survivor of severe abuse may utilize similar defenses that, at least initially, preclude a working relationship with his or her therapist. As many clinicians will attest, there is no short-cut to the process of

developing trust in such instances. Instead, the clinician must provide ongoing reliable data to the survivor that he or she is not in danger -- neither from physical or sexual assaults, nor from rejection, domination, intrusion, or abandonment.

Beyond providing a secure base from which the client can explore his or her internal and interpersonal environment, therapeutic safety and support allows for the habituation of CERs associated with relatedness. As noted earlier, for activation of traumatic memories to be therapeutic, there must be a disparity between the contents of the traumatic memory (i.e., violence, danger, or violation) and the client's experience of the current environment (i.e., as safe and supportive). When this occurs, the emotional reactions conditioned to the traumatic memory slowly lose their power as they are unreinforced and, eventually, extinguished by the absence of current traumatic experience. In other words, as the client recalls, at sensory and autobiographical levels, her abusive experiences in childhood, the emotional experiences present at that time (e.g., fear or anger) also are evoked. However, these conditioned, abuse-era emotional responses are not relevant to the current safety of the therapy session, and so their association to the original abuse memory is not reinforced and eventually becomes attenuated. When this attenuation is complete, memories of the abuse cease to produce major abuse-era affects even when activated.

Facilitating self-awareness and positive identity

In the context of sustained and reliable support and acceptance, the survivor has the opportunity to engage in the relative luxury of introspection. Looking inward may have been punished by the survivor's early environment in at least two ways: it took attention away from hypervigilance and, therefore, safety, and greater internal awareness meant, by definition, greater pain. As a result, many untreated survivors of severe abuse are surprisingly unaware of their internal processes and individual identity, and may, in fact, appear to have very little self-knowledge. This may present, for example, as reports of diminished access to an internal sense of self, the inability to predict one's own reactions or behavior in various situations, or of little insight regarding the abuse or its effects.

By facilitating self-exploration and self-reference (as opposed to defining self primarily in terms of others' expectations or reactions), abuse-focused therapy potentially allows the survivor to gain a greater sense of personal identity. Increased self-awareness may be especially fostered by what cognitive therapists call "Socratic" questioning (Beck, 1995), wherein the client is asked primarily open-ended questions throughout the course of treatment. These include multiple, gentle inquiries about, for example, the client's early perceptions and experiences, the options that were and were not available to him or her at the time of the abuse, his or her feelings and reactions during and after victimization experiences, and what conclusions he or she might form about the abuse from the answers to these various questions. Equally important, however, is the need for the client to, literally, discover what he or she feels about current things, abuse-related or otherwise. Because the external-directedness necessary to survive abuse generally works against self understanding and identity, 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.

In the process of self-exploration, many opportunities arise for the reworking of abuse-related, verbally-mediated cognitive distortions and negative self-perceptions, as noted later in this chapter. These distortions typically involve harsh self-judgments of having caused, encouraged, or deserved the abuse (Briere, 2000a; Janoff-Bulman, 1992; Jehu, 1988). By exploring with the survivor the specifics of the abuse and the limits of his or her options as a child, the therapist can provide an environment wherein the client can reconsider the validity of any erroneous perceptions or assumptions he or she made as a child, thereby assisting in the development of a more positive sense of self. The reader is referred to Resick and Schnicke (1993), Chard, Weaver, and Resick (1997), and Jehu (1988) for further information on interventions helpful with these cognitive sequels of interpersonal victimization.

Self-other entitlements and boundary issues

As noted earlier, many survivors of severe childhood abuse have difficulty distinguishing the boundary between self and others. This problem is thought to arise both from attachment disruption, wherein the child is deprived of the opportunity to learn normal self-other behaviors and demarcations, and from early intrusion by the abuser into the child's bodily space (McCann & Pearlman (1990).

Effective abuse-focused therapy addresses both of these bases. The clinician is careful to honor the client's dignity, rights, and psychological integrity -- even if the abuse survivor is unaware of his or her entitlement to such treatment. Over time, the therapist's consistent respect for the client's rights to safety and freedom from intrusion can be internalized by the client as evidence of his or her physical and psychological boundaries. Part of this learning process is overtly cognitive -- during the client's recounting of his or her child abuse history and later adult experiences of violation or exploitation, the therapist actively reinforces the survivor's previous and current entitlement to integrity and self-determinism. Other aspects of this process are intrinsic, and the learning implicit -- as he or she is treated with compassion and respect by the therapist, and slowly develops a growing sense of personal identity, the survivor begins to *assume* or understand that he or she has entitlements and intrinsic validity.

This latter, nonverbal component of self-trauma therapy is critical: because early maltreatment lead to the formation of pre-verbal relational schemata, merely (verbally) insisting to a client that she is good, or safe, or entitled to positive treatment will rarely be entirely effective. Instead, the client must be provided with the opportunity to learn (not just hear) that he or she is valued and is entitled to not be violated. In other words, much of distorted relational schemas are, by definition, non-verbal; as a result, their remediation must also be nonverbal -- the clinician must show, not merely tell.

