Clinical Models of Treatment for Trauma Experiences and Symptoms specific to Sexual Abuse and Sexual Assault

Initial Review of Existing Literature (2005-2012)

3/31/2013
Prepared for the Association of Alberta Sexual Assault Services
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"Victimization is not a discrete clinical, social, or legal phenomenon; rather, it is better characterized as a cluster of problems that may include psychiatric, physiological, social, and legal problem areas . . . victimization responses also include great diversity in problem severity and complexity, ranging from women with minimal symptoms of distress to women with severe physical and mental health problems and co-occurring substance abuse" (Logan et al. 2006, p. 134 cited in Jordan, Cambell, & Follingstad, 2010).[1]

Introduction:

This scan of the literature (2005-2012) to locate clinical models of treatment for trauma experiences and symptoms specific to sexual abuse and sexual assault is best introduced with a section from a literature scan on treatment models that was undertaken in 2009 to support planning for a trauma centre in Manitoba. In general, treatment modalities, research challenges and questions continue to exist similar to what is identified below.

"There are a wide range of treatments commonly used for trauma reactions consisting of: critical incident stress debriefing, psycho education, exposure therapy, eye movement desensitization reprocessing (EMDR), stress inoculation therapy, trauma management therapy, cognitive behavioural therapy, psychodynamic psychotherapy, hypnotherapy, imagery rehearsal, memory structure intervention, interpersonal psychotherapy and dialectical behaviour therapy, trauma work based on the recovery model (safety, remembrance and mourning, and reconnection) based on the work of Herman and Courtois; individual, group, insight driven, narrative and cognitive behavioural therapies; holistic and complimentary approaches such as yoga, auricular acupuncture, mindfulness, massage, aromatherapy and collective community practice. Because of the current vastness of the outcomes literature, it is difficult to isolate evidence based practice on all treatment modalities with the exception perhaps of cognitive behavioural therapy which has a considerable evidence based body of knowledge. Despite this vastness, research on outcomes is considered to be in the early stages of development due to the ambiguity of the nature of trauma that has been treated with diverse therapies (Bisson & Andrew, 2006; Seidler & Wagner, 2006). In addition, the term complex post traumatic disorder has been introduced into the literature over the past ten years. Complex trauma responses, distinct from post-traumatic stress, include: suicidal, addictive, and other self-harm behaviors; dissociative episodes; severe difficulties with trust and intimacy; emotional disturbances, including anxiety, depression, and rage; numerous somatic (physical) complaints and ongoing feelings of intense shame and poor self-worth (Courtois, 2004). These complex variables require a sophisticated and intensive search beyond the scope of our scan of the treatment literature in order to isolate evidence based practices." (Proulx, J. (2009). *Planning for a Comprehensive Trauma Recovery System and Resource Centre in Manitoba*: Summary Report of the Initial Planning Day. Resolve, MB, p. 33).

The following are brief summaries of articles found in the literature that address treatment models for sexual abuse and sexual assault. The articles vary and may include assessment, crisis work, short and long term individual counselling, families and groups and residential treatment for children, adolescents and adults who have experienced either singular or multiple traumas of sexual violence.

[1] Jordan, C. E., Campbell, R., & Follingstad, D. (2010). Violence and women's mental health: the impact of physical, sexual, and psychological aggression. Annual review of clinical psychology, 6(1), 607-628.

1 Children and Adolescents

Kemp, K., Signal, T., Botros, H., Taylor, N., & Prentice, K. (2013). Equine Facilitated Therapy with Children and Adolescents Who Have Been Sexually Abused: A Program Evaluation Study. Journal of Child and Family Studies, 1-9.

Purpose: Treating young people who are presenting with the detrimental effects of CSA is often difficult because these effects off-set efforts at establishing a therapeutic bond. Animals have been found to facilitate the development of the therapeutic alliance between client and practitioner and therapies utilizing horses have the added bonus of empowering clients. This study aimed to evaluate an Equine Facilitated Program (EFT) run by Phoenix House, a sexual assault referral centre in Queensland, Australia. Participants (Indigenous and non-Indigenous) were six boys and nine girls (aged 8–11 years) and 15 adolescent girls (aged 12–17 years).
Results/Conclusion: Overall the results show that EFT proved an effective therapeutic approach for the children and adolescents referred to the service. Of particular note was the finding that efficacy was similar across gender, age and Indigenous/non-Indigenous status. This result is important as previous research has suggested that mono-cultural therapies may not be as effective for Indigenous people for a number of reasons. Further studies should examine the effect of ethnicity on therapeutic alliance and attrition rates as it may be that EFT programs prove more suited to some cultures (particularly collective or Indigenous cultures), than traditional therapy based on verbalizations.

Lalor, K. & McElvaney, R. (2010). Child sexual abuse, links to later sexual exploitation/high-risk sexual behavior, and prevention/treatment programs. ***Trauma, Violence, & Abuse, 11*****(4) 159-177.**

Purpose: This paper reviews the literature on the nature and incidence of child sexual abuse, explores the link between child sexual abuse and later sexual exploitation, and reviews the literature on prevention strategies and effective interventions in child sexual abuse services. Our understanding of the international epidemiology of child sexual abuse is considerably greater than it was just 10 years ago, and studies from around the world are examined. Childhood sexual abuse can involve a wide number of psychological sequelae, including low self-esteem, anxiety, and depression. Numerous studies have noted that child sexual abuse victims are vulnerable to later sexual revictimization, as well as the link between child sexual abuse and later engagement in high-risk sexual behaviour. Survivors of child sexual abuse are more likely to have multiple sex partners, become pregnant as teenagers, and experience sexual assault as adults. Various models which attempt to account for this inter-relationship are presented; most invoke mediating variables such as low self-esteem, drug/alcohol use, PTSD and distorted sexual development. Prevention strategies for child sexual abuse are examined including media campaigns, schoolbased prevention programmes, and therapy with abusers. The results of a number of meta-analyses are examined.
Results/Conclusion: The authors reported that although an ecological approach is promoted in the area of prevention, their study highlights the need for such an approach in the area of therapy—with the child who has been abused, the family (which may or may not include the abuser), and the community. To date, such an approach has not been evident in practice or in the research literature. In general, there is considerable evidence to support the use of various

therapeutic modalities in intervening with children and families following the experience of CSA but the authors did not elaborate. They stated that researchers have identified significant methodological limitations in the extant research literature that impede the making of recommendations for implementing existing therapeutic programs unreservedly.

McPherson, P., Scribano, P., & Stevens, J. (2012). Barriers to Successful Treatment Completion in Child Sexual Abuse Survivors. *Journal of Interpersonal Violence 27*(1) 23–39.

Purpose: using a retrospective chart review, evaluate the linkage and successful completion of trauma treatment goals to CSA victims between the ages of 3 and 16 years who present for medical evaluation at a child advocacy center (CAC), a collocated medical/mental health treatment facility for victims of child sexual abuse. Specifically, the authors sought to describe the differences between children who do not engage in trauma treatment versus those who do when referred for CSA treatment; and, to identify predictors of successful completion of treatment goals for CSA patients and their families. For this study, CSA is defined as engaging a child in sexual activities that the child cannot comprehend, for which the child is developmentally unprepared and cannot give informed consent, and/or that violate societal taboos. Furthermore, exposure to pornography, and/or the patient being used as the subject of child pornography was also included as part of the definition of CSA victimization.
CSA treatment in children: Mental health sequelae of CSA include behavioral problems, anxiety, depression, substance use, eating disorders, sexualized behaviors, and post-traumatic stress disorder. Trauma models such as trauma-focused cognitive behavioral therapy (TF-CBT) may decrease the severity and duration of acute psychological disorders and may prevent long-term adverse psychological outcomes in survivors of. This treatment has been shown in multiple trials to decrease behavioral symptomatology acutely when reevaluated at 1- and 2-year follow-up with significantly greater improvement of internalizing and externalizing behaviors, depression, and social competence symptoms of sexually abused children. When the non-offending caregiver was involved in the child's therapy, there were greater improvements in self-reported measures of depression, abuse-specific distress, support of the child and effective parenting practices.
Results/Conclusion: According to the authors, this is the first study to evaluate mental health utilization and outcomes for sexually abused children who underwent the medical/diagnostic evaluation and received mental health services in a center designed to provide both abuse-related services in one location. An integrated model of evaluation and treatment appears to mitigate the effect of certain patient characteristics (i.e., demographics, abuse characteristics, therapist characteristics) that have been previously recognized as barriers to successful linkage and completion of mental health services for victims of CSA. The consistency of these results with previous studies suggests that engaging nonoffending caregivers in patient treatment, and providing appropriate levels of support/therapeutic intervention for the caregivers themselves, will significantly increase the likelihood of positive mental health outcomes for the child victim: i.e., engaging caregivers' involvement in therapy services had a positive effect with successfully achieving treatment goals.

Sprang, G., Craig, C. D., Clark, J. J., Vergon, K., Tindall, M. S., Cohen, J., & Gurwitch, R. (2013). Factors Affecting the Completion of Trauma-Focused Treatments What Can Make a Difference?. *Traumatology*, *19*(1), 28-40.

Purpose: Evidence-based interventions stipulate that children and caregivers must participate in treatment for at least the minimum prescribed times that have been found to establish and consolidate therapeutic effects. Unfortunately, premature treatment dropout is a significant problem in the field of child psychotherapy. High treatment attrition may indicate that the prescribed intervention is ineffectual for addressing the needs of the target population, and those who drop out early may fail to realize any or only limited symptom relief and/or improvement in functioning.
Results/Conclusion: The findings of this study suggest that African American race, placement in state custody, and a diagnosis of posttraumatic stress disorder, oppositional defiant disorder, and major depressive disorder predict treatment attrition.

