Journal of Traumatic Stress, Vol. 10, No. 3, 1997

An Affect-Management Group for Women with Posttraumatic Stress Disorder and Histories of Childhood Sexual Abuse

Caron Zlotnick,[1,3] Tracie M. Shea,[2] Karen Rosen,[1] Elizabeth Simpson,[1] Kate Mulrenin,[1] Ann Begin,[1] and Teri Pearlstein[1]

Systematic research on effective treatment for survivors of childhood sexual abuse with posttraumatic stress disorder (PTSD) is virtually non-existent. The aim of the present study was to compare the effectiveness of an affect-management treatment (AM) group to a wait list control condition for female survivors of childhood sexual abuse with PTSD. Forty-eight female survivors of childhood sexual abuse with PTSD were randomly assigned to either a 15-week affect-management treatment group or to a wait list control condition. All subjects received individual psychotherapy and pharmacotherapy for the duration of the study, and for at least 1-month prior to the study. Controlling for pretreatment scores, subjects who completed the affect-management treatment group (n = 17) reported significantly fewer posttreatment symptoms of PTSD and dissociation than subjects in the wait list control condition (n = 16). Our findings suggest that an affect-management group treatment is beneficial as an adjunct to individual psychotherapy and pharmacotherapy for survivors of childhood sexual abuse with PTSD.

KEY WORDS: sexual abuse survivors; posttraumatic stress disorder; dissociation; affect-management group therapy.

[1]Butler Hospital, Brown University Department of Psychiatry & Human Behavior, Providence, Rhode Island 02906.
[2]Brown University Department of Psychiatry & Human Behavior, Providence, Rhode Island 02906.
[3]To whom correspondence should be addressed.

0894-9867/97/0700-0425$12.50/1

Epidemiological studies indicate that between 9 to 33% of women report a history of childhood sexual abuse (Burnam et al., 1988; Finkelhor & Dzuiba-Leatherman, 1994; Russell, 1986). Furthermore, a substantial body of literature has documented that childhood sexual abuse has profound and lasting effects for women (Browne & Finkelhor, 1986; Bryer, Nelson, Miller, & Krol, 1987; Burnam et al., 1988). Over the last decade, there have been a flood of books, reports and articles on the treatment of adult sexual abuse survivors. Unfortunately, systematic research on treatment in this area is woefully lacking.

To date, the only controlled outcome study on treatment of sexual abuse survivors is a study which investigated the effectiveness of two group treatments for female incest survivors, an interpersonal transaction group and a process treatment group (Alexander, Neimeyer, Follette, Moore, & Harter, 1989). Both these treatment formats facilitated discussions on issues related to subjects' experiences of sexual abuse. In this study, Alexander et al. (1989) found that both treatments were more effective than a wait list condition in reducing depression, alleviating distress, and improving social adjustment. However, the study by Alexander et al. did not address the effects of treatment on symptoms of dissociation and posttraumatic stress, prominent features of survivors of sexual abuse (Chu & Dill, 1990; Zlotnick, Shea, Pearlstein, Begin, et al., 1996). Further, the study excluded subjects with suicidal ideation. This limitation in subject selection means we have little empirical data regarding the most effective group treatment for a subgroup of sexually abused patients at great clinical risk. Finally, since treatment response was poor for survivors with high levels of pretreatment psychological distress (Follette, Alexander, & Follette, 1991), it remains unclear if these poor treatment responders would benefit from another type of group treatment.