At the same time that the demarcation of his or her own psychological rights are being demonstrated and learned, the survivor in therapy may be exposed to important lessons regarding the boundaries of others. This may occur as the client impinges on the therapist, typically through inappropriate questions, requests, or behavior. As the therapist carefully repels such intrusions, he or she both teaches about the needs and rights of others to boundary integrity, and models for the survivor appropriate limit-setting strategies the survivor can use in his or her own life (Elliott & Briere, 1995). In this way, the interpersonal give-and-take of psychotherapy tends to replicate some of the self-other lessons the survivor would have learned in childhood were it possible.

Affect modulation and affect tolerance

Because affect tolerance and modulation are such important issues for adults severely abused as children, the self-trauma Model addresses these issues in as many ways as possible. It stresses two general pathways to the development of what may be called affective competence: the acquisition of an affect regulation repertoire and the strengthening of inborn, but underdeveloped, affective capacities.

Skills training in this area is best outlined by Linehan (1993), in her outstanding manual on the cognitive behavioral treatment of borderline personality disorder. She notes that distress tolerance and emotional regulation are internal behaviors that can be taught in clinical settings. Among the specific skills directly taught by Linehan's "dialectical behavior therapy" (DBT) for distress tolerance are distraction, self-soothing, "improving the moment" (e.g., through relaxation), and thinking of the "pros and cons" of behavior (p. 148). In the area of emotional regulation skills, Linehan teaches the survivor to (a) identify and label affect, (b) identify obstacles to changing emotions, (c) reduce vulnerability to hyper-emotionality through decreased stress, (d) increase the frequency of positive emotional events, and (e) develop the ability to experience emotions without judging or rejecting them (p. 147-148).

Self-trauma therapy makes use of these skills training approaches, although it cannot replicate the formally programmatic, group-oriented aspects of DBT. Linehan's (1993) model, which has been shown in outcome research to be effective for borderline personality disorder (Linehan, 1993), stresses a central issue: affect dysregulation does not reflect a structural psychological defect (as suggested by some analytic theories and approaches) as much as skills deficits arising from distorted or disrupted childhood development.

Affect regulation and tolerance is also learned implicitly during self-trauma therapy. Because, as outlined in the next section, trauma-focused interventions involve the repeated activation, processing, and resolution of distressing but non-overwhelming affect, 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 affective states, in turn, fosters an increased sense of emotional control and reduced fear of negative affect. In this regard, the nonoverwhelming exposure and processing of traumatic memories may intrinsically increase the client's affect regulation skills.

Finally, in the process of developing affect regulation capacities, the survivor is encouraged to identify and describe the intrusive and repetitive cognitions that often exacerbate, or even trigger, trauma-related affect. Thus, for example, the client's attention may be focused on childhood-era self-talk that occur after a traumatic memory and just before an intense negative emotional reaction (e.g., "they're trying to hurt me," or "I'm so disgusting"), and the catastrophizing cognitions triggered by strong emotion that produce panic and fears of being overwhelmed or inundated (e.g., "I'm out of control," or "I'm making a fool of myself"). As the client becomes more aware of these cognitive antecedents to overwhelming affect, he or she can also learn to lessen the impact of such thoughts by, in some sense, explicitly disagreeing with them (e.g., "nobody's out to get me," "I look/sound fine," or "I can handle this"), or merely by experiencing such cognitions as "old tapes" rather than accurate perceptions. In this regard, one of the benefits of what is referred to as *insight* in psychodynamic therapy is the realization that one is acting in a certain way by virtue of erroneous beliefs or perceptions -- an understanding that often reduces the power of those cognitions to produce distress or motivate dysfunctional behavior. In other words, for distorted cognitions to be most impactful, they probably need to act outside of full consciousness and to be agreed-with or at least unchallenged.

Disturbed relatedness

As noted earlier, many survivors of severe abuse and neglect suffer from significant difficulties in the interpersonal domain. Because relationships are of major importance to most people, and are, in fact, the context in which much of human life unfolds, most therapies for abuse survivors devote considerable attention to this area. The self-trauma approach addresses relatedness problems by habituating negative CERs to powerful relational figures and the vulnerability associated with intimacy and connectedness, and by processing negative attachment-related schema.