Trask, E.V., Walsh, K., & DiLillo, D. (2011). Treatment effects for common outcomes of child sexual abuse: A current meta-analysis. *Aggression Violent Behavior*, *16*(1), 6–19. Retrieved from http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3095890/.

Purpose: 1) to systematically evaluate the effectiveness of therapeutic interventions in reducing the most commonly documented effects of childhood sexual abuse, and; 2) to examine participant and treatment characteristics that may moderate treatment effectiveness. To accomplish these goals, 35 published studies and unpublished dissertations that utilized diverse treatment modalities, research designs, and theoretical orientations to treatment were quantitatively synthesized. In doing the authors aimed to build on prior meta-analyses, which were older, left out relevant studies, or examined only one type of treatment modality, research design, or theoretical orientation to treatment.
Results/Conclusion: cognitive-behavioral interventions were more beneficial than treatments based on "other" theoretical models for reducing CSA-related symptomatology. Although the bulk of studies reviewed here (62%) investigated treatment as usual or supportive therapy approaches, the accumulating evidence suggests that further evaluation of CBT approaches is needed. Specific cognitive-behavioral interventions, such as Trauma-Focused CBT appear especially promising and worthy of further evaluation. Overall, treatment effectively reduced PTSD, externalizing, and internalizing problems following sexual abuse; longer interventions were associated with greater treatment gains; group and individual treatments were equally effective; and studies with older children and a greater proportion of males had larger treatment effects.

Payne, C., & Edwards, D. J. (2010). What services and supports are needed to enable trauma survivors to rebuild their lives? Implications of a systematic case study of cognitive therapy with a township adolescent girl with PTSD following rape. *Pragmatic Case Studies in Psychotherapy*, *6*(4). Retrieved from http://reaper64.scc-net.rutgers.edu/journals/index.php/pcsp/article/viewFile/1055/2468.

Purpose: This systematic clinical case study describes the psychological assessment and treatment (23 sessions) with cognitive therapy of Zanele, a Xhosa-speaking adolescent rape

survivor with major depressive disorder and posttraumatic stress disorder (PTSD). A case narrative was developed to document the main features of the therapy process and progress was monitored using scales measuring symptoms of depression and PTSD. The narrative documents the operation in a local context of factors that maintain PTSD that have been identified in the international literature and, with the self-report scales, provides evidence for Zanele's recovery from PTSD and the transportability to this context of an evidence-based psychological treatment. The narrative also documents the lack of safety for young women and girls in a South African township as well as significant limitations in the professional services available: in this case, Zanele was infected with HIV and other sexually transmitted diseases but medical management had not been followed through, and criminal charges against the rapist were dropped, and dropped again even after he had committed another rape on a six-year-old girl.
Results/Conclusion: The present study contributes to the literature on the abuse of children in South Africa by documenting the precarious conditions under which many children and adolescents live in South African townships. It provides evidence for the value in the local South African clinical context of a treatment model for PTSD developed by in the United Kingdom (Ehlers & Clark 2000; Clark & Ehlers 2005), and shows how a therapist and client from different cultural backgrounds and languages were able to work together and achieve substantial therapeutic gains. However it also highlights how failures in the criminal justice system made the task of treatment more difficult.

Meca, J. S., Alcázar, A. I. R., & Soler, C. L. (2011). The psychological treatment of sexual abuse in children and adolescents: A meta-analysis. *International Journal of Clinical and Health Psychology, 11*(1), 67-93.

Purpose: The main purpose of this meta-analysis was to examine the efficacy of the different psychological treatments that have been tested with children and adolescents victims of sexual abuse. Out of the 51 groups identified in the meta-analysis, 7 groups were comparison or control groups, whereas the remaining 44 groups were composed of children that had received some psychological treatment. Therapeutic approaches that have been researched scientifically for treating children who are victims of sexual abuse come from various different psychological models. Of all of these, the treatments that have been the subject of the most research are those based on the cognitive-behavioural model (CBT), and trauma-focused CBT. The authors identified the CBT model to be the only empirically-supported treatment. This treatment deals with the four traumagenic dynamics: traumatic sexualisation, stigmatization, a feeling of powerlessness and a feeling of betrayal. The intervention with the child consists of various techniques, amongst which are included coping skills training, gradual exposure, processing traumatic memories and reminders, and education about child sexual abuse, healthy sexuality and personal body safety skills training. From the psychodynamic model, programs based on psychodrama and play therapy have been used. From the humanistic model the most used treatments were those based on client-centered therapy, which main aim is to empower the self-awareness and self-reliance of the child.
Results/Conclusion: the best improvements in children's psychological wellbeing are achieved by combining trauma-focused CBT, supportive therapy and, to a lesser extent, psychodynamic therapy. In the other outcome measures (anxiety, depression, self-esteem, and other outcomes) there were no significant differences among the treatment modalities, but CBT, supportive therapy, and psychodynamic therapy, alone or in combination, were revealed as the most

effective treatments. In particular, for improving the self-esteem of abused children, CBT alone or in combination with supportive therapy and play therapy were the only treatment elements that achieved a statistically significant result. In general, trauma-focused cognitive-behavioural treatments combined with supportive therapy and a psychodynamic element (e.g., play therapy) showed the best results. Mixing these treatment elements enables simultaneous treatment of the feelings, thoughts, and behaviours of the abused children. In any case, it is important to take into account the particular symptoms of the child in order to apply the most appropriate treatment elements for him/her. Finally, when the treatment for child sexual abuse occurs in a group therapy context, it is important to take into account that the progress of each child may be different and that some of them may suffer a worsening in the therapeutic process. As a consequence, fixing **a priori** the number of group sessions can be problematic in practice.

Olafson, E. (2011). Child sexual abuse: Demography, impact, and interventions. *Journal of Child & Adolescent Trauma, 4*(1), 8-21.
Purpose: Because child sexual abuse (CSA) includes experiences from noncontact abuse to violent rape, the impact on victims varies greatly. Rape has the highest rates of posttraumatic stress disorder of any trauma. Depression and anxiety are associated with CSA, whereas sexualized behaviors, victim stigmatization, and shame are specific to it. The demography of CSA differs from other forms of child maltreatment by gender and social class, so that the risk factors for occurrence and prevention also differ.
Results/Conclusion: For children and early adolescents, there exists a well-established treatment, TF-CBT. Additional TF-CBT studies are underway for older adolescents, especially those with poly-victimization histories, and also for a number of similar CBT group and individual treatment protocols. Additional gender-specific interventions that address the unique challenges of male-on-male sexual abuse, female-on female sexual abuse, and specific interventions to help adolescents and young adults with sexual behavior problems linked to their sexual abuse histories would broaden the scope of evidence-based treatments.

Green, E. J. (2008). Reenvisioning Jungian analytical play therapy with child sexual assault survivors. *International Journal of Play Therapy, 17*(2), 102-121. doi: 10.1037/a0012770

Purpose: Child sexual abuse (CSA) is a pervasive, traumatic event affecting hundreds of thousands of ethnically and socioeconomically diverse children and families across the United States. The author noted that integrative therapies--those that combine directive and nondirective strategies--possess the capacity to benefit a child traumatized by sexual assault. Jungian analytical play therapy (JAPT) is a creative, integrative therapy that may be beneficial when applied to children affected by CSA.
Results/Conclusion: Within the safety of a nonjudgmental, therapeutic relationship, children affected by CSA may become consciously aware of and subsequently resolve conflicting emotions associated with sexual assault in symbolic, less-threatening ways. Through participation in JAPT, the child's psyche may begin the therapeutic process of integrating inner and outer emotional polarities in an archetypal quest for self-healing after sexual trauma.

Hetzel-Riggin, M. D., Brausch, A. M., & Montgomery, B. S. (2007). A meta-analytic investigation of therapy modality outcomes for sexually abused children and adolescents: An exploratory study. *Child Abuse & Neglect, 31*, 125-141.

Purpose: Hetzel-Riggin et al. (2007) looked at both the effect of treatment modality and also investigated different secondary problems such as behavior problems and psychological distress for sexually abused children and adolescents.
Results/Conclusion: The results indicated that psychological treatment after childhood or adolescent sexual abuse tended to result in better outcomes than no treatment. There was significant heterogeneity in the effectiveness of the various psychological treatment elements. Play therapy seemed to be the most effective treatment for social functioning, whereas cognitive-behavioral, abuse-specific, and supportive therapy in either group or individual formats was most effective for behavior problems. Cognitive-behavioral, family, and individual therapy seemed to be the most effective for psychological distress, and abuse-specific, cognitive-behavioral, and group therapy appeared to be the most effective for low self-concept. The authors concluded that the choice of therapy modality should depend on the child's main presenting secondary problem. Neither the age nor gender of the sample affected the treatment effectiveness, but ethnicity did affect the effect sizes, showing better results as the proportion of non-Caucasian people in the sample increased. Moreover, better results were found as the percentage of children in the sample that had suffered intra-familial sexual abuse decreased. Finally, a positive relationship was found between the duration of the treatment and the effect size.

Cloitre, M., Stovall-McClough, K. C., Nooner, K., Zorbas, P., Cherry, S., Jackson, C. L., ... & Petkova, E. (2010). Treatment for PTSD related to childhood abuse: A randomized controlled trial. *American Journal of Psychiatry*, *167*(8), 915-924. Retrieved from http://journals.psychiatryonline.org/article.aspx?articleid=102390.