Research on psychosocial treatments for other trauma populations has focused almost exclusively on combat veterans and rape victims. Of the systematic studies on behavioral treatments, flooding and prolonged exposure appear to be the most effective forms of treatment for patients with posttraumatic stress disorder (PTSD) (Solomon, Gerrity, & Muff, 1992). Another psychosocial treatment, cognitive processing therapy (CPT), was found to be superior to a wait list control group in the treatment of rape victims with PTSD (Resick & Schnicke, 1992). These treatment outcome studies may not generalize to survivors of childhood sexual abuse with PTSD because flooding techniques have little effect on PTSD symptoms that relate to emotional numbing and avoidance (Solomon et al., 1992), symptoms that are frequently found among survivors of childhood sexual abuse (Herman, 1992; van der Kolk & van der Hart, 1989; Zlotnick, Shea, Pearlstein, Begin, et al., 1996). Moreover, flooding is contra-indicated for

PTSD subjects with depression (Pitman et al., 1991), and there are high rates of depression in survivors of childhood sexual abuse (Cutler & Nolen-Hoeksema, 1991; Mullen, Romans-Clarkson, Walton, & Herbison, 1988). In terms of CPT treatment, this treatment format is not recommended for patients who have displayed self-mutilative behavior and suicidal behavior (Resick & Schnicke, 1993), both of which are behaviors prevalent among childhood sexual abuse survivors (Briere & Runtz, 1986; Browne & Finkelhor, 1986; van der Kolk, Perry, & Herman, 1991; Zlotnick, Shea, Pearlstein, Simpson, et al., 1996). Thus, there is a need for much research in the treatment of survivors of childhood sexual abuse, and especially in the treatment of PTSD in survivors of childhood sexual abuse.

Recently, experts have suggested that trauma-focused therapy (i.e., treatment that facilitates the disclosure of sexual abuse experiences) may be detrimentral for survivors of sexual abuse in the early stages of recovery (Herman, 1992). Support for this view is found in the poor treatment response to trauma-focused groups by highly distresssed women (Herman & Schatzow, 1984), and in reports from the clinical literature that high drop-out rates and increased levels of anxiety are common in these groups (Dye & Roth, 1991; Goodman & Nowak-Scibelli, 1985).

As an alternative to trauma-focused treatment for survivors in early recovery, Herman (1992) has recommended a "first-stage" group that emphasizes safety, stabilization, and stress management skills. In particular, survivors of childhood sexual abuse with PTSD should benefit from affect-management strategies and interventions because PTSD is a disturbance in which the identification, regulation, and expression of affect are severely impaired (Stone, 1993). More specifically, patients with PTSD are characterized by problems with anger, episodic depression, anxiety, and irritablity. Further, avoidant symptoms are regarded as a defense against strong affect, while the re-experiencing symptoms are marked by high levels of arousal (Stone, 1993). Another reason to target affect-management in patients with PTSD is that emotional dysregulation can interfere with daily functioning, as well as the therapeutic process. Theoretical formulations of recovery from PTSD emphasize that mastery over symptoms of PTSD is necessary before integration of trauma can occur (Herman, 1992; Horowitz, 1986). Lastly, affect-management strategies are essential skills for childhood sexual abuse survivors, as a core feature of survivors of childhood sexual abuse is a deficit in the ability to self-soothe (van der Kolk & Fisler, 1994).

Another recommendation in the treatment of survivors of childhood sexual abuse has been the use of group therapy. A group format lessens the feelings of stigma, isolation and shame resulting from the sexual abuse experience (Courtois, 1988). In addition, a group setting provides partici-

pants with greater opportunities to observe and learn from one another, especially in the acquisition of skills.

In conclusion, although there are strong theoretical reasons to support the use of an affect-management group in treating survivors of childhood sexual abuse with PTSD, empirical data are needed to test these assumptions. Thus, the aim of the present study was to compare the effects of group treatment that focused on affect-management skills to a wait list control group in female survivors of childhood sexual abuse with PTSD.

Method

Subjects

Subjects were 48 women who were recruited via their individual therapists to participate in a 15-week group for survivors of childhood sexual abuse with PTSD. The referring clinicians included private practitioners and therapists working at a psychiatric hospital or outpatient clinic. All subjects met criteria for PTSD based on their past sexual abuse experiences, i.e., a history of sexual contact before the age of 17. All subjects received individual therapy for at least one month prior to the group, and reported no changes in their psychotropic medication in the month before the study. Exclusionary criteria for the study were psychosis, current substance abuse, and/or dissociative identity disorder as determined by consultation with the subject's individual therapist. For the duration of the study period, subjects remained in individual therapy. The group therapists did not communicate with the individual therapists during the study period.