Because most disturbed relatedness appears to arise from reactions to maltreatment in early relationships, and these maltreatment effects are often triggered by later interpersonal stimuli, it is not surprising that the most effective interventions for relational problems appear to occur within a therapeutic relationship. As is discussed below in the abuse-related intrusive symptoms section, the self-trauma model views the therapeutic relationship as directly and specifically curative, as opposed to being the nonspecific placebo effect or inert ingredient suggested by some cognitive-behavioral theorists. Among other things, the therapeutic relationship is a powerful source of interpersonal triggers -- the give-and-take between client and clinician will almost always include phenomena that trigger abuse-related relational schemata (e.g., moments of decreased therapist empathy or attunement, or client perceptions or expectations of therapist abandonment or dangerousness) and affects (e.g., feelings of rage or despondency associated with these perceptions or expectations), as well as activating more complex attachment-level relational phenomena (e.g., preoccupied or ambivalent responses to the positive components of the therapeutic relationship). The therapeutic relationship, however, also is a powerful source of disparity and resolution -- once triggered and activated by relational stimuli, cognitive-emotional responses can be examined and processed in the context of safety, soothing, and support, potentially leading to clinical improvement, including reduced abuse-specific difficulties in current and future relationships. The actual processing of traumatic memory, relational or otherwise, is described below.

Intervening in Abuse-related Posttraumatic Symptoms

Assuming that the client either has sufficient self skills or that these self functions have been strengthened sufficiently, the treatment of intrusive trauma symptoms can be undertaken. The current model suggests at least five major steps in this process: identification of traumatic (i.e., abuse-related) events; gradual re-exposure to memories (implicit or explicit) of the abuse; activation of associated CERs and cognitions; disparity between the original trauma and the current environment; and cognitive-emotional processing.

Identification of traumatic events

In order for traumatic material to be processed efficiently in treatment, it should be identified as such. Although this seems an obvious step, it is more difficult to implement in some cases than otherwise might be expected. The survivor's avoidance of abuse-related material may lead to suppression of abuse-specific thoughts, conscious reluctance to think about or speak of upsetting abuse incidents, or to less conscious dissociation of such events. In the case of conscious avoidance, for example, the survivor may believe that a detailed description of the abuse would be more painful than he or she is willing to endure, or that exploration of the abuse would overwhelm his or her self resources. Dissociation of abuse material, on the other hand, may present as incomplete or absent recall of the events in question². In addition, those with an avoidant-dismissive adult attachment style (in which the individual tends to avoid close relationships and often does not acknowledge significant emotional distress) are hypothesized to have less access to painful childhood memories than those with a secure attachment style (Fraleigh, Davis, & Shaver, 1998).

Whether through suppression, denial, or dissociation, avoidance of abuse-related material should be respected, since it indicates the survivor's implicit judgment that exploration in that area would challenge or exceed his or her capacity to regulate the associated negative affect. The role of the therapist at such junctures is not to overpower the client's defenses or in any way to convince him or her that abuse occurred, but rather to provide the conditions (e.g., safety, support, and a trustworthy environment) whereby avoidance is less necessary and exposure is more possible. Because this latter step can require significant time and skill, the specific enumeration and description of abusive events is far from a simple matter (Courtois, 1999).

In other instances, a specific traumatic event cannot be recalled for a different reason: the relevant material may not be an explicit or narratively-encoded memory of a single traumatic event, but rather implicit, nonverbal, sensorimotor memories of abusive *processes* (e.g., sustained emotional neglect, repetitive boundary incursions, or parental narcissistic disattunement) that occurred early in childhood. Thus, for example, although specific instances of abandonment, rejection, or violation may or may not be recalled in the context of a painful childhood, or may have occurred prior to language, the critical memory material may be of the general sense of not being loved, of being seen as bad, or of feeling entirely alone in the world. These latter reactions, as described earlier, may be incorporated into generalized working models of self and others, deep cognitive structures, or distorted relational schema -- much of which may be outside of the abuse survivor's conscious awareness, let alone describable/explicit memory. This issue may be especially relevant for abuse or neglect which occurred in the first two or three years of life, at which point, although implicit/sensory memory of maltreatment may be retained, explicit/verbal encoding did not occur and thus cannot be retrieved.

It might appear that, in the absence of explicit memory, early childhood maltreatment would have to go unprocessed. However, because such memory material is often triggered by reminiscent -- often relational -- stimuli, as described above, therapists are frequently able to work with the manifestations of childhood maltreatment that are activated in the therapy session. This may occur, in fact, without either client or therapist necessarily ever having a detailed, narrative understanding of the actual abuse or neglect that the client experienced. The actual process of treating implicit, as well as explicit, maltreatment memories is described below.

Gradual exposure to abuse-related material

For the purposes of this chapter, it is helpful to divide exposure activities into two kinds, based on what type of memory is being addressed. These will be referred to as *direct* exposure, involving conscious self-access to explicit, autobiographical memories, and *indirect* exposure, involving implicit memories that are activated in the context of the therapeutic relationship.

Direct exposure is the usual technique utilized by cognitive-behavioral therapy. According to Abueg and

² Although this issue is a source of controversy, with some individuals claiming that psychological amnesia for childhood abuse is virtually impossible, the last three editions of the American Psychiatric Association's diagnostic manual (DSM-III, DSM-III-R, DSM-IV) and recent research (see Courtois, 1999, Pezdek and Banks, 1996, and Williams and Banyard, 1999, for reviews) suggest that some level of dissociative amnesia for traumatic events is not especially rare.