Purpose: Posttraumatic stress disorder (PTSD) related to childhood abuse is associated with features of affect regulation and interpersonal disturbances that substantially contribute to impairment. Existing treatments do not address these problems or the difficulties they may pose in the exploration of trauma memories, an efficacious and frequently recommended approach to resolving PTSD. CBTs were designed specifically to resolve PTSD symptoms. They do not include interventions that explicitly address the additional interpersonal and emotion regulation problems observed among those with PTSD stemming from childhood abuse. These problems may occur equally or with greater frequency than PTSD symptoms. In addition, despite endorsement by professional guidelines, most clinicians do not regularly use exposure therapy, citing concerns about difficulties patients may have in managing feelings that arise from memory processing and the consequent risk of adverse effects.
Theoretical models of treatment for chronically traumatized individuals have proposed that the restoration or strengthening of day-to-day life competencies be a prerequisite for the exploration of the past. It has been suggested that this type of preparation might enhance the benefits of confronting and re-evaluating the meaning of past traumatic events, while protecting against potential adverse consequences. The authors evaluated the benefits and risks of a treatment combining an initial preparatory phase of skills training in affect and interpersonal regulation (STAIR) followed by exposure by comparing it against two control conditions: Supportive Counseling followed by Exposure (Support/Exposure) and skills training followed by Supportive Counseling (STAIR/Support). Participants were women with PTSD related to childhood abuse (N=104) who were randomly assigned to the STAIR/Exposure condition, Support/Exposure

condition (exposure comparator), or STAIR/Support condition (skills comparator) and assessed at post-treatment, 3 months, and 6 months.
Results/Conclusion: The present study demonstrated that among women with early-life and chronic traumatization, a phase-based treatment in which skills training preceded exposure provided superior benefits and fewer adverse effects than an exposure treatment without skills and no greater or fewer adverse effects than a non-exposure skills condition. The STAIR/Exposure group was more likely to achieve sustained and full PTSD remission relative to the exposure comparator, while the skills comparator condition fell in the middle. STAIR/Exposure produced greater improvements in emotion regulation than the exposure comparator and greater improvements in interpersonal problems than both conditions. The STAIR/Exposure dropout rate was lower than the rate for the exposure comparator and similar to the rate for the skills comparator. There were significantly lower session-to-session PTSD symptoms during the exposure phase in the STAIR/Exposure condition than in the Support/Exposure condition. STAIR/Exposure was associated with fewer cases of PTSD worsening relative to both of the other two conditions. For a PTSD population with chronic and early-life trauma, a phase-based skills-to-exposure treatment was associated with greater benefits and fewer adverse effects than treatments that excluded either skills training or exposure.

Paul, L. A., Gray, M. J., Elhai, J. D., Massad, P. M., & Stamm, B. H. (2006). Promotion of evidence-based practices for child traumatic stress in rural populations: Identification of barriers and promising solutions. *Trauma, Violence, & Abuse, 7*(4), 260-273.

Purpose: Child physical abuse, child sexual abuse, and other forms of traumatic stress in childhood are unfortunately quite prevalent. Although most children exhibit striking resiliency in the face of such harrowing experiences, the ubiquity of childhood trauma translates into a significant number of children in need of clinical services to address resultant unremitting distress. The article briefly reviews the prevalence and sequelae of childhood trauma and depicts the numerous barriers to effective treatment faced by rural populations. The authors then briefly review promising evidence-based interventions for child traumatic stress and conclude by enumerating mechanisms for increasing rural populations' access to these services.
Results/Conclusion: The authors briefly describe the three interventions cited in the Kauffman Best Practices Project Final Report (Chadwick Center for Children and Families, 2004) as the optimal treatments for child traumatic stress. The three evidence-based practices (EBPs) that were selected to be highlighted in the Kauffman report are trauma-focused cognitive behavioral therapy (TF-CBT), abuse-focused cognitive behavioral therapy (AF-CBT), and parent-child interaction therapy (PCIT). In terms of sexual abuse treatment, TF-CBT was designed to treat child and adolescent victims of sexual abuse and other traumas and their non-offending parents or guardians. With this population, TF-CBT has been shown to produce superior therapeutic gains compared with child-centered therapy, nondirective supportive therapy, and treatment as usual in the community. These studies demonstrate significant and lasting improvements on measures of depression, social competence, behavioral problems, shame and abuse-related attributions, and body safety. TF-CBT also benefits parents of traumatized children as it has been shown to improve parental-reported levels of self-depression, abuse-specific distress, support of the traumatized child, and effective parental practices. The involvement of both the child and parent, which is a major component of TF-CBT, has been found to significantly affect treatment

outcomes in a positive direction. AF-CBT and PCIT were described as effective for other forms of abuse such as physical.

2 Adults

Abbas, A., & Macfie, J. (2013). Supportive and Insight-Oriented Psychodynamic Psychotherapy for Posttraumatic Stress Disorder in an Adult Male Survivor of Sexual Assault. *Clinical Case Studies, 12*(2), 145-156.

Purpose: To have a clearer picture of treatment efficacy for individuals with PTSD, more research needs to be conducted using various treatment modalities and theoretical orientations. More attention needs to be paid to less visible victims of severe trauma, specifically adult male rape victims. This case study utilizes a time-series methodology to assess the efficacy of supportive and insight-oriented psychodynamic psychotherapy for an adult male sexual assault survivor. It is a single case study of a middle-aged man with posttraumatic stress disorder (PTSD) and Dissociative Disorder Not Otherwise Specified following sexual assault as an adult. Treatment consisted of supportive psychodynamic psychotherapy, focusing on reintegrating the patient into his community, followed by insight-oriented psychodynamic psychotherapy with an emphasis on processing trauma and decreasing PTSD and dissociative symptoms. Daily subjective, self-report measures were used to track his symptoms. The total treatment phase was 28 months of individual psychotherapy in which the first 24 months were conducted weekly and the last four months were switched to biweekly sessions. Simulation Modeling Analysis for time-series was utilized to assess the phase change from pretreatment baseline phase to total treatment phase and also between supportive psychotherapy phase and insight-oriented psychotherapy phase. Symptoms tracked included overall distress, preoccupation with the trauma, and dissociation.
Results/Conclusion: All symptoms significantly improved from the pretreatment baseline phase to the total treatment phase. Overall distress and preoccupation with the trauma significantly improved from the supportive to the insight-oriented psychotherapy phase. Moreover, overall distress and preoccupation with the trauma improved significantly from the supportive psychodynamic psychotherapy treatment phase to the insight-oriented psychodynamic psychotherapy treatment phase. This demonstrates the effectiveness of insight-oriented psychodynamic psychotherapy above and beyond the improvement that generally occurs simply by the individual entering treatment. The case study participant's dissociation score improved significantly between the time before therapy and his average dissociation score during therapy. However, dissociation did not change significantly between the supportive psychodynamic psychotherapy treatment phase and the insight-oriented psychodynamic psychotherapy treatment phase. This is likely due to a floor effect as dissociation had almost completely disappeared by the end of the supportive psychodynamic psychotherapy treatment phase. The significant decrease of dissociation demonstrates the necessity of treating individuals with supportive psychodynamic psychotherapy prior to insight-oriented psychodynamic psychotherapy in order to stabilize the individual, strengthen adaptive coping skills, and bolster self-efficacy before dismantling the individual's resistance and defenses.

Alvidrez, J., Shumway, M., Morazes, J., & Boccellari, A. (2011). Ethnic disparities in mental health treatment engagement among female sexual assault victims. *Journal of Aggression, Maltreatment & Trauma, 20*(4), 415-425.

Purpose: Few female sexual assault victims receive mental health treatment following victimization. This is particularly true for ethnic minority women. This descriptive study examined ethnic differences in treatment need and treatment engagement in a diverse sample of 104 women (White, Black, Latina, and other) offered no-cost mental health services following a sexual assault.
Results/Conclusion: Despite equivalent or higher need for services, Black women were less likely than White women to engage in treatment in the year following assault. Results suggest that Black–White differences in help-seeking after sexual assault are not explained solely by differences in access. Further exploration of additional barriers to mental health care for Black women after sexual assault is needed.

Ponniah, K., & Hollon, S. D. (2009). Empirically supported psychological treatments for adult acute stress disorder and posttraumatic stress disorder: a review. *Depression and Anxiety, 26*(12), 1086-1109.

Purpose: Acute stress disorder (ASD) predicts the development of posttraumatic stress disorder (PTSD), which in some sufferers can persist for years and lead to significant disability. The authors carried out a review of randomized controlled trials to give an update on which psychological treatments are empirically supported for these disorders, and used the criteria set out by Chambless and Hollon [1998: J Consult Clin Psychol 66:7–18] to draw conclusions about efficacy, first irrespective of trauma type and second with regard to particular populations.
Results/Conclusion: Looking at the literature undifferentiated by trauma type, there was evidence that trauma-focused cognitive behavioral therapy (CBT) and eye movement desensitization and reprocessing (EMDR) are efficacious and specific for PTSD, stress inoculation training, hypnotherapy, interpersonal psychotherapy, and psychodynamic therapy are possibly efficacious for PTSD and trauma-focused CBT is possibly efficacious for ASD. Not one of these treatments has been tested with the full range of trauma groups, though there is evidence that trauma-focused CBT is established in efficacy for assault- and road traffic accident-related PTSD. Trauma-focused CBT and to a lesser extent EMDR (due to fewer studies having been conducted and many having had a mixed trauma sample) are the psychological treatments of choice for PTSD, but further research of these and other therapies with different populations is needed.