The mean age of the subjects was 39 years (SD = 9.59). Twenty nine (60%) were single, widowed, separated, or divorced, and 19 (40%) were married or lived with an intimate partner. All of the participants were White with the exception of one Native American. Fourteen (29%) of the women had incomes of $10,000 or less, 25 (52%) had incomes between $11,000 and $30,000, and 9 (19%) had incomes over $30,000. All participants had at least a high school diploma, and 16 (33%) had a college degree. Twenty four (50%) of the women had previously been hospitalized for psychiatric reasons, and of these women the average number of prior hospitalizations was 1.52 (SD = 2.36). In addition, all subjects met criteria for current disorder of extreme stress as determined by the Structured Interview for Disorders of Extreme Stress (Pelcovitz et al., 1997), although this was not an inclusionary criterion for the present study.

In reporting their sexual abuse experiences, 37 (77%) reported intrafamilial sexual abuse (abuse by a relative) with 17 (35%) reporting parental

sexual abuse. Thirty-seven (77%) had also experienced rape. The mean number of lifetime sexual abuse offenders reported was 3.71 (*SD* = 3.45), and the average age at which the sexual abuse began was 6.86 years of age (*SD* = 2.36 years). All subjects scored above the recommended threshold for the sexual abuse subscale of the Childhood Trauma Questionnaire that maximally discriminates between non-abused and the most severely sexually abused individuals (Bernstein et al., unpublished).

Measures

To determine if subjects met criteria for PTSD, the Clinician-Administered PTSD Scale (CAPS-1), an interview designed to assess the 17 core symptoms of PTSD in the past month as defined in the DSM-IV, was administered. The CAPS-1 has been shown to possess sound psychometric properties (Blake et al., 1990), and excellent diagnostic utility against the SCID PTSD diagnosis (Weathers et al., 1992).

Subjects also completed the Davidson Trauma Scale (DTS; Davidson, 1995), a scale that provides a 5-point measure of the frequency ("not at all" to "every day") and the severity ("not at all" to "extremely distressing") of each of the 17 symptoms listed in the DSM-IV diagnosis of PTSD. The time frame for the PTSD symptoms was "the past week." The DTS has been shown to have convergent and discriminant validity in survivors of sexual abuse with PTSD (Zlotnick, Davidson, Shea, & Pearlstein, 1996). Also, the DTS has demonstrated good internal consistency, test-retest reliability and validity in a variety of other trauma populations (Davidson et al., unpublished). For this study, the ratings of the frequency and severity subscales of the DTS were summed to provide an index of the degree of PTSD symptoms.

Subjects were administered the Symptom Checklist 90-R (SCL-90-R; Derogatis, 1983). As another measure of PTSD symptomatology, this study focused on a 28-item subscale within the SCL-90-R referred to as the Crime-Related Post-Traumatic Stress Scale (CR-PTSD; Saunders, Mandoki, & Kilpatrick, 1990). The CR-PTSD subscale has a five-point measure of the frequency ("not at all" to "extremely") of PTSD symptoms. The CR-PTSD has a high degree of internal consistency, and specificity for correct classification of PTSD cases (Saunders et al., 1990).

The Dissociative Experiences Scale (DES; Bernstein & Putnam, 1986), quantified dissociative experiences. PTSD is regarded as a disorder with a dissociative component (Bremner et al., 1992; Carlson et al., 1993), and dissociative symptomatology is common among survivors of childhood sexual abuse (Zlotnick, Shea, Pearlstein, et al., 1996). The DES has adequate

test-retest reliability, good split-half reliability, and good clinical validity (Bernstein & Putnam, 1986; Carlson & Putnam, 1993).