Fairbank (1992), this approach can be defined as "repeated or extended exposure, either in vivo or in imagination, to objectively harmless but feared stimuli for the purpose of reducing anxiety" (p. 127). Several types of direct exposure have been used to treat traumatic stress, one of which, prolonged exposure, has been shown to be effective in treating acute adult traumas, most notably sexual assault (Foa & Rothbaum, 1998). This approach typically eschews titrated or graduated access to traumatic memories and, instead, involves extended exposure to the full force of traumatic memories until the associated anxiety is habituated -- an approach that may be most effective with those who were victimized as adult and who have the affect regulation capacities required for such activities.

In contrast, however, the direct exposure approach suggested here is a form of systematic desensitization (Wolpe, 1958), wherein the survivor is asked to recall non-overwhelming, but somewhat distressing abuse-specific experiences in the context of a safe therapeutic environment. The exposure is titrated according to the intensity of the recalled abuse, generally with less upsetting memories being recalled, verbalized, and desensitized before more upsetting ones are considered. However, the self-trauma approach does not adhere to a strict, pre-planned series of extended exposure activities. This is because the survivor's ability to tolerate exposure may be quite compromised, and may vary considerably from session to session as a function of outside life stressors, level of support from friends, relatives, and others, and, most importantly, the extent of self capacities available to the abuse survivor at any given point in time.

As suggested earlier, for abuse-focused therapy to work well, there should be as little avoidance as possible during treatment. Specifically, the client should be encouraged to stay as "present" as he or she can during his or her verbalization and activation of abuse memories, so that exposure, per se, is maximized. The very dissociated survivor may have little true exposure to abuse material during treatment -- despite what may be detailed renditions of a given memory. Of course, the therapist must keep the therapeutic window in mind, and not interrupt survivor dissociation that is, in fact, appropriate in the face of therapeutic overstimulation. This might occur, for example, when the therapist requires or allows client access to memories whose associated CERs exceed the survivor's self resources. On the other hand, it is not uncommon for avoidance responses to become so overlearned that they automatically (but unnecessarily) emerge during exposure to stress. In this case, some level of reduced dissociation during treatment is not only safe, but frequently imperative for significant desensitization to occur.

In contrast to direct exposure, indirect exposure relies on the therapeutic relationship to trigger -- and thus provide exposure to -- implicit or suppressed memory material. As described earlier, implicit memories of abuse and neglect are nonverbal in nature, composed primarily of sensory/perceptual material. Such memories are often encoded early in life, prior to the acquisition of language and the full development of certain brain structures. Later traumatic memories also may have implicit memory components, however, especially if the brain responds to incoming stress by selectively blocking explicit encoding (van der Kolk, et al, 1996). Such memories cannot be "recalled," per se, but instead emerge when they are triggered by reminiscent events in the environment. Thus, the therapeutic relationship, with its many triggering characteristics, emerges as a potent source of indirect exposure opportunities.

Interestingly, it is likely that classic psychodynamic interventions, because they typically focus on the recollection and discussion of early childhood trauma and the processing of cognitions and affects triggered by the therapeutic relationship, involve some degree of indirect exposure. In fact, as is addressed below, the psychodynamic notion of transference may be reconceptualized as the cued activation of implicit, relational memories in the context of therapy.

Activation

Once exposure has occurred, it is necessary that at least some degree of cognitive and emotional activation take place. Activation, in this context, refers primarily to triggered CERs to abuse memories, such as fear, sadness, or horror, or cognitive reactions such as the intrusion of negative self-perceptions or activation of negative relational schema. Also activated may be other implicit or explicit memories associated with the triggering stimulus that are made more salient as the original abuse context becomes reinstated through increasingly detailed memory. For example, a woman who is asked to describe a childhood sexual abuse experience undergoes therapeutic exposure to the extent that she recalls aspects of that event during the therapy session. If these memories trigger further cognitive associations or self-schema (e.g., "I am such a slut that I let that happen") or emotional responses conditioned to the original abuse stimuli (e.g., fear or horror), or stimulate further memories

(e.g., of other aspect of the abuse triggered by remembering certain aspects of it), therapeutic activation can be said to have taken place.

When activation is primarily of relational schema, the process is quite similar to what is referred to psychodynamically as "transference." For example, consider a 24 year-old woman with a long history of emotional abuse by her narcissistic father, who enters therapy with a older male clinician. Although the client initially views her therapist as supportive and caring, she soon comes to feel increasing distrust toward the therapist, begins to see subtle "put-downs" in his remarks, and eventually finds herself angry at the therapist's perceived lack of empathy, lapses in attunement and caring, and judgmental behavior. Although psychodynamic theory would hold that the client is experiencing a significant transference reaction, the self-trauma model suggests, not that dissimilarly, that the benign behaviors of the clinician nonetheless contains stimuli (e.g., the clinician's age and sex, the power differential between client and therapist, the growing feeling of emotional intimacy as treatment progresses) that cue and activate early, implicit abuse memories. As will be discussed, this phenomenon, whether described as transference or activation of implicit relational memories, is potentially a positive development, despite its distressing qualities for client and (on occasion) therapist.