Russell, P. L., & Davis, C. (2007). Twenty-five years of empirical research on treatment following sexual assault. *Best Practices in Mental Health: An International Journal, 3*(2), 21-37.

Purpose: The authors reviewed the empirical research on interventions following sexual assault, identified gaps in the research, and considered future directions for research and practice.
Results/Conclusion: The primary types of interventions found were comparison studies of more than one intervention, cognitive-based therapies, educational interventions, eye movement desensitization and reprocessing (EMD or EMDR) therapies, group therapies, hypnosis or

trance-based therapies, and imagery or exposure therapies. Most of the published articles presented in the review reported positive results. However, the strength, quality, and relative efficacy of the research suggested further analysis was required. The authors recommended that given the strength of accumulated evidence, rape crisis centers and social workers would be well advised to consider exposure and cognitive behavioral interventions when presented with a rape survivor. The authors indicated in the studies they reviewed:

- CBT and its derivatives (including CPT) are among the most thoroughly researched interventions.
- All studies of prolonged exposure (PE) and its variants indicate strong therapeutic effects for PTSD in rape victims.
- Imagery Rehearsal therapy (IRT), a variant of exposure and cognitive therapies, is used to treat recurrent nightmares in sexual assault survivors. They highlight one study where significant improvements were seen not just for sleep quality and nightmare frequency, but also for PTSD symptomology, compared to the control groups.
- Although Stress Inoculation Therapy (SIT) has been shown to effectively treat symptoms of rape survivors, it appears to be less effective than other treatment modalities.
- Some professionals have postulated that the beneficial effects of EMDR may be due to their relationship with ET. At present, it is difficult to ascertain, but unlike exposure or cognitive therapies, EMDR does not have strong empirical support in the literature.
- Group work is a popular form of therapy for a variety of psychosocial dilemmas, and groups for sexual assault survivors are commonly offered at rape crisis centers. The authors noted that as some form of support group is often suggested to rape survivors, better research is needed to determine if benefits are distinct from those achieved through individual counseling.
- Initial anxiety immediately following assault has been shown to correlate with increased risk for psychosocial difficulties. Studies suggest that early intervention can have a significant effect on the long-term distress and negative outcomes experienced by rape survivors. However, the difficulties in getting rape survivors to seek immediate treatment are well known.
- Little is available in the literature concerning what treatment options are presented to survivors when they seek counseling. Rape crisis centers are thought to primarily use crisis intervention, despite the lack of empirical support. Further research on the efficaciousness of this type of treatment is needed.

Forbes, D., Creamer, M., Phelps, A., Bryant, R., McFarlane, A., Devilly, G. J., ... & Newton, S. (2007). Australian guidelines for the treatment of adults with acute stress disorder and post-traumatic stress disorder. *Australasian Psychiatry*, *41*(8), 637-648. Retrieved from http://www.devilly.org/Publications/Tx_Guidelines_ANZJP.pdf.

Purpose: Over the past 23 years, clinical practice guidelines (CPGs) for post-traumatic stress disorder (PTSD) and acute stress disorder (ASD) have been developed in the USA and UK. There remained a need, however, for the development of Australian CPGs for the treatment of ASD and PTSD tailored to the national health-care context. Therefore, the Australian Centre for Posttraumatic Mental Health in collaboration with national trauma experts, has recently developed Australian CPGs for adults with ASD and PTSD, which have been endorsed by the National Health and Medical Research Council (NHMRC).

Results/Conclusion: Key recommendations indicate the use of trauma-focused psychological therapy (cognitive behavioural therapy or eye movement desensitization and reprocessing in addition to in vivo exposure) as the most effective treatment for ASD and PTSD. Where medication is required for the treatment of PTSD in adults, selective serotonin re-uptake inhibitor antidepressants should be the first choice. Medication should not be used in preference to trauma-focused psychological therapy. In the immediate aftermath of trauma, practitioners should adopt a position of watchful waiting and provide psychological first aid. Structured interventions such as psychological debriefing, with a focus on recounting the traumatic event and ventilation of feelings, should not be offered on a routine basis. Instead, practitioners are advised to adopt a stance of 'watchful waiting' combined with the provision of general psychological first aid where required. Psychological first aid includes provision of information, as well as emotional and instrumental support. Additional assistance should be progressively provided according to individual need. The ventilation of emotions and narration of events on a routine basis is not supported by the evidence. However, individuals who wish to discuss the experience, and who demonstrate a capacity to tolerate associated distress, should be supported in doing so. Where adults exposed to trauma develop an extreme level of distress or are at risk of harm to self or others, immediate crisis intervention and possible psychiatric intervention should be provided.

For PTSD: Key practice recommendations were made based on the accumulated research evidence:

- Adults with PTSD should be provided with trauma-focused interventions (trauma-focused CBT or EMDR in addition to in vivo exposure).
- Non-trauma-focused interventions such as supportive counselling and relaxation should not be provided to adults with PTSD in preference to trauma-focused interventions.
- Where symptoms have not responded to a range of trauma-focused interventions, evidence-based non-trauma-focused interventions (such as stress management) and/or pharmacotherapy should be considered.
- Sessions that involve imaginal exposure generally require 90 min.
- Following assessment, diagnosis and treatment planning, 8 to 12 sessions of trauma-focused treatment is usually sufficient.

The following recommendations were also made based on the accumulated research evidence:

- Adults displaying ASD or PTSD reactions at least 2 weeks after the traumatic event should be offered trauma-focused CBT including exposure and/or cognitive therapy once a clinical assessment has been undertaken.
- For adults with ASD, treatment should be provided on an individual basis.
- For adults with ASD, trauma-focused CBT should, under normal circumstances, be provided in 5-10 sessions.
- For adults with ASD, 90 min should be allowed for sessions that involve imaginal exposure.
- Combination psychological interventions for ASD should not be used routinely.

Hebert, M., & Bergeron, M. (2007). Efficacy of a group intervention for adult women survivors of sexual abuse. *Journal of Child Sexual Abuse, 16*(4), 37-61.

Purpose: This study evaluates the effects of a group intervention for women sexually abused in childhood or adulthood. The sample consisted of 41 women involved in a group intervention based on a feminist approach offered by help centers for sexual assault victims in Quebec and 11 women in a wait-list comparison group.
Results/Conclusion: The main outcomes investigated were selected from among those explored in previous studies: self-esteem, psychological distress, depression symptoms, and posttraumatic stress symptoms. In addition, outcomes more closely related to the traumagenic dynamics of SA were also considered: self-blame/stigmatization and powerlessness, sexual anxiety, assertiveness, and strategies used to cope with SA memories. Results revealed that the group intervention reduced psychological distress and consequences associated with sexual abuse and that gains were maintained at three-month follow-up. Analyses of potential factors related to differential gains indicated that abuse-related variables and concurrent individual interventions were not linked to outcomes. Exploratory analyses suggested that women experiencing severe physical partner violence showed greater gains with respect to self-blame/stigmatization, sexual anxiety, and anxiety related to assertiveness. Group approaches such as the one evaluated in this study may relieve distress and symptomatology in a relatively brief period of time and in a cost-effective manner.

Cohen, L. R., & Hien, D. A. (2006). Treatment outcomes for women with substance abuse and PTSD who have experienced complex trauma. *Psychiatric Services, 57*(1), 100-106.

Purpose: to evaluate the effectiveness of short-term cognitive-behavioral therapy on a range of problems associated with complex trauma in a sample of 107 women with comorbid PTSD and substance use disorders. By using a quasi-experimental design, end-of-treatment outcomes for participants who received cognitive-behavioral therapy were compared with those of participants in a control group on various measures: PTSD, substance use disorders, depression, dissociation, and social and sexual functioning.
Results/Conclusion: At the end of treatment (three months post-baseline), compared with participants in the control group, those in the active treatment group showed significant reductions in symptoms of PTSD and alcohol use disorders, with a trend toward reductions in symptoms of drug use disorders. No significant differences were found between the groups on depression, dissociation, and social and sexual functioning outcomes. These findings demonstrate that although short-term cognitive-behavioral interventions may decrease some symptom clusters, other problems associated with complex trauma may be less amenable to this type of treatment. These findings underscore the challenge and necessity of addressing the unique and wide-ranging needs of women with substance use disorder who have been exposed to early and multiple interpersonal traumas. Interventions designed for one or two discrete problem areas are not likely to consider the whole clinical picture and may not be practical for this population. More comprehensive multi-model treatments are often recommended for these patients. Incorporating interventions that specifically target features associated with complex trauma in this population may extend treatment results. For example, treatment focusing on deficits in emotional regulation and social functioning in addition to PTSD symptoms has been used successfully in a non–substance-abusing population of women with extensive trauma histories. Finally, the authors suggested that the presence of comorbid disorders and multiple impairments strongly influences the duration of treatment that is provided. Treatments longer

than those typically used in treatment protocols (for example, three months) may result in superior outcomes, although this practice needs to be empirically tested.

Cloitre, M. (2009). Effective psychotherapies for posttraumatic stress disorder: a review and critique. *CNS Spectrums, 14*(1), 32-43. Retrieved from http://032912b.membershipsoftware.org/libdocuments/PTSD_Psychological_Tx.pdf.