To assess childhood sexual abuse, the Childhood Trauma Questionnaire (CTQ; Bernstein et al., 1994) was used. This self-report questionnaire has demonstrated good test-retest reliability as well as good convergent validity (Bernstein et al., 1994). The CTQ does not inquire about specific details regarding sexual abuse experiences. To gather detailed information about relationship to offender, age of onset of the abuse and lifetime sexual abuse experiences, a self-report questionnaire, the Sexual Assault Questionnaire, developed by the authors, was administered. Although formal reliability or validity studies have not been established for this questionnaire, some evidence of validity has been shown by demonstration of predicted relationships between number of sexual abuse offenders and age of onset of sexual abuse and scores on the Dissociative Experiences Scale (Zlotnick, Begin, Shea, et al., 1994).

To examine if there were differences in individual treatment received between the treatment group and the wait list control group during the study period, subjects completed a self-report measure, an abridged self-report version of the Psychosocial Treatment Form (Perry, Goisman, Maisson, Peterson, & Steketee, unpublished). The Psychosocial Treatment Form assesses subjects' perceptions of the degree to which they received different modalities of treatment (specific factors) and the nature of the therapeutic relationship (a non-specific factor). We also included questions about whether individual therapy facilitated the disclosure of sexual abuse experiences, and whether there were changes in psychotropic medication during the study period.

Procedure

After administration of the CAPS-I, subjects who met criteria for PTSD completed the self-report questionnaires, and were randomly assigned to either the wait list control condition or the affect-management group condition. Subjects were subsequently evaluated on the same self-report measures following the termination of the group or approximately 16 weeks later if they had been assigned to the wait list condition. The groups met for a 2-hr session each week for 15 weeks. Group sizes ranged from 6 to 8 members. There were three groups, with each group led by a different therapist who had an accompanying co-therapist. The senior author of this study was a therapist for only one of the groups, but trained and supervised all other therapists in the implementation of the Affect-Management Group.

Format and Type of Group Therapy

Each session of the Affect-Management (AM) group treatment comprises of a review of the previous week's homework, a psychoeducational presentation, followed by skill building, application of skills, and assignment of homework. Therapists used a standardized manual for the affect-management group that outlines, in detail, each session (i.e., the objectives, the "mini-lecture" on the selected topic, how to conduct the practice of new skills in session, and hand-outs of homework assignments and of relevant issues associated with the material presented in the session). Material covered in sessions included education regarding PTSD, dissociation, flashbacks, "safe" sleep, identification of emotions, crisis planning, anger management, and techniques for distraction, self-soothing, distress tolerance, and relaxation. Sources for group material included Linehan's Dialectical Behavior Therapy (Linehan, 1993), and Matsakis's Treatment Guide for Post-Traumatic Stress Disorder (Matsakis, 1994).

Decisions concerning the format of the group, the length of each group session, and the number of group sessions evolved from several Affect-Management groups piloted by the authors.

Results

There were no significant differences between the AM condition and the wait list control condition in age, $t(33) = 0.83$, ns, in marital status, χ^2 $(3, N = 33) = 2.95$, ns, in education, χ^2 $(2, N = 33) = 0.37$, ns, or in income, χ^2 $(3, N = 33) = 0.96$, ns. At the onset of the study, all subjects reported the use of psychotropic medication.

There were no significant differences between the two conditions in the following pretreatment scores: the DTS, $t(33) = 0.93$, ns; the CR-PTSD subscale, $t(33) = 1.91$, ns; the DES, $t(33) = 0.96$, ns; or the total CAPS-I, $t(33) = 1.27$, ns. Table 1 presents the means and standard deviations for the pretreatment variables for those subjects who completed the treatment group ($n = 16$), and those subjects in the wait list control group who completed posttreatment measures ($n = 17$).

Six (25%) women from the wait list control group did not complete posttreatment scores. A total of seven (29%) women failed to complete treatment. These subjects had an average age of 37.85 years ($SD = 8.75$). Subjects who failed to complete treatment ($n = 7$) obtained higher scores on the pretreatment PTSD symptoms ($M = 106.85$, $SD = 38.50$) and on pretreatment Dissociative Experiences Scale ($M = 37.42$, $SD = 27.53$), compared to subjects who completed the treatment group ($n = 16$) (See Table 1).

