Affect Management in Group Therapy for Women with Posttraumatic Stress Disorder and Histories of Childhood Sexual Abuse

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Affect dysregulation is pervasive among women with histories of childhood sexual abuse. It is an important aspect of the clinical presentation of posttraumatic stress disorder (PTSD), a disorder that frequently characterizes survivors of childhood abuse. Based on distinctions between approach and avoidance orientations to coping, there is controversy regarding whether initial treatment for trauma survivors should employ an exposure-based approach to increase affect or an affect-management approach to reduce it. In this article, we review theoretical and empirical literature regarding affect dysregulation and its relations with childhood sexual abuse and PTSD. We then describe a new affect-management group for adult survivors of childhood sexual abuse that is based on a stage approach to the treatment of trauma. This group emphasizes skill acquisition, symptom reduction, and patient stabilization. Affect-management strategies such as mindfulness, crisis planning, and challenging distorted thinking are presented to patients. Preliminary research findings support the use of this treatment. © 2001 John Wiley & Sons, Inc. J Clin Psychol/In Session 57: 169–181, 2001.

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Affect dysregulation, which can be defined as an inability to adaptively manage or tolerate intense emotions, is pervasive among women with histories of childhood sexual abuse. This dysregulation may manifest in a number of ways, including overwhelming anger, sadness, and anxiety, difficulties regulating sexual involvement, chronic engagement in self-destructive, impulsive, and risk-taking behaviors, and suicidality (Herman, 1992; van der Kolk, Pelcovitz, Roth, Mandel, McFarlane, & Herman, 1996). Affect dysregulation also is an important part of the clinical presentation of posttraumatic stress disorder (PTSD), a disorder that frequently characterizes women with histories of childhood sexual abuse.

As an associated feature of PTSD, affect dysregulation may disrupt an individual's daily functioning, as well as interfere with the therapeutic relationship and impede progress in psychotherapy. Thus, many experts suggest that stabilization of the patient should be the primary goal of treatment early in recovery from PTSD (e.g., Herman, 1992; van der Kolk et al., 1996). However, there is some controversy as to whether treatment for survivors of sexual abuse should focus on trauma disclosure and integration, or whether treatment should deal with the management of intense distressing affect. In this article, we review theoretical and empirical literature regarding affect dysregulation and its relations with childhood sexual abuse and PTSD. We then describe the rationale for, and details of, a new affect-management group for adult survivors of childhood sexual abuse.

Affect Dysregulation, PTSD, and Childhood Sexual Abuse

In an effort to make distinctions among highly similar constructs, Gross (1998) defined affect regulation as a superordinate term that incorporates the somewhat overlapping phenomena of coping, defenses, mood regulation, and emotion regulation. In our discussion of these issues, affect regulation is used in a similarly broad manner, and includes emotion regulation, which Gross defined as "the processes by which individuals influence which emotions they have, when they have them, and how they experience and express these emotions" (Gross, 1998, p. 275). Therefore, affect dysregulation refers to disruptions in these processes.

PTSD as a Disorder of Affect Regulation

Symptoms that comprise the diagnostically defined syndrome of PTSD include psychological reexperiencing (e.g., intrusive thoughts, nightmares), avoidance of trauma-related stimuli and emotional numbing (e.g., avoidance of people, places, or thoughts that remind the individual of the trauma, restricted range of affect), and hyperarousal (e.g., hypervigilance, exaggerated startle response). In addition, these symptoms are associated with significant disruptions in the management and tolerance of distressing emotions, and in important aspects of interpersonal functioning such as trust, security, and honesty.

Consistent with the widely held view that PTSD is a disorder of affect regulation, results of the PTSD DSM-IV field trial indicated a strong, positive relation between PTSD and affect dysregulation (van der Kolk et al., 1996). In addition, a greater percentage of participants with current PTSD reported difficulty with affect modulation compared to participants with a history of PTSD and participants who never had PTSD. Importantly, slightly more than half of all participants with a history of PTSD (including both treatment-seeking and community adults) reported continued difficulty with modulation of affect. This suggests that significant disruptions in affect modulation may persist even after the clinical syndrome of PTSD has remitted.

The Role of Childhood Sexual Abuse in Affect Dysregulation and PTSD

According to epidemiological studies, between 9 and 33% of women report a history of childhood sexual abuse (Finkelhor & Dzuiba-Leatherman, 1994). Research suggests that up to 72% of adult female psychiatric patients have histories of abuse, depending on the sample under investigation (Bryer, Nelson, Miller, & Krol, 1987). Therefore, most clinicians can expect to encounter in their practice patients with histories of childhood sexual abuse.

Childhood sexual abuse is frequently a chronic stressor that is characterized by physical violation, injury, helplessness, and terror. Herman (1992) asserts that the presence of these elements increases the likelihood that traumatic events will result in psychological harm. She maintains that the salient characteristics of the trauma are the feelings of helplessness and terror it elicits in its victims. Given the tremendous inequity of power between a sexually abused child and an adult perpetrator, and the related helplessness and terror experienced by the child, the likelihood for the development of profound and extensive trauma-related difficulties subsequent to childhood sexual abuse is relatively high.