Purpose: This review organizes the empirical literature on psychotherapy outcome trials for posttraumatic stress disorder according to type of intervention. Substantial progress has been made in the use of cognitive behavioral therapies and eye movement desensitization and reprocessing for the resolution of PTSD. Innovations in PTSD treatments are identified.
Results/Conclusion: Further advances are needed in the treatment of populations with complex and chronic forms of PTSD such as those found in childhood abuse populations, refugee populations, and those experiencing chronic mental illness. The need to address comorbid emotional, social, and physical health consequences of trauma, to implement treatments in community-based settings, and to incorporate larger systems of care into study designs is noted. Cognitive-behavioral treatments have been shown to be superior to waitlist, supportive counseling, nonspecific therapies and treatment as usual. Exposure therapy has been studied in the largest number of trials and has consistently shown beneficial effects. Cognitive therapy is associated with the largest effect size, however the limited number of trials using pure cognitive therapy as compared to control conditions and as compared to exposure suggest that it is premature to draw conclusions about the relative benefits of cognitive therapy compared to exposure. Combination treatments of exposure and cognitive therapy show small but consistent advantages over either of the interventions alone. EDMR, like exposure and cognitive therapy, has established efficacy. There have been a fairly large number of studies comparing EMDR to exposure and/or cognitive therapy, and the evidence to date does not allow a determination of any particular advantage of one versus the other in terms of PTSD outcome. Cognitive-behavioral approaches to the treatment of chronically traumatized populations have been successful. Several innovative approaches are also promising (for example, alternative medicine, hypnotherapy, body-oriented therapies utilizing yoga and acupuncture, imaginal rehearsal therapy focused on nightmares, psychodynamic-CBT blends).

Taylor, J. E., & Harvey, S. T. (2009). Effects of psychotherapy with people who have been sexually assaulted: A meta-analysis. *Aggression and Violent Behavior, 14*(5), 273-285.

Purpose: This paper presents the results of a meta-analysis of the treatment outcome studies of different types of psychotherapeutic approaches for sexual assault victims experiencing PTSD or rape trauma symptoms. There were 15 outcome studies identified for inclusion in the meta-analysis dating from 1988–2005, and these studies comprised 25 treatment conditions. Separate meta-analyses were conducted according to study design (independent samples and repeated measures), in keeping with meta-analytic conventions.
Results/Conclusion: The majority of studies mostly used community-based individual cognitive–behavioral treatment approaches. All participants were women and most identified as white/Caucasian and had an undergraduate education. Unfortunately, few studies described the characteristics of assault experienced by their participants; therefore, any variation in treatment effects due to these variables could not be investigated. The overall results suggest that

psychotherapy for the effects of sexual assault typically provides beneficial outcomes, which was primarily assessed in terms of symptom reduction. Furthermore, effects were maintained at follow-up from 6–12 months after treatment. Studies represented diverse treatment approaches, and most treatments were effective in improving outcome according to symptom reduction. A number of moderating variables were examined. Better outcomes were achieved with individual therapy compared to group approaches. The use of semi-structured approaches and homework techniques were positively related to the magnitude of effect size.

Mossman, E., Jordan, J., MacGibbon, L., Kingi, V., & Moore, L. (2009). Responding to sexual violence: A review of the literature on good practice. Wellington, New Zealand: Ministry of Women's Affairs/Minitatanga Mō Ngā Wāhine. Retrieved from http://mwa.govt.nz/documents/responding-sexual-violence-review-literature-good-practice-2009.

Purpose: In a review of the literature on effective treatment approaches to sexual violence, the authors found evidence on what is effective was limited and incomplete. The authors stated that this lack of research means that interventions available may or may not be the most appropriate ones to respond to a victim/survivors needs. The most comprehensive information they located was from a recent World Health Organization review on therapeutic approaches to victim/survivors' mental health needs (Wang and Rowley, 2007). In reviewing evidence on the major therapeutic approaches used to treat survivors of sexual violence findings on the comparative superiority of approaches were also inconsistent. A summary of findings from the Wang and Rowley (2007) review are as follows:

- Different types of cognitive behavioural therapies aimed at managing the memory of the trauma were found to reduce sequelae such as anxiety, depression and PTSD, at different post-rape stages. These included prolonged exposure treatment and stress inoculation training. Cognitive processing therapy has also been found to be effective in treating PTSD.
- There is evidence that brief interventions improve functioning and decrease the severity of re-experiencing and arousal symptoms associated with PTSD.
- Relational therapy, which integrates a victim/survivor's immediate social network into the treatment, has also been found to decrease symptoms of depression compared with those undergoing individual treatment, although decreases in PTSD symptoms were similar and there were no significant differences in family functioning between the two groups.
- Not all forms of therapy have been evaluated. For example, feminist approaches often integrate elements of cognitive behavioural therapy with group therapy to reduce short-term fear and anxiety as well as longer-term issues of self-blame, shame and guilt. Feminist therapies seek to help the survivor to see a victim/survivor‟ s experience as part of a larger social problem and thus to reframe the causes of the sexual violence and reduce long-term feelings of personal guilt, shame and self-blame. There are some indications that feminist therapeutic approaches are effective, but there does not seem to have been any research documenting integrated therapies. The latter point highlights one of the inherent limitations of literature reviews and what can and cannot be inferred.

Effective long term mental health interventions

- Trauma-focused cognitive behavioural approaches to therapy (e.g. prolonged exposure treatment, stress inoculation training, and cognitive processing therapy) can be effective, particularly in reducing short-term post-rape fear and anxiety symptoms.
- Feminist therapies are less well researched, but may be helpful in addressing longer-term self-blame.

Resick, P. A., Uhlmansiek, M. O. B., Clum, G. A., Galovski, T. E., Scher, C. D., & Young-Xu, Y. (2008). A randomized clinical trial to dismantle components of cognitive processing therapy for posttraumatic stress disorder in female victims of interpersonal violence. ***Journal of consulting and clinical psychology*****, *76*(2), 243.**

Purpose: The purpose of this study was to conduct a dismantling study of cognitive processing therapy in which the full protocol was compared with its constituent components—cognitive therapy only (CPT-C) and written accounts (WA)—for the treatment of posttraumatic stress disorder (PTSD) and comorbid symptoms. The primary purpose of this study was to examine the components of CPT, singly and compared with the full protocol. The authors hypothesized that the original CPT protocol would be more efficacious than either component: CPT-C or WA administered alone, although they also planned to compare CPT-C with WA to determine whether either single component was superior to the other. The design of the study, which included assessment of PTSD and depressive symptoms throughout therapy, as well as before and after, allowed for a powerful examination of change across conditions and time. A secondary purpose of this study was to examine patterns of change to determine whether those findings are replicated and to determine when change occurs during the course of treatment. Finally, the study aimed to expand the investigation of the effects of the three therapy conditions on a range of comorbid symptoms known to be associated with post-trauma functioning. The relationships among treatment and depression, anger, anxiety, and cognitions (including guilt, shame, and other dysfunctional cognitions) were also examined. Participants were included if they had experienced sexual or physical assault in childhood or adulthood and met criteria for PTSD at the time of the initial assessment, were at least 3 months post-trauma (no upper limit), and if on medication, were stabilized. Women with current substance dependence were included if/when they had been abstinent for 6 months. Those with substance abuse were permitted to participate if they agreed to desist in usage during the period of treatment. The sample included 150 adult women with PTSD who were randomized into 1 of the 3 conditions. Each condition consisted of 2 hr of therapy per week for 6 weeks; blind assessments were conducted before treatment, 2 weeks following the last session, and 6 months following treatment. Measures of PTSD and depression were collected weekly to examine the course of recovery during treatment as well as before and after treatment. Secondary measures assessed anxiety, anger, shame, guilt, and dysfunctional cognitions.
Results/Conclusion: Both components of CPT as well as the full protocol were successful in treating PTSD and other secondary symptoms in this highly traumatized and chronic sample, as evidenced by the large decreases in PTSD and depression symptoms. The results of the trial were quite similar to other trials of cognitive behavioral treatments for PTSD, with large improvements realized over the 6 weeks of treatment and maintained throughout the follow-up period. Participants improved, across conditions, not only on PTSD symptoms but also on depression, anxiety, anger, guilt, shame, and cognitive distortions. The combination of cognitive

therapy and WAs did not improve upon the results of either component. This study joins the growing body of research that has found cognitive therapy alone to be at least as effective as exposure in the treatment of PTSD. However, on the basis of one dismantling study, the authors would not recommend eliminating the WA component from the CPT protocol in all cases. Some may need to reconstruct the event and/or access emotions that have been particularly avoided. However, for those clients who are unwilling to undergo exposure-based treatments or only have a few sessions to attend treatment, cognitive therapy may be the treatment of choice.
This was the first study to examine a WA protocol that was set up to parallel prolonged imaginal exposure, with writing assignments focusing on the worst traumatic event, reading and processing the account with the therapist, and homework to reread the traumatic event daily. The fact that this protocol was also successful in reducing symptoms has potential for use by therapists who are less skilled in cognitive therapy or when therapist access is limited, such as in rural areas or when the need is great, such as in post-disaster environments.
Theoretically, this study supports the idea that alteration in the meaning of the traumatic event may be an active mechanism of change and that systematic and extensive exposure to the trauma memory may not be a necessary condition of treatment. Most theories of PTSD recovery propose that repeated exposure to the trauma memory is needed for habituation of a fear response, to facilitate restructuring of unhelpful fear appraisals, or to activate situationally accessible memories. It is possible that a cognitive therapy that focuses not only on current cognitions and appraisals of future danger but also on the traumatic events themselves, along with a broader array of associated cognitions, may be able to promote change more directly.

Foa, E. B., Zoellner, L. A., & Feeny, N. C. (2006). An evaluation of three brief programs for facilitating recovery after assault. *Journal of Traumatic Stress, 19*(1), 29-43. Retrieved from http://filer.case.edu/org/feenylab/documents/Facilitating_Trauma_Recovery.pdf.