Table 1. Mean Scores on Measures of Posttraumatic Stress Disorder (PTSD) and Dissociative Symptoms[a]

		Pretreatment		Posttreatment	
Scale/condition	*n*	*M*	*SD*	*M*	*SD*
DTS					
AM	16	66.88	22.00	45.76	34.12
Wait list	17	74.69	25.83	73.06	29.86
CR-PTSD					
AM	16	33.53	18.88	26.29	19.88
Wait list	17	46.88	21.16	51.43	24.19
DES					
AM	16	20.00	12.88	11.94	12.73
Wait list	17	24.72	16.01	25.22	18.29

[a]DTS = Sum of the frequency and severity subscale of the Davidson Trauma Scale; CR-PTSD = Crime-Related Posttraumatic Stress Subscale of the SCL-90-R; DES = Dissociative Experiences Scale.

An Analysis of Covariance (ANCOVA), controlling for pretreatment scores on the DTS, indicated that subjects in the AM treatment group reported significant improvement in posttreatment DTS scores compared to subjects in the wait list control condition, $F(2,31) = 6.09$, $p = .02$. An ANCOVA, controlling for pretreatment scores on the CR-PTSD subscale of the SCL-90-R, showed that subjects in the AM condition obtained lower posttreatment CR-PTSD subscale scores compared to subjects in the wait list control condition, $F(2,31) = 5.68$, $p = .02$. An ANCOVA, controlling for pretreatment DES scores, showed that subjects in the AM condition obtained lower posttreatment DES scores compared to subjects in the wait list control condition, $F(2,32) = 6.43$, $p = .02$. Table 1 also provides the mean scores and standard deviations for measures of PTSD and dissociation at posttreatment.

In the absence of a diagnostic interview to determine how many subjects continued to meet criteria for PTSD at termination, the current study attempted to estimate the presence of PTSD. To do so, the posttreatment ratings of the DTS were used, and the PTSD "diagnosis" was based on the PTSD diagnostic criteria of the CAPS-1. At termination, two (13%) of the subjects in the AM treatment group met criteria for PTSD, in contrast to 10 (59%) of subjects in the wait list control condition.

Of the 24 subjects who completed the Psychosocial Treatment Form, there were no significant differences in individual treatment received between the treatment group ($n = 11$) and the wait list control group ($n = 13$) in degree of various forms of therapy, cognitive therapy, $t(24) = 1.47$, ns, and behavior therapy, $t(24) = 0.75$, ns, and whether subjects received therapy that facilitated disclosure of the sexual abuse, χ^2 (1, $N = 23$) = 0.47, ns. There were also no significant differences between the two groups

in subjects' perceptions of the therapeutic relationship in individual treatment, $t(24) = 0.72$, ns. Finally, there were no differences between the two groups in whether subjects reported changes in psychotropic medication during the study period, χ^2 (1, $N = 23$) = 0.45, ns.

Discussion

The present study found that an affect-management (AM) treatment group as an adjunct to individual psychotherapy and pharmacotherapy was more effective than a wait list control condition for survivors of sexual abuse with PTSD. More specifically, this study found that women who attended an AM treatment group showed more improvement in PTSD and dissociative symptoms than those who were in a wait list control condition. These findings are important as they provide empirical support that therapy can indeed be effective in reducing symptoms of PTSD and dissociation in a high risk clinical group of survivors of childhood sexual abuse who present with PTSD and comorbid disorder of extreme stress. In addition, our study is the first study, to our knowledge, to demonstrate that treatment can reduce dissociative symptomatology, a relatively persistent and stable feature of survivors of sexual abuse (Herman, 1992). Furthermore, it is encouraging that our results suggest that group treatment, which, in this case, targeted affect-dysregulation, is associated with a reduction of dissociative symptoms, as studies on the treatment effects of PTSD have reported that the "negative" symptoms of PTSD related to numbing experiences are most resistant to change (Meichenbaum, 1994; Solomon et al., 1990).