Early abuse may disrupt the development of adaptive affect-regulation skills. Children in abusive environments are unlikely to acquire internal symbols and/or images of a safe caretaker and the concomitant ability to self-sooth in adaptive ways. This, in turn, impairs a child's later ability to develop adaptive skills in affect regulation. Rather than developing secure attachment patterns that are characterized by confidence in important others to reliably provide security and comfort, the majority of abused children develop insecure attachment styles that are characterized by uncertainty about important others that may manifest in the avoidance of, or anxious involvement in, relationships. These insecurely attached children are not soothed by attachment figures and are unable to use adaptive internal strategies for affect regulation. In such situations, maladaptive affect-regulation strategies may develop (e.g., dissociation, self-harm behaviors). Empirical research supports this viewpoint and indicates that early and chronic traumatic experiences in childhood are associated with long-term affect-regulation disturbances (van der Kolk et al., 1996).

Because disruptions in affect regulation and subsequent maladaptive behavior patterns are so pronounced in survivors of sexual abuse, researchers and clinicians have asserted that the impact of sexual abuse cannot be explained sufficiently within the framework of PTSD. Thus, Herman (1992) proposed complex PTSD as an expanded conception of PTSD for victims of early or prolonged trauma. A central feature of complex PTSD is affect dysregulation, including phenomena such as dissociation and somatization (Herman 1992; van der Kolk et al., 1996). The development of complex PTSD and the associated difficulties with affect regulation may be particularly likely among survivors of childhood sexual abuse. For example, results of the DSM-IV field trial for PTSD indicated that 77% of participants who suffered early-onset physical and/or sexual abuse described difficulties with affect modulation (compared to 37% of disaster survivors; van der Kolk et al., 1996).

Why Use an Affect-Management Treatment?

Because posttraumatic responses are complex in nature, treatment approaches to PTSD must acknowledge and address a multitude of difficulties. As noted earlier, one issue that has caused some controversy in the field is the extent to which treatment should focus on the trauma itself (i.e., exposure-based models) versus focus on current symptoms and affect management (i.e., affect-management approaches). Underlying this controversy

are two different perspectives on coping with stress. Exposure-based models for the treatment of PTSD are consistent with an orientation that advocates approaching and dealing directly with stress. This orientation allows for acquisition of information and understanding, and an opportunity for emotional expression (Roth & Newman, 1991). Likewise, exposure-based treatments include desensitization to the traumatic event and related situations, and integration of the traumatic memory into a new, adaptive meaning system (Roth & Newman, 1991). Unfortunately, such strategies may exacerbate distress. In contrast, affect-management models for the treatment of PTSD are more consistent with an orientation that advocates avoiding and containing overwhelming stress. This orientation creates some distance between the individual and the traumatic situation and, at least in the short-term, reduces distress. Unfortunately, avoidance may prevent important information from being received, may constrict life both emotionally and interpersonally, and may exacerbate emotional distress in the long-term. Therefore, the question becomes how to strengthen and integrate the benefits of both approaches in a way that limits each one's potential pitfalls.

Exposure-based treatments for PTSD are widely accepted and have extensive research support (for review, see Keane, 1998). However, there are some limitations to this approach, especially for PTSD related to childhood abuse. For example, exposure-based treatments seem to have little effect on emotional numbing and avoidance symptoms, and may be contraindicated for PTSD patients with depressed mood (Solomon, 1997). These symptoms are frequently found among adult survivors of child sexual abuse (Herman, 1992). In addition, treatment that emphasizes working through the traumatic experience cognitively is not recommended for patients who demonstrate self-mutilative and suicidal behavior (Resick & Schnicke, 1993), behaviors also prevalent among survivors of sexual abuse.

Furthermore, a premature focus on traumatic childhood experiences may "magnify the horror" for some patients (Herman, 1992). Although exposure-based approaches are both important and effective in the treatment of PTSD, research findings suggest that highly distressed women with histories of childhood sexual abuse may respond poorly to trauma-focused groups (e.g., Roberts & Gwat-Yong, 1989). In addition, poor compliance with exposure-based treatment for PTSD may be related to the severity of comorbid depression (Scott & Stradling, 1997). Patient difficulties in tolerating and/or benefiting from exposure-based treatments have been attributed to deficits in coping and affect-regulation skills, both common sequelae of childhood sexual abuse (van der Kolk et al., 1996).

Based on these findings, there is a general acknowledgment that an early focus on traumatic experiences may be retraumatizing and may result in patient decompensation (Herman, 1992). However, there also is widespread agreement among experts in this area that avoidance of traumatic material over time may ironically worsen symptoms (e.g., Herman, 1992; van der Kolk et al., 1996). Therefore, the answer to treatment is not a simple one, and clinicians are faced with a dilemma. The critical issue becomes how to best balance and time the exposure to traumatic material and emotions with the containment of those emotions (cf. Linehan, 1993; Roth & Newman, 1991; van der Kolk et al., 1996). Despite a vast clinical literature addressing the treatment of adult survivors of childhood sexual abuse, there are few empirical studies to guide clinicians. Further, most of these studies are preliminary and focus predominantly on exposure-based treatments.