Purpose: The study replicated and extended Foa et al.'s (1995) study and was designed to address several of its limitations, including small sample size, lack of randomization, and relatively short follow-up (i.e., 5months). In addition, this was the largest published study looking at early interventions in a sample of female assault survivors. Ninety female recent assault survivors who met symptom criteria for posttraumatic stress disorder (PTSD) were randomized to one of three interventions: Brief Cognitive Behavioral Intervention, which focused on processing the traumatic event (B-CBT); assessment condition (AC); or supportive counseling (SC). Within 4 weeks of an assault, participants met weekly with a therapist for four 2-hr sessions.
Results/Conclusion: Across all interventions, participants reported decreases in PTSD symptoms, depression, and anxiety over time. At post-intervention, participants in B-CBT reported greater decreases in self-reported PTSD severity and a trend toward lower anxiety than those in SC. At 3-month follow-up, participants in B-CBT evidenced lower general anxiety than those in SC and a trend toward lower self-reported PTSD severity. At last available follow-up (on average, 9-months postassault), all three interventions were generally similar in outcome. These findings suggest that a trauma-focused intervention aimed at those with severe PTSD symptoms after an assault can accelerate recovery.

Ferdinand, L. G., Kelly, U. A., Skelton, K., Stephens, K. J., & Bradley, B. (2011). An Evolving Integrative Treatment Program for Military Sexual Trauma (MST) and One Veteran's Experience. *Issues in Mental Health Nursing*, *32*(9), 552-559.

Purpose: Military sexual trauma (MST) increases the risk for Posttraumatic Stress Disorder (PTSD) and multiple other comorbidities, presenting substantial challenges for nurses and psychiatric and medical clinicians. A specialized VA Medical Center outpatient program is patterned after Herman's three-phased, empirically supported, recovery treatments. The authors used a case example of a female veteran MST survivor to illustrate their treatment model. She presented to their program meeting diagnostic criteria for PTSD, Major Depressive Disorder, and a history of substance abuse. Post-treatment she demonstrated improved scores on measures of PTSD, quality of life, and socialization.
Results/Conclusion: One emerging model of treatment for complex symptom presentations in trauma survivors is a phase model, which includes an initial phase focused on stabilization, a second phase focused on trauma memories, and a third phase focused on re-establishing adaptive functioning (Ford & Cloitre, 2009; Ford, Courtois, Steele, van der Hart, & Nijenhuis, 2005; Loewenstein &Welzant, 2010).This model shows promise for treatment of MST survivors with PTSD. Implementation of a VA MST treatment program utilizes a three phase (stabilization, trauma-focused treatment, reconnection) model of intervention. The authors designed this program based on the best evidence available for the treatment of sexual assault-related PTSD (PE and CPT) and psychosocial skills development but recognized that these focal treatments are not designed to treat the broad range of symptoms with which veterans often present. They therefore built on clinical theory and research on Complex PTSD/DESNOS to design this phase-based approach to treatment. At each phase they attempt to provide multidisciplinary care (psychology, social work, psychiatry, and nursing) to support each veteran's recovery process.

Ford, J. D., Courtois, C. A., Steele, K., Hart, O. V. D., & Nijenhuis, E. R. (2005). Treatment of complex posttraumatic self-dysregulation. Journal of Traumatic Stress, 18(5), 437-447.

Purpose: The authors describe a three-phase sequential integrative model for the psychotherapy of complex posttraumatic self-dysregulation: Phase 1 (alliance formation and stabilization), Phase 2 (trauma processing), and Phase 3 (functional reintegration). The technical precautions designed to maximize safety, trauma processing, and reintegration regardless of the specific treatment approach are discussed. Existing and emerging treatment models that address posttraumatic dysregulation of consciousness, bodily functioning, emotion, and interpersonal attachments are also described.
Results/Conclusion: Several manualized interventions for the treatment of posttraumatic self-dysregulation have been developed and appear promising in clinical application and early clinical trial scientific findings. These interventions have adapted features of cognitive–behavioral (CBT) and interpersonal–affect regulation (IAT) therapy modalities that previously were found to be effective in the treatment of PTSD and psychiatric disorders that co-occur with PTSD (e.g., depression, substance abuse). Both CBT and IAT interventions consistently use a phase-oriented approach, emphasizing Phase 1 work on skills for self-regulation as a precondition to therapeutic disclosure of traumatic memories (whether via purposive "exposure" exercises, or by re-examination of the personal meaning and effects on emotion and relationships of intrusive trauma re-experiencing symptoms). The authors stated that there is much overlap

both within and across the two major domains of therapies for posttraumatic self-dysregulation, as well as between these treatments and the better-established therapies for PTSD per se. Given the evidence that CBT interventions designed for rape survivors are helpful for the 57–73% of female survivors of childhood sexual abuse who complete treatment (McDonagh-Coyle et al., 2005; Resick et al., 2002), it will be important to study when, for whom, and how to provide these efficient and potentially efficacious interventions so as to hasten the recovery of as many trauma survivors as possible without inadvertently causing harm. Further, the authors agreed that dismantling of the concepts of self-regulation and dysregulation is needed both in theory and in empirical research (Ford, 2005) for trauma therapists to know what they are treating in addition to PTSD and its co-occurring disorders and impairments. In so doing, clinical researchers will be able to develop clearer theoretical models and empirical studies testing the nature of the relationship between PTSD and self-dysregulation, as well as between recovery from or prevention of PTSD and enhancement of self-regulation.

Martsolf, D.S. & Draucker, C.B. (2005). Psychotherapy approaches for adult survivors of childhood sexual abuse: An integrative review of outcomes research. *Issues in Mental Health Nursing*, *26*, 801 – 825.

Purpose: Martsolf and Drucker (2005) in their synthesis of 26 outcomes research studies and two meta-analyses that evaluated abuse-focused psychotherapy techniques for survivors of childhood sexual abuse, found that no one therapeutic approach was superior in terms of effectiveness of resolution of symptoms, i.e. decreased general psychiatric symptoms, depression, and trauma specific symptoms. Their review included individual versus group therapy, psycho didactic support, process oriented groups, family systems therapy, emotion focused, multi modal, eclectic survivor, psycho-educational, problem-solving, skill building and cognitive restructuring.
Results/Conclusion: Their conclusions suggest that abuse-focused psychotherapy is generally beneficial for survivors of childhood sexual abuse. The outcomes research is however in the early stages of development and offers tentative conclusions with multiple limitations to the conducted studies.

Posmontier, B., Dovydaitis, T., & Lipman, K. (2010). Sexual violence: Psychiatric healing with eye movement reprocessing and desensitization. *Health Care for Women International*, *31*(8), 755-768. Retrieved from http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3125707/.

Purpose: The purpose of this article is to introduce health care providers to the technique of EMDR, review safety and appropriateness, and discuss clinical and research implications. The authors discuss the appropriateness of EMDR as evidenced by the presence of a strong positive rapport between client and psychotherapist, the client's ability to use relaxation techniques and maintain self-control to regain emotional balance between sessions, and her ability to ask for help if needed. The client should have no evidence of additional crises in the present that needs to be dealt with before the start of EMDR, no need to do a legal deposition in a crime case, and no current need to make important decisions. The ideal client should have access to a nurturing support system such as family and friends, and no evidence of an unsafe social environment or resistant social network. In addition, the client should have no evidence of eye pain during sessions (unless alternate EMDR techniques are used such as hand tapping), long-term drug and

alcohol abuse, current sedation with medications such as benzodiazepines, dissociative identity disorder (e.g., multiple personality disorder), organic brain damage, epilepsy, heart disease, or other medical conditions that would preclude the somatic experience of stress. Finally, she should have no evidence of resistance to treatment because of competing concerns.
Results/Conclusion: Although there is still much to learn, EMDR is an effective, low-cost, brief intervention therapy for treatment of acute and chronic PTSD in victims of sexual violence. Health care providers caring for women are in an ideal position to identify the symptoms of sexual-violence-induced PTSD in their patients and to recommend EMDR to promote psychiatric healing.

van der Kolk, B. A., Spinazzola, J., Blaustein, M. E., Hopper, J. W., Hopper, E. K., Korn, D. L., & Simpson, W. B. (2007). A randomized clinical trial of eye movement desensitization and reprocessing (EMDR), fluoxetine, and pill placebo in the treatment of posttraumatic stress disorder: treatment effects and long-term maintenance. *Journal of Clinical Psychiatry*, *68*(1), 37.

Purpose: The relative short-term efficacy and long-term benefits of pharmacologic versus psychotherapeutic interventions have not been studied for posttraumatic stress disorder (PTSD). This study compared the efficacy of a selective serotonin reuptake inhibitor (SSRI), fluoxetine, with a psychotherapeutic treatment, eye movement desensitization and reprocessing (EMDR), and pill placebo and measured maintenance of treatment gains at 6-month follow-up. Eighty-eight PTSD participants diagnosed according to DSM-IV criteria were randomly assigned to EMDR, fluoxetine, or pill placebo. They received 8 weeks of treatment and were assessed by blind raters posttreatment and at 6-month follow-up. The primary outcome measure was the Clinician-Administered PTSD Scale, DSM-IV version, and the secondary outcome measure was the Beck Depression Inventory-II.
Results/Conclusion: The present study supported the empirical literature that proposes that skilled confrontation with traumatic memories within a safe therapeutic setting is the treatment of choice for PTSD with adult-onset trauma. The psychotherapy intervention was more successful than pharmacotherapy in achieving sustained reductions in PTSD and depression symptoms, but this benefit accrued primarily for adult-onset trauma survivors. At 6-month follow-up, 75.0% of adult-onset versus 33.3% of child-onset trauma subjects receiving EMDR achieved asymptomatic end-state functioning compared with none in the fluoxetine group. In contrast, for most individuals with childhood-onset trauma (all of whom, in this study, were victims of chronic intra-familial physical and/or sexual abuse), 8 weeks of therapy was not enough to resolve longstanding trauma imprints and adaptations. For most childhood-onset trauma patients, neither treatment produced complete symptom remission.
This study supported the efficacy of brief EMDR treatment to produce substantial and sustained reduction of PTSD and depression in most victims of adult-onset trauma. It suggests a role for SSRIs as a reliable first-line intervention to achieve moderate symptom relief for adult victims of childhood-onset trauma. The authors recommended that future research should assess the impact of lengthier intervention, combination treatments, and treatment sequencing on the resolution of PTSD in adults with childhood-onset trauma.