Emotional activation is usually critical to recovery from trauma. Therapeutic interventions that consist solely of the narration of abuse-related memories, without also supporting (and allowing) emotional and cognitive activation will not necessarily produce symptom relief (Foa & Kozak, 1986; Samoilov & Goldfried, 2000). As outlined in the next section, in most cases a conditioned emotional response to the trauma must be elicited before it can be extinguished or habituated. Probably for this reason, exposure that occurs in the presence of substance intoxication, significant dissociation, or emotional over-control is often relatively unsuccessful (Briere, 1996), since normal emotional activation is, to some extent, blocked.

Disparity

Although not always mentioned explicitly in cognitive-behavioral texts, it is not sufficient to have exposure and activation in trauma treatment; there also must be disparity. For conditioned emotional responses to traumatic memories to be extinguished, they must not be reinforced by similar danger (physical or emotional) in the current environment. Approximating the language of Foa and Kazak (1986), the fear structure associated with traumatic memory must be activated (i.e., the client must remember, and experience fear conditioned to the memory) in the presence of information incompatible with that fear structure (i.e., experience safety in a relational context that originally was associated with danger).

To be effective, safety should be manifest in at least two ways. First, the client should come to realize that he or she is safe from the therapist. This safety should not be only from physical injury and sexual exploitation, of course, but also from harsh criticism, punitiveness, boundary violation, or narcissistic disregard for the client's experience. Because the survivor of interpersonal violence, maltreatment, or exploitation tends to perceive danger in interpersonal situations (Briere, 2000a; Janoff-Bulman, 1992), the absence of danger in the session must be experienced directly, not just promised. In other words, for the client's anxious associations to victimization memories to extinguish over time, they must not be reinforced by current maltreatment in the session, however subtle.

Secondly, safety in treatment should be from the client's own internal experience. The survivor whose recollection and activation of abuse memories produces overwhelmingly negative affect will not necessarily find therapeutic exposure to be substantially disparate from her original experience. Such overwhelming affect may occur because one or both of two things are present: (1) the memory is so traumatic and has so much painful affect (e.g., anxiety, rage) or cognitions (e.g., guilt or shame) conditioned to it that untitrated exposure produces considerable psychic pain; or (2) the survivor's affect regulation capacities are sufficiently compromised that any major reexperiencing is overwhelming. In each instance, however, safety -- and therefore disparity -- can be provided within the context of the therapeutic window. Because treatment within the window means that exposure to memories does not, by definition, exceed self-capacities, reexperiencing is not associated with the danger of overwhelming negative affect, identity fragmentation, or powerful feelings of loss of control.

Disparity is not just the absence of danger, however -- in the best circumstances, it is the presence of positive phenomena that are antithetic to danger. Thus, in the example of the younger woman in therapy with the older man, her "transferential" (triggered relational schema) expectations of therapist criticism, rejection, and

abandonment are not merely met with the absence of those things in treatment, but, as well, the presence of therapist acceptance, validation, and reliable nurturance. In this regard, the most powerful disparity for many clients may be to expect hatefulness or disregard from their therapists and to get, instead, loving attention.

Processing and resolution

It is likely that there are at least two types of activities that take place when exposure activates memories (implicit or explicit) in the presence of safety: *Emotional processing* and *cognitive processing*. However, because cognitions and emotions are often inextricably tied (Siegel, 1999), perhaps especially in response to activated traumatic material, both forms of processing may occur simultaneously.

Emotional processing.

Emotion processing occurs when painful memories of past trauma, whether implicit or explicit, are experienced in the presence of disparity and, as noted below, emotional expression. Processing during disparity, as discussed, probably involves habituation and desensitization, wherein the link between painful memory and conditioned emotional responses to that memory is weakened over time. In order for this to happen, painful affects must be repeatedly activated within and across sessions -- a process that must be controlled by the constraints of the therapeutic window in order to be tolerable. Even under the best of circumstances, the CER activation that accompanies exposure activities in trauma treatment is seen by most clients as distressing and challenging. As a result, exposure must be carefully titrated to keep it from motivating unwanted avoidance behavior, including treatment drop-out.

Recovery from abuse and other traumas also is facilitated by emotional expression and release during self-exposure. Teleologically speaking, for example, the biological "reason" for crying in response to upsetting events may be that such release engenders a relatively positive emotional state (i.e., relief) that can then countercondition the fear and related affects initially associated with the trauma. In other words, the lay suggestion that someone "have a good cry" or "get it off of your chest" may reflect support for ventilation and other emotional activities that naturally countercondition abuse-memory CERs. From this perspective, just as traditional systematic desensitization pairs a formerly distressing stimulus to a relaxed (anxiety-incompatible) state, in an attempt to neutralizes the original anxious response over time, repeated emotional release during nondissociated exposure to painful memories is likely to pair the traumatic stimuli to the relatively positive internal states associated with emotional release. This process typically is facilitated in the session by gentle support for -- and reinforcement of -- emotional expression during exposure to traumatic memories. The level of emotional response in such circumstances will vary from person to person, partially as a function of his or her affect regulation and tolerance capacities. As a result, the therapist should not "push" for emotional response when the client is unable or unwilling to engage in such activities.