As the treatment of PTSD has become increasingly refined, many experts have recommended a stage approach to treatment to address this issue (Herman, 1992; van der Kolk et al., 1996). More specifically, Herman (1992) presents a model of recovery from traumatic events that addresses the core intra- and interpersonal sequelae of trauma (i.e., helplessness and lack of safety, emotional, internal, and interpersonal disconnection, and

destruction of meaning systems) in three stages. Herman maintains that the "fundamental stages of recovery [from trauma] are [1] establishing safety, [2] reconstructing the trauma story, and [3] restoring the connection between survivors and their community" (p. 3). Although presented as sequential steps, these three stages of treatment are not fixed, and individuals may move dynamically among them.

Consistent with a stage approach to treatment, many experts maintain that the establishment of physical and emotional safety is the most urgent clinical need in the treatment of PTSD (Herman, 1992). Therefore, "first-stage" treatments emphasize safety and stabilization. They use a present-time orientation, and focus on education, teaching of affect-management and coping skills, abstinence from substances, elimination of self-harm behaviors, achievement of control over acute symptoms, and increasing self-care. This initial focus on affect-management skills in patients with PTSD may be particularly useful because deficits in this area may interfere with both daily functioning and the therapeutic process (Zlotnick, Shea, Rosen, Simpson, Mulrenin, Begin, & Pearlstein, 1997).

Although an affect-management approach is distinct from a strict exposure-based approach to the treatment of PTSD, the two are not incompatible. "First-stage" treatments may form the foundation for later stages of treatment that include mourning pain and losses associated with traumatic experiences and PTSD, and reconnection with positive feelings, productivity, meaningful life goals, and interpersonal relationships. These subsequent stages of recovery include additional key aspects of treatment such as exposure and desensitization to the traumatic material, creation of a narrative that facilitates comprehension of the traumatic experiences, recreation of a world view, and discovery of meaning from these experiences (Herman, 1992). In this way, a stage perspective may integrate the long-term strengths of exposure-based models with the more immediate benefits of affect-management models.

The affect-management group described here (Zlotnick, Simpson, Begin, & Costello, 1995) was based on the work of Linehan (1993), Matsakis, (1994), Meichenbaum (1994), and McKay and colleagues (e.g., McKay, Rogers, & McKay, 1989), and is a first-stage treatment for adult survivors of sexual abuse with PTSD. This group treatment was developed as an adjunct to ongoing individual treatment and provides a foundation of affect-management skills from which patients may work with exploratory and/or exposure-based approaches in individual treatment. In this way, the affect-management group provides a base of containment to which patients may return when trauma-focused work becomes too painful.

Overview of the Affect-Management Group

Rationale for the Treatment Format

The affect-management group is characterized by a cognitive–behavioral approach, and focuses on current difficulties and symptoms. Because it is a first-stage treatment, the affect-management group does not address core beliefs associated with PTSD (e.g., "I am worthless;" "the world is hostile") or aim to restructure traumatic memories or meanings. Rather, one focus of the group is on restructuring distorted thinking about current difficulties and trauma-related affect such as all-or-nothing thinking (thinking in polarized, absolute terms), emotional reasoning (relying too heavily on emotions to interpret reality and guide behavior), and overgeneralization (extrapolating overarching rules from single facts or events; Zlotnick et al., 1995).

As a first-stage treatment, a second focus of the group is on increasing patients' ability to manage and tolerate distress. Cognitive–behavioral approaches teach patients

how to use adaptive coping skills to manage distress, an ability that may never have developed in the face of childhood sexual abuse. For example, the group presents information and practice regarding the use of problem solving, positive self-talk, and relaxation. Cognitive–behavioral approaches also are useful for treating recurrent difficulties, such as affect dysregulation, because they include training in relapse prevention. That is, this approach teaches patients how to cope with potentially triggering situations before they occur without using maladaptive attempts at affect regulation such as dissociation or self-harm.

Group therapy has been used in the treatment of survivors of incest, rape, domestic abuse, and war trauma. Traumatized individuals may benefit from group treatment because it reduces feelings of stigma, isolation, and shame, and allows opportunities for observation, learning, modeling, and sharing of new coping skills (Zlotnick et al., 1997). In addition, during the early stages of recovery, highly structured groups can facilitate feelings of safety and predictability, and may be particularly useful and well-received by patients.

Patient Screening and Selection

Depending on the context in which the group takes place, the patient screening process may be more formal (i.e., involving psychometrically sound measures, if part of a clinical trial) or less formal (i.e., involving clinical interview, if not part of research). To participate in the group, patients must meet the diagnostic criteria for current PTSD and report a history of sexual abuse prior to age 17. Patients who are carrying a diagnosis of dissociative identity disorder, actively abusing substances, acutely suicidal, or actively psychotic are not appropriate for the group.

The Role of the Therapist

Ideally, the group is run by two co-therapists, which facilitates maintenance of patient safety in the event that intense emotions are triggered in patients during session. The therapists adopt an active stance and work to establish collaborative therapeutic relationships with patients. At the outset, the group leaders provide patients with guidelines for expectations of the