Seidler, G.H. & Wagner, F.E., 2006. Comparing the efficacy of EMDR and trauma-focused cognitive- behavioural therapy in the treatment of PTSD: A meta-analytic study. *Psychological Medicine, 36,* 1515-1522.

Purpose: Eye movement desensitization and reprocessing (EMDR) was developed in 1987 and is used to treat PTSD. While the efficacy of EMDR is generally accepted, certain aspects of the treatment are controversial, specifically the relationship of the eye movement component to treatment outcomes.
Results/Conclusion: Results from this meta-analytical review show that the present research is not adequate to demonstrate that one treatment (EMDR or trauma-focused cognitive behavioural therapy) is superior to the other. Key considerations for future research are: isolating the specific nature of traumatic events, controlling for pre-treatment differences that affect assessment of the treatment, awareness that severely disturbed trauma survivors may be re-traumatized by any kind of exposure therapy, moving beyond efficacy and efficiency of therapy methods to establish which clients are most likely to benefit from specific treatments.

Tambling, R. B. (2012). Solution-Oriented Therapy for Survivors of Sexual Assault and Their Partners. Contemporary Family Therapy, 34(3), 391-401.

Purpose: Research suggests that survivors of sexual assault are not only significant in their numbers, but also struggle with a variety of negative outcomes following assault. Further, female survivors of sexual assault often report significant challenges to their sexual and relationship functioning following sexual assault. Among the most common treatments are supportive counseling and cognitive behavioral approaches to ameliorating symptoms of acute stress disorder and post-traumatic stress disorder post-assault. While cognitive behavioral models of treatment have been successful in treating posttraumatic stress symptoms, this manuscript suggests that a solution-oriented framework for working therapeutically with survivors of sexual assault and their partners may offer another treatment option. This solution-oriented framework seeks to access and amplify positive outcomes and opportunities for growth within relationships.
Results/Conclusion: The author suggested that solution focused therapy may be particularly useful for survivors of sexual assault. Solution focused therapy is naturally empowering to the client. By focusing on what the client is already doing well, amplifying expectations to problems, emphasizing the client's inherent strengths, and making behavioral modifications the client is able to achieve changes and enhance her sense of mastery over problems. Perceived control over current symptoms, and solutions, is consistently related to better adjustment and better outcomes in therapy. A solution-oriented approach may help survivors and their partners to mobilize resources, access strengths, and assist survivors and their partners in returning to positive relationship functioning and experiencing intimacy. Research has suggested that solution focused models of therapy are effective with adults and children of all ages and with clients of diverse ethnic and socioeconomic backgrounds. Future research which explores the efficacy of a solution-oriented approach with the population of sexual assault survivors is critical in determining whether this approach has merit.

Steil, R., Dyer, A., Priebe, K., Kleindienst, N., & Bohus, M. (2011). Dialectical behavior therapy for posttraumatic stress disorder related to childhood sexual abuse: a pilot study of an intensive residential treatment program. *Journal of Traumatic Stress, 24*(1), 102-106.

Purpose: The authors conducted an uncontrolled pilot study to examine acceptance, safety, and efficacy of dialectical behavior therapy for posttraumatic stress disorder (DBT-PTSD). They developed a 3-month residential DBT-PTSD program specifically tailored to patients suffering from chronic PTSD related to childhood sexual abuse (CSA). DBT-PYSD is based on principles and methods of DBT (Linehan, 1993) and integrates methods of trauma-focused cognitive–behavioral therapy (CBT). DBT-PTSD is tailored for adults with PTSD from childhood sexual abuse (CSA). DBT-PTSD aims to help patients (a) reduce their fear of trauma-associated primary emotions, (b) question secondary emotions like guilt and shame, and (c) radically accept trauma facts. To evaluate acceptance and safety, the authors treated 29 women with chronic CSA-related PTSD plus at least one other comorbid diagnosis. The Posttraumatic Diagnostic Scale (PDS), Symptom Checklist 90-Revised, Beck Depression Inventory, and State Trait Anxiety Inventory were administered prior to, at the end of, and 6 weeks after 3 months of intensive residential treatment.
Results/Conclusion: The results suggested that DBT-PTSD has promise for reducing severe and chronic PTSD after CSA. The program showed excellent acceptance: No patient dropped out of treatment. Because treatment did not exacerbate PTSD or other symptoms in any of the patients or cause any form of crisis, it appeared to be safe. Strong pre- and post-test changes were found on PDS and BDI, indicating a strong treatment effect. The pilot design did not allow for the determination of whether or how DBT components contributed to treatment effects over and above what the CBT components contributed. Improvements were greater than those found among CSA-related PTSD patients receiving no treatment.

Zoellner, L. A., Feeny, N. C., Eftekhari, A., & Foa, E. B. (2011). Changes in negative beliefs following three brief programs for facilitating recovery after assault. *Depression and Anxiety*, *28*(7), 532-540. Retrieved from http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3138647/.

Purpose: This study examined whether changes in negative beliefs about oneself, others, and the world occur as a result of early intervention aimed at preventing the development of chronic PTSD and further explores whether changes in negative beliefs during early intervention mediate long-term changes in psychopathology and functioning. Ninety recent female assault survivors (sexual and physical) were randomized to 4-week early intervention programs: brief cognitive behavioral intervention, weekly assessment, or supportive counseling (SC). Changes in negative beliefs were examined from pre-intervention to post-intervention.
Results/Conclusion: Negative beliefs improved across interventions, with somewhat less benefit reported by participants receiving SC. As expected, before intervention more severe negative beliefs were associated with higher initial trauma reactions and these negative beliefs generally improved from pre-intervention to post-intervention. Moreover, for the brief cognitive–behavioral intervention, changes in perceptions of self and one's safety mediated longer-term changes in trauma-related symptoms. The present results highlight the potential importance of changes in negative beliefs in long-term adjustment of recent assault survivors.

Cox, D. (2008). *Working with Indigenous survivors of sexual assault*. Australian Institute of Family Studies. Retrieved from http://www.aifs.gov.au/acssa/pubs/wrap/w5.html.

Purpose: The Western style of service delivery incorporates the use of clinical-based intervention, often imposed by an external influence. This would include having counselling sessions in an office environment and with just the professional and the survivor. Most non-Indigenous people are identified by Indigenous people as power figures, regardless of their position, thus setting up an unequal power balance from the outset for Indigenous survivors, and in an unfamiliar environment. Because Indigenous people are not a homogenous group, with the diversity ranging from different clan and language groups, to different beliefs and practices, it becomes difficult to provide a set of guidelines or a model when working with Indigenous survivors.
Results/Conclusion: The need for culturally appropriate services is of great importance in attempting to work with already debilitating levels of trauma that exist in Indigenous communities. Historical and contemporary aspects of trauma must be taken in to context. Key points:

- One size doesn't fit all for Indigenous sexual assault survivors.
- Encourage the use of alternative ways of servicing and working with survivors.
- Allow the power balance to be equal between all parties.
- Undertake evaluation of your service for Indigenous people.
- Engage Indigenous communities in the processes for service change.

3 Some additional approaches and issues in the literature

Revictimized clients.
Childhood sexual abuse (CSA) is a factor associated with greater risk for adult sexual assault with estimates suggesting that CSA survivors are two to three times more likely to be sexually assaulted in adolescence and adulthood than the general population. Researchers (e.g.,Walsh, Blaustein, Knight, Spinazzola, & van der Kolk, 2007) have suggested that an internal locus of control and effective coping strategies may serve as a protectivefactor against sexual re-victimization in adulthood. Thus, it is important for counselors to address these variables during the treatment process. Hodges and Myers (2010) proposed a wellness-based model for working with adult survivors that may increase self-efficacy, resiliency, and awareness of healthy coping skills.
See: Hodges, E. A., & Myers, J. E. (2010). Counseling adult women survivors of childhood sexual abuse: Benefits of a wellness approach. *Journal of Mental Health Counseling*, *32*, 139-154.

Mindfulness-Based Approaches
Mindfulness-based approaches (e.g., Acceptance and Commitment Therapy [ACT] Hayes, Luoma, Bond, Masuda, & Lillis, 2006; Dialectical Behavioral Therapy [DBT] Linehan, 2000; Mindfulness-Based Stress Reduction [MBSR] Kabat-Zinn, 1982) may be effective in the treatment of adult CSA survivors. Although research on these approaches is still in its infancy, there have been several studies which have shown mindfulness-based approaches as promising interventions for adult survivors of CSA. Kimbrough, Magyari,Langenberg, Chesney, and Berman (2010) found that an 8-week MSBR program decreased self-reported

depressive and PTSD symptoms in adult survivors of CSA. Similarly, Steil, Dyer, Priebe, Kleindienst andBohus (2011) found that DBT was helpful in reducing PTSD symptomology in adult survivors of CSA.