Cognitive processing.

In addition to emotional processing, it is clear that effective abuse (or trauma)-focused treatment must facilitate *cognitive processing*. This domain includes at least the following activities: Acquiring and integrating new information, developing a coherent narrative and deriving meaning, altering existing cognitive structures, and processing activated relational schema.

New information. The acquisition of new information relates both to the psychoeducational component of trauma therapy and to the learning about self that typically arises during psychotherapy. The former may include the clinician providing information regarding, for example, the relative commonness of child abuse, frequent abuser justifications for maltreating children, and the fact that the client's symptoms are a frequent effect of such maltreatment. Such data may decrease the abuse survivor's sense of self-blame and stigma, and may serve to depathologize, to some extent, the psychological symptoms that he or she experiences. Informational learning will only be helpful, however, to the extent that it is integrated; i.e., the client successfully applies it to his or her own specific experience. Therapists may assist in this integration by helping the client to see the personal applicability of this new information to his or her memories of the abuse and current model of self.

New information also arises from -- and may be most powerful in -- the process of self-exploration, as described earlier in the "self-capacities" section. As the client observes himself or herself in therapy, integrates

feedback from the therapist, examines his or her thoughts, motives, past behaviors, and considers previous abuse-related assumptions and cognitive distortions in light of current knowledge, a form of insight into one's past and one's self often develops. Such knowledge, in turn, may foster increased self-acceptance, as the client comes to reinterpret former "bad" behaviors, deservingness of maltreatment, and presumed inadequacies in a more positive light. Self-knowledge and self-acceptance, almost by definition, can then serve as powerful antidotes to future negative self-thoughts, and may interfere with the capacity of memories or misinterpreted environmental events to trigger painful affects such as shame or self-hatred.

Developing a coherent narrative. Recent research (e.g., Amir, Stafford, Freshman, & Foa, 1998; Foa, Molnar, & Cashman, 1995) supports a common clinical impression that as the trauma survivor's rendition of his or her trauma experience becomes more coherent (i.e., is clearly articulated, well-organized, and detailed), his or her trauma symptoms decrease. Although it is likely that narrative coherence arises intrinsically from trauma recovery, it is also likely that the development of a "story" of one's trauma is salutary. In this regard, it is probable that a coherent trauma (or abuse) narrative increases the survivor's sense of control over his or her experience, reduces feelings of chaos, and increases the sense that the universe is predictable and orderly, if not beneficent. Further, deriving meaning from one's experiences may provide some degree of closure, in that it "makes sense" and fits into existing models of understanding. Finally, a more coherent trauma narrative, by virtue of its organization and complexity, may support more efficient and complete emotional and cognitive processing (Amir, et al., 1998). In contrast, fragmented recollections of traumatic events that do not have an explicit chronological order and do not have obvious causes may easily lead to additional anxiety, insecurity, and the derealization that sometimes occurs in the presence of incomprehensible events, and may, ultimately, inhibit trauma processing.

Narrative coherence typically arises from the detailed discussion and multiple revisitation of trauma or abuse memories during psychotherapy. In this regard, the tendency for exposure and activation to increase the details of traumatic memory (Foa & Rothbaum, 1998) and to reinstate awareness of the original context in which it occurred, also supports the development of a detailed and logical "story" of what happened and, in some cases, why. As the client becomes more aware of the details of his or her victimization, and of his or her own options and lack thereof at the time it occurred, it is also likely that the narrative will shift in valence, as described below.

Altering cognitive structures. An important part of cognitive processing is the modification of negative cognitive structures, as described earlier in this chapter. These structures may be divided into two types: consciously-available cognitive distortions, and "deep," less conscious negative cognitive structures. These cognitive phenomena often are interrelated, however, and a given cognitive sequel of abuse may contain aspects of both types.

Cognitive distortions refer to consciously available thoughts and assumptions about self and others that are inaccurate and typically detrimental to the individual, such as feelings of low self-esteem, helplessness, hopelessness, self-blame, shame, or perception of others as intrinsically dangerous or hurtful. Some of these distortions may reflect verbalized interpretations of less verbally-mediated "core" schemas, as will be described later. Other distortions may arise from negative perceptions of self and others that occurred as a result of childhood psychological abuse, such as ongoing criticism, devaluation, and blaming verbalizations by parents or caretakers (Briere, 1992).