Our study found that those survivors of sexual abuse with PTSD who dropped out of group therapy reported high levels of pretreatment PTSD and dissociative symptomatology relative to those survivors who remained in treatment. Other studies have found that pretreatment levels of distress were associated with poorer treatment response for survivors of sexual abuse who attended group treatment (Follette et al., 1991; Zlotnick, Begin, Pearlstein et al., 1994). Perhaps a group treatment format is not beneficial for survivors of sexual abuse with extremely high levels of psychopathology. Other factors, such as personality difficulties, interpersonal functioning, and past history of treatment, may also be related to attrition in group treatment for survivors of sexual abuse.

Several limitations of the present study warrant attention. First, it was not possible to know whether symptom changes in the AM treatment group were maintained over time, given the absence of follow-up data. Second, the use of self-report measures rather than the use of evaluators blind to the subject's group condition may have resulted in a response bias. Subjects

who were in the treatment condition may have reported less pathology due to a placebo effect. It is also possible that group participants responded favorably to the self-report measures at termination because they wished to please the group therapists.

Another limitation of the present study was the confound of individual psychotherapy and pharmacotherapy. Although the inclusion of concurrent treatment provided a stringent test of the effects of the AM treatment group, our positive findings may be attributable to differences between the two conditions in individual treatment, such as number of psychotherapy sessions received, length of treatment prior to the study, and interventions that included affect-management strategies. Likewise, the differences between the two conditions found in this study may have been due to differential effects of drug therapy in the AM group verse the wait list control group. It would be useful for future research to standardize current treatment, or, if possible, have group therapy as the only treatment modality. In addition, since differences between the AM treatment group and the wait list control group may be due to "non-specific" factors of group therapy, future studies with survivors of sexual abuse should compare the effects of an affect-management group to other group treatment modalities, such as the interpersonal transaction group or process group (Alexander et al., 1989).

Another important step in the evalaution of treatment for survivors of sexual abuse is to identify which survivors are most likely to benefit from group therapy, and which type of group would enhance the effects of treatment. As Herman (1992) has noted, "exploring the traumatic experiences in a group can be highly disorganizing for a survivor in the first stage of recovery, (while) the same work can be extremely productive once that survivor reaches the second stage" (p. 221). The findings of our study support clinical observations that survivors of sexual abuse with PTSD can profit from a group that focuses exclusively on mastery of symptoms.

Acknowledgment

This research was supported by a grant from Brown University, Department of Psychiatry and Human Behavior.

References

Alexander, P. C., Neimeyer, R. A., Follette, V. M., Moore, M. K., & Harter, S. (1989). A comparison of group treatments of women sexually abused as children. *Journal of Consulting and Clinical Psychology, 57,* 479-483.

Bernstein, E. M., & Putnam, F. W. (1986). Development, reliability, and validity of a dissociation scale. *Journal of Nervous and Mental Disease, 174*, 727-735.

Bernstein, D. P., Fink, L., Handelsman, L., Foote, J., Lovejoy, M., Wenzel, K., Sarapeto, E., & Ruggiero, J. (1994). Initial reliability and validity of a new retrospective measure of child abuse and neglect. *American Journal of Psychiatry, 151*, 1132-1136.

Blake, D. D., Weathers, F. W., Nagy, L. N., Kaloupek, D. G., Kaluminzer, G., Charney, D. S., & Keane, T. M. (1990). A clinician rating scale for assessing current and lifetime PTSD: The CAPS-I. *The Behavior Therapist, 18*, 187-188.

Bremner, J. D., Southwick, S., Brett, E., Fontana, A., Rosenheck, R., & Charney, D. S.(1992). Dissociation and posttraumatic stress disorder in Vietnam combat veterans. *American Journal of Psychiatry, 149*, 328-332.

Briere, J., & Runtz, M. (1986). Suicidal thoughts and behaviors in former sexual abuse victims. *Canadian Journal of Behavioral Science, 18*, 413-423.