See: Kimbrough, E., Magyari, T., Langenberg, P., Chesney, M., and Berman, B. (2010). Mindfulness intervention for child abuse survivors. *Journal of Clinical Psychology*, *66*, 17-31.

Narrative Approaches

Counselors who work with adult survivors of CSA are tasked with finding a way to move the client from *victim* to *survivor* (Bogar & Hulse-Killacky, 2006; Kress & Hoffman, 2008). Narrative approaches to treatment (e.g., externalization of the abuse, letter writing) may be helpful in empowering the survivor to externalize the abuse event (Kress, Hoffman, & Thomas, 2008). It is important to note that language can be powerful element of effective treatment. In fact, adult CSA survivors have noted the importance of moving beyond the labels associated with the experience of CSA. Philips and Daniluk (2004) identified that letting go of the *victim* identity and embracing the *survivor* identity is a very powerful experience for women in treatment; however, eventually, clients note that letting go of the *survivor* label becomes an important goal as counseling proceeds.

See: Bogar, C. B., & Hulse-Killacky, D. (2006). Resiliency determinants and resiliency processes among female adult survivors of childhood sexual abuse. *Journal of Counseling & Development, 84,* 318-327.

Kress, V. E., Hoffman, R. M., & Thomas, A. M. (2008). Letters from the future: The use of therapeutic letter writing in counseling sexual abuse survivors. *Journal of Creativity in Mental Health, 3*, 105-118.

Kress, V. E., & Hoffman, R. M. (2008). A strength-based, solution-focused Ericksonian counseling group for sexually abused adolescents. *Journal of Humanistic Counseling, Education, and Development, 47,* 172 – 186**.**

Men

Until recently, male survivors of child sexual abuse have not been adequately represented in the research literature. However, recent researchers have discussed the importance of understanding the unique treatment needs of male survivors of CSA. Hovey, Stalker, Schachter, Teram, and Lasiuk (2011) pointed out various considerations for male survivors, including the following: a) issues with seeing a counselor who is of the same gender of the perpetrator, b) experience of triggers during medical procedures which may result in untreated physical health concerns, and c) fear of making the initial disclosure of the abuse.

See: Hovey, A., Stalker, C. A., Schachter, C. L., Teram, E., & Lasiuk, G. (2011). Practical ways psychotherapy can support physical healthcare experiences of male survivors of childhood sexual abuse. *Journal of Child Sexual Abuse*, *20*, 37-57.

4 Identification/Assessment Instruments most often cited in the literature reviewed

Clinician Administered Interviews

Clinician-Administered PTSD Scale (CAPS; Blake et al., 1990, 1995).

Structured Clinical Interview for DSM–IV Axis I Disorders—Patient Edition (SCID;

First, Gibbon, Spitzer, & Williams, 1996).

Standardized Trauma Interview. The standardized trauma interview adapted from Resick, Jordan, Girelli, Hutter, and Marhoeder-Dvorak's (1988) treatment study and includes both investigator-generated and standardized questionnaires.

Structured Clinical Interview for DSM-IV Axis I and Axis II Disorders (SCID I and SCID II) (First MB, Spitzer RL, Gibbon M, et al. Structured Clinical Interview for DSM-IV Axis I Disorders (SCID-I). Washington, DC: American Psychiatric Press, Inc.; 1996). This structured interview is used for determination of PTSD and comorbid diagnoses.

PTSD Symptom Scale-Interview (PSS-I; Foa et al., 1993). The PSS-I is a 17-item interview assessing the severity of each of the DSM-IV PTSD symptoms during the past 2 weeks and ascertaining PTSD diagnostic status. Each symptom is rated on a 4-point scale ranging from 0 (not at all) to 3 (very much).

Standardized Assault Interview: (SAI; Rothbaum, Foa, Riggs, Murdock, &Walsh, 1992). The SAI is a 136-item semi-structured interview that gathers information regarding demographic variables, previous victimization history, assault characteristics, and legal-system contact. The SAI assesses other Criterion A potentially traumatic events, either in adult or childhood, based on the DSM-IV. Regarding the index assault-related characteristics, the SAI assesses the time since assault, perception of life threat during the assault, and injury during the assault.
Trauma Symptom Inventory (TSI; Briere, 1995)

Self-Report Measures

Beck Depression Inventory—II (BDI–II; Beck, Steer, & Brown, 1996): The BDI–II contains 21-items assessing depressive symptoms corresponding to the DSM–IV criteria for MDD. The BDI–II has demonstrated reliability and validity in a heterogeneous out-patient sample (Beck et al., 1996).

Beck Anxiety Inventory (BAI; Beck, Epstein, Brown, & Steer, 1988)**.** The BAI is a 21-item inventory measure for trait anxiety with good internal consistency, acceptable reliability, and acceptable convergent and discriminant validity (Fydrich, Dowdall, & Chambless, 1992; Hewitt & Norton, 1993).

Children's Depression Inventory (CDI): The CDI (Kovacs 2003) was created from the Beck Depression Inventory with 21 items adjusted semantically for age appropriateness and another five items added to account for school and peer functioning. Total scores range from 0 to 54 with higher scores denoting depressive symptomatology.
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Expectancy of Therapeutic Outcome (ETO; Foa, Rothbaum, Riggs,&Murdock, 1991). The ETOis a four-item scale that evaluates the credibility of treatment. Items are rated on an 8-point Likert scale (0 = not at all, 8 = extremely) and a total range of 4 to 32.

The Experience of Shame Scale (ESS; Andrews, Qian, & Valentine, 2002): The ESS is a

25-item questionnaire that assesses characterological, behavioral, and bodily shame over the past month. Participants rate each item on a scale ranging from 1 (not at all) to 4 (very much), with higher scores indicating greater shame. The ESS has demonstrated reliability and validity, including internal consistency reliability of .92 for the total score and construct validity as demonstrated by the questionnaire's relationship with an alternate measure of shame (Andrews et al., 2002).

The Personal Beliefs and Reactions Scale (PBRS; Mechanic & Resick, 1999): The PBRS examines trauma-related beliefs. The PBRS is a 50-item measure that assesses disruptions in beliefs concerning self-blame, safety, trust, control, esteem, and intimacy.

Posttraumatic Diagnostic Scale (PDS; Foa, 1995): The PDS is a 49-item self-report measure that assesses trauma history and all DSM–IV criteria for the diagnosis of PTSD. Respondents rate the frequency of each symptom item on a scale ranging from 0 to 3, with higher scores indicating greater frequency of symptoms. The PDS has demonstrated reliability and validity with a heterogeneous trauma group (Foa, Cashman, Jaycox, & Perry, 1997).

Sexual Abuse Exposure Questionnaire (SAEQ; Rowan, Foy, Rodriguez, & Ryan, 1994): The SAEQ is a retrospective self-report measure of childhood sexual abuse. The overall exposure portion of the SAEQ has demonstrated reliability and validity in a treatment-seeking sample, including 2-week test–retest reliability ranging from .73 to .93 and statistically significant relationships with PTSD diagnoses and symptom severity (Rowan et al., 1994).

State-Trait Anger Expression Inventory (STAXI; Speilberger & Sydeman, 1994): The STAXI is a 44-item measure that assesses several components of anger.

State-Trait Anxiety Inventory (STAI; Speilberger, 1970): The STAI is a 40-item measure that assesses state and trait anxiety. The STAI has demonstrated reliability and validity (Spielberger et al., 1999).

Therapeutic Outcome Questionnaire: This questionnaire (Foa et al., 1991), an adaptation of Borkovec and Nau's (1972) scale, measures the perceived credibility of each active treatment.

Trauma-Related Guilt Inventory (TRGI; Kubany et al., 1996): The TRGI is a 32-item questionnaire that assesses several components of trauma-related guilt. Items are scored on a 5-point scale ranging from 1 (never/not at all true) to 5 (always/extremely true). In this study, we examined Guilt Cognitions that consists of 22 items. The Guilt Cognitions subscale has demonstrated reliability and validity, including internal consistency reliability of .86 and moderate correlations with PTSD and depression symptoms in a trauma sample (Kubany et al., 1996).

The Trauma Symptom Inventory (TSI; Briere, 1995) is a 100-item self-report measure developed for use in adults to assess a wide range of trauma-related symptoms. The TSI is composed of 10 clinical scales and 3 validity scales. Five clinical scales (i.e., Anxious Arousal, Depression, Anger/Irritability, Intrusive Experiences, and Defensive Avoidance) measure symptoms associated with the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-

TR) diagnosis of posttraumatic stress disorder (PTSD; American Psychiatric Association, 2000). The other five clinical scales (i.e., Dissociation, Sexual Concerns, Dys-functional Sexual Behavior, Impaired Self-Reference, and Tension-Reduction Behavior) measure additional symptoms often seen in trauma survivors, especially survivors of childhood trauma.

5 Final points

- Effective assessment and treatment must include complex factors i.e., cumulative trauma, revictimization, etc.
- Research in general still reports there are methodological limitations that impede making recommendations for implement treatment/therapeutic programs unreservedly.
- Some research recognizing that PTSD diagnostic framework is inherently limiting and these limitations may be particularly salient for survivors of CSA, PA and witnessing DV.
- Individuals with CSA histories display a wide range of relational and interpersonal problems that contribute to distressed lives. As such, there is growing clinical consensus that these individuals require multimodal interventions and applied consistently over longer periods of time.
- CBT and related therapies remain the most empirically researched treatment modalities.