Intervention in conscious cognitive distortions often involves providing the client with opportunities to reconsider or reevaluate inaccurate self or other perceptions in light of new information. Clinical experience suggests that this process is less likely when the clinician merely disagrees (or argues) with the client about his or her cognitions. Rather, reconsideration may be most effective when it arises from disparity. Most typically, this will involve exposure and cognitive interventions that, in addition to addressing CERs, allow the client to experience both the original abuse-related phenomenon (e.g., memories of parental derogation for poor grades) and a concomitant, disparate, logical perspective (e.g., that the poor grades were due to explainable events [e.g., abuse], and that poor grades do not mean low intelligence or intrinsic inadequacy).

As is also true of "deeper" cognitive phenomena, reconsideration activities are often most effective when the abuse survivor, herself, realizes the disparity between early abuse-related messages and current, more accurate data about self or others. This is done not in a confrontational manner, but rather through a series of gentle questions (i.e., via the Socratic approach mentioned earlier) that allow the client to examine questionable assumptions and interpretations that he or she has made about the abuse. The point here is to provide the client with an opportunity to explore his or her understanding, not to argue with the client regarding his or her thinking

“errors.” The reader is referred to the excellent treatment manual by Resick and Schnicke (1993) on “cognitive processing therapy” for additional coverage on cognitive (and a version of exposure) interventions in this area.

Suppressed or “deep” cognitive structures are similar to more surface cognitive distortions, except that the emotional associations to these cognitions are sufficiently distressing that the thoughts are consciously avoided. Although excluded from conscious awareness, suppressed cognitions, by virtue of their susceptibility to internal and external triggers, are often activated in therapy by the same processes used to address other cognitive distortions, i.e., during the process of recalling and describing childhood trauma. Such reemergence is typically brief, however, since the negative affect associated with -- by definition -- suppressed thoughts motivate their rapid re-suppression. Experienced therapists often are alert to such intrusions, whether signaled by changed facial expressions, gaps in discourse, or sudden self-derogation, at which point the clinician supports conscious attention to -- and verbalization of -- the thought. Generally, clinical experience suggests that the verbal processing of previously suppressed material is associated with a temporary increase in distress (as found experimentally by Wenzlaff et al., 1991), which eventually decreases as the material is consciously addressed. This subsequent decrease, which may occur over several sessions, is probably due to both (a) the habituation and counterconditioning of anxiety associated with the suppressed thought once it has been processed, and (b) the reduction in pressure to keep the thought suppressed. Regarding the former, although suppressed thoughts are often out of conscious awareness, their emotional sequels (e.g., anxiety, anger) may still be experienced consciously when activated by reminiscent stimuli (Wegner & Smart, 1997), and thus may be reduced as affective aspects of the thought are desensitized.

Once suppressed thoughts and memories of childhood maltreatment are verbalized and (though habituation and counterconditioning) stripped of some of their negative CERs, they can be cognitively processed in light of new information. For example, as an abuse survivor's previously suppressed thoughts (and associated feelings) of self-blame regarding her pseudo-participation in incestuous contact with her father are accessed and discussed, she can more logically assess and seek feedback regarding the accuracy of her belief that she was to blame for her abuse -- a process that was impossible when this gestalt of thoughts and feelings were unavailable to conscious awareness. Similarly, intrusive negative self-talk associated with childhood psychological abuse may be suppressed from awareness, leading to a stream of unmonitored, negative self-perceptions and commentary that cannot be evaluated for its validity or fairness. As the clinician gently focuses attention on such statements or assumptions, further suppressed material is usually activated and potentially disclosed, allowing emotional and cognitive processing that otherwise might not occur.

Processing activated relational schema. The final form of cognitive processing discussed in this chapter involves relational schema. Although presented here as a cognitive phenomenon, thought, per se, is rarely involved, but rather a gestalt of interpersonal expectations and perceptions based on early, pre-verbal, childhood experience. As well, concomitant emotional responses conditioned to the same maltreatment (e.g., feelings of loss, emptiness, and sadness) that produce negative relational schema often means that triggers of these cognitive structures will also activate associated strong negative affects.

As described earlier, negative relational schema usually are triggered within the context of a close or significant relationship, since the primary activators of such schema are phenomena such as intimacy, interpersonal vulnerability, loss or abandonment, betrayal, or violation. Once triggered, negative relational schemata are often accompanied by intense negative affect and sudden, seemingly impulsive, often developmentally archaic behavior. This behavior may be proximity-seeking (e.g., demandingness or excessive dependency), punitive (e.g., verbal or physical aggression), or tension-reducing (e.g., self-mutilation, sexual acting-out). Most characteristically, such thoughts, feelings, and behaviors may be more relevant to the individual's childhood experiences than to the interpersonal context in which it is triggered.

Although such seemingly “borderline” responses are often immediately problematic during therapy, ultimately their emergence is both predictable and, to some extent, necessary for significant recovery to occur. Absent such relational triggers, therapy might be easier to conduct but would be unlikely to activate the very material that has to be processed before the client's relational life can improve. Thus, just as treatment for classic posttraumatic stress symptoms includes titrated exposure to traumatic memories and activation of conditioned emotional responses in the context of disparity, therapy for the relational aspects of severe childhood maltreatment must include similar components.