Browne, A., & Finkelhor, D. (1986). Impact of child sexual abuse: A review of the research. *Psychological Bulletin, 99*, 66-77.

Bryer, J. B., Nelson, B. A., Miller, J. B., & Krol, P. A. (1987). Childhood sexual and physical abuse as factors in adult psychiatric illness. *American Journal of Psychiatry, 144*, 1426-1430.

Burnam, M. A., Stein, J. A., Golding, J. M., Siegel, J. M., Sorenson, S. B., Forsythe, A. B., & Telles, C. A. (1988). Sexual assault and mental disorders in a community population. *Journal of Consulting and Clinical Psychology, 56*, 843-851.

Carlson, E. B., & Putnam, F. W. (1993). An update on the Dissociative Experiences Scale. *Dissociation, 1*, 16-27.

Carlson, E. B., Putnam, F. W., Ross, C. A., Torem, M., Coon, P., Dill, D. L., Lowenstein, R. J., & Braun, B. G. (1993). Validity of the Dissociative Experiences Scale in screening for multiple personality: A multicenter study. *American Journal of Psychiatry, 147*, 887-892.

Chu, J. A., & Dill, D. L. (1990). Dissociative symptoms in relation to childhood physical and sexual abuse. *American Journal of Psychiatry, 147*, 887-892.

Courtois, C. A. (1988). *Healing the incest wound*. New York: Norton.

Cutler, S. E., & Nolen-Hoeksema, S. (1991). Accounting for sex differences in depression through female victimization: Childhood sexual abuse. *Sex Roles, 24*, 425-437.

Davidson, J. (1995). *Self-Rating Traumatic Stress Scale*. Durham, NC: Duke University Medical Center.

Derogatis, L. R. (1983). *The SCL-90: Administration, scoring and procedure manual-II for the R (revised) version*. Towson, MD: Clinical Psychometric Research.

Dye, E., & Roth, S. (1991). Psychotherapy with Vietnam veterans and rape and incest survivors. *Psychotherapy, 28*, 103-120.

Finkelhor, D., & Dzuiba-Leatherman, J. (1994). Victimization of children. *American Psychologist, 3*, 173-183.

Follette, V. M., Alexander, P. C., & Follette, W. C. (1991). Individual predictors of outcome in group treatment for incest survivors. *Journal of Consulting and Clinical Psychology, 59*, 150-155.

Goodman, B., & Nowak-Scibelli, D. (1985). Group treatment for women incestuously abused as children. *International Journal of Group Psychotherapy, 35*, 531-544.

Herman, J. L. (1992). *Trauma and recovery*. New York: Basic Books.

Herman, J., & Schatzow, E. (1984). Time-limited group therapy for women with a history of incest. *International Journal of Group Psychotherapy, 34*, 605-616.

Horowitz, M. (1986). *Stress response syndromes* (2nd ed.). Northvale, NJ: Jason Aronson.

Linehan, M. (1993). *Cognitive-behavioral treatment of borderline personality disorder*. New York: Guilford Press.

Matsakis, A. (1994). *Post-traumatic stress disorder: A complete treatment guide*. Oakland, CA: New Harbinger Publications.

Meichenbaum, D. (1994). *A clinical handbook/practical therapist manual for assessing and treating adults with post-traumatic stress disorder (PTSD)*. Waterloo, Ontario, Canada: Institute Press.

Mullen, P. E., Romans-Clarkson, S. E., Walton, V. A., & Herbison, G. E. (1988). Impact of sexual and physical abuse on women's mental health. *Lancet, 1*, 841-845.

Pelcovitz, D., van der Kolk, B. A., Roth, S., Mandel, F., Kaplan, S., & Resick, P. (1997) Development of a criteria set and a structured interview for disorders of extreme stress (SIDES). *Journal of Traumatic Stress, 10*, 3-16.

Pitman, R. K., Altman, B., Greenwald, E., Longpre, R. E., Macklin, M. L., Poire, R. E., & Steketee, G. S. (1991). Psychiatric complications during flooding therapy for posttraumatic stress disorder. *Journal of Clinical Psychiatry, 52*, 17-20.

Resick, P. A., & Schnicke, M. K. (1992). Cognitive Processing Therapy for sexual abuse victims. *Journal of Consulting and Clinical Psychology, 60*, 748-756.

Resick, P. A., & Schnicke, M. K. (1993). *Cognitive Processing Therapy for rape victims: A treatment manual.* Newbury Park, CA: Sage Publications.

Russell, D. E. H. (1986). *The secret trauma: Incest in the lives of girls and women*. New York: Basic Books.

Saunders, B. E., Mandoki, K. A., & Kilpatrick, D. G. (1990). Development of a crime related posttraumatic stress disorder scale within the Symptom Checklist-90-Revised. *Journal of Traumatic Stress, 3*, 439-448.

Solomon, S. D., Gerrity, E. T., & Muff, A. M. (1992). Efficacy of treatments for posttraumatic stress disorder. An empirical review. *Journal of the American Medical Association, 5*, 633-638.

Stone, A. M. (1993). Trauma and affect: Applying the language of affect theory to the phenomena of traumatic stress. *Psychiatric Annals, 23*, 567-584.

van der Kolk, B. A., & Fisler, R. E. (1994). Child abuse and neglect and loss of self-regulation. *Bulletin of the Menninger Clinic, 58*, 145-168.

van der Kolk, B. A., Perry, J. C., & Herman, J. L. (1991). Childhood origins of self-destructive behavior. *American Journal of Psychiatry, 148*, 1665-1671.

van der Kolk, B. A., Pelcovitz, D., Roth, S., Mandel, F. S., McFarlane, A., & Herman, J. L. (1996). Dissociation, somatization, and affect dysregulation: The complexity of adaptation to trauma. *American Journal of Psychiatry, 153*, 83-93.

van der Kolk, B. A., & van der Hart, O. (1989). Pierre Janet and the breakdown of adaptation in psychological trauma. *American Journal of Psychiatry, 146*, 1530-1540.

Weathers, F. W., Blake, D. D., Krinsley, K. E., Haddad, W., Huska, J., & Keane, T. M. (1992, October). *The Clinician Administered PTSD Scale: Reliability and construct validity.* Paper presented at the Annual Meeting of the International Society for Traumatic Stress Studies, Beverly Hills, CA.

Zlotnick, C., Begin, A., Shea, M. T., Pearlstein, T., Simpson, E., & Costello, E. (1994). The relationship between characteristics of sexual abuse and dissociative experiences. *Comprehensive Psychiatry, 35*, 465-470.

Zlotnick, C., Davidson, J., Shea, M. T., & Pearlstein, T. (1996). The validation of the Davidson Trauma Scale (DTS) in a sample of survivors of childhood sexual abuse. *Journal of Nervous and Mental Disease, 184*, 255-257.

Zlotnick, C., Shea, M. T., Pearlstein, T., Begin, A., Simpson, E., & Costello, E. (1996). Differences in dissociative experiences between survivors of childhood incest and survivors of assault in adulthood. *Journal of Nervous and Mental Disease, 184*, 52-55.

Zlotnick, C., Shea, M. T., Pearlstein, T., Simpson, E., Costello, E., & Begin, A. (1996). The relationship between dissociative symptoms, alexithymia, impulsivity, sexual abuse, and self-mutilation. *Comprehensive Psychiatry, 37*, 12-16.

Zlotnick, C., Zakriski, A., Shea, M. T., Begin, A., Pearlstein, T., Simpson, E., & Costello, E. (1996). The long-term sequelae of childhood sexual abuse: Support for a complex PTSD. *Journal of Traumatic Stress, 9*, 195-205.

Zlotnick, C., Begin, A., Pearlstein, T., Costello, E., & Simpson, E. (1994, August). *Predictors of outcome in group treatment for survivors of sexual abuse*. Paper presented at the American Psychological Association, Los Angeles, CA.