Specifically, per the earlier trauma-processing formulation, the client encounters *exposure* (i.e., to stimuli that are in some way similar between the original traumatic relationship and the current therapeutic one), *activation* (the client feels, on some level, suspicious, maltreated, unappreciated, or judged, thereby experiencing what can be considered a relational flashback), *disparity* (although the client feels this way, in reality the therapist is not doing any of these things to an appreciable extent, and may be doing the opposite), and *processing* (the client's repeated expectation and perception of the therapist as, to some extent, abusive, in the presence of the therapist's manifest non-abusiveness and non-dangerousness, eventually extinguishes the original conditioned emotional responses through nonreinforcement).

As per the treatment for posttraumatic stress, these various components occur within the therapeutic window, except that instead of titrated exposure to sensory/autobiographical abuse memories, the titration is to the level of contact with the therapist. In this regard, the clinician is careful to be neither too close (running the risk of triggering intrusion and boundary violation issues, as well as, paradoxically, reinforcing some clients' dependency needs) nor too distant (potentially triggering abandonment or rejection issues). Finally, the therapist must monitor his or her behavior for evidence of his or her own activated relational schema (e.g., punitiveness or rescuing behavior) in response to the client's schema-related behavior, since such "countertransference" would eliminate the disparity requirement of trauma processing.

The frequent need for abuse survivors to process relational issues, in addition to cognitive distortions and posttraumatic stress, means that -- as opposed to simple cognitive-behavioral therapy (CBT) for uncomplicated posttraumatic stress -- successful therapy may require regular sessions over considerably longer periods of time. The actual length of treatment will vary according to the extent of the client's affect regulation difficulties, use of avoidance, degree and valence of deep cognitive disturbance, and the severity of his or her negative relational schema.

Access to previously unavailable material

Taken together, the self-trauma approach outlined in this chapter allows the therapist to address the impaired self functioning, cognitive disturbance, and posttraumatic stress found in some adults who were severely abused as children. The activation and serial resolution of painful memories and intrusive cognitive states is likely to slowly reduce the survivor's overall level of posttraumatic stress and associated dysphoria -- a condition that eventually lessens the general level of avoidance required by the survivor for internal stability. This process also increases self resources -- as noted earlier, 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 increasingly more painful memories without exceeding the survivor's (now greater) self capacities.

In combination, processing traumatic memory and increasing self resources can lead to a relatively self-sustaining process: As the need to avoid painful material lessens with treatment, memories, affects, and cognitions previously too overwhelming to de-suppress become more available for processing. As this new material is, in turn, desensitized and cognitively accommodated, self capacity is further improved and the overall stress level is further reduced -- thereby permitting access to (and processing of) even more previously unavailable material. Ultimately, treatment ends when traumatic material is sufficiently desensitized and integrated, and self resources are sufficiently learned and strengthened, that the survivor no longer experiences significant intrusive, avoidant, or dysphoric symptoms.

This progressive function of self-trauma therapy removes the need for any so-called "memory recovery" techniques. Instead of relying on hypnosis or drug-assisted interviews, for example, to increase access to unavailable material, the self-trauma approach allows these memories to emerge naturally as a function of the therapeutic relationship and the survivor's reduced need for avoidance. Whereas some memory recovery techniques might easily exceed the therapeutic window and flood the survivor with destabilizing memories and affects, the current approach only allows access to trauma- or abuse-related material when, by definition, the therapeutic window has not been exceeded.

CONCLUSIONS

This chapter has presented a synthesis of current dynamic, cognitive, and behavioral approaches that have been found helpful in the treatment of severe child abuse trauma. This model holds that post-abuse "symptomatology" generally reflects the survivor's adaptive attempts to maintain internal stability in the face of potentially overwhelming abuse-related pain. It further suggests that many of these symptoms are, in actuality, inborn recovery algorithms that only fail when overwhelming stress or inadequate internal resources motivate the hyperdevelopment of avoidance responses.

It is argued here that successful treatment for abuse-related distress and dysfunction should not impose alien techniques and perspectives upon the survivor, but rather should help the client to do better what he or she is already attempting to do. Thus, like the survivor, the therapist should be especially concerned with balancing challenge with resource, and growth with safety. The natural healing aspects of intrusion and avoidance are not countered in treatment, but instead are refined to the point that they are maximally helpful and can be abandoned once successful.

In this way, the self-trauma model is ultimately optimistic; It assumes that much of abuse-related "pathology" and dysfunction are solutions in the making, albeit ones intrinsically more focused on survival than recovery. At the same time, unfortunately, the inescapable implication of abuse-focused therapy (and any other exposure-based treatment) is that in order to reduce posttraumatic pain and fear, both must be repeatedly confronted and experienced. As therapists, we should not forget what we are asking of our clients in this regard, lest we lose track of the courage and strengths that they inevitably must bring to the treatment process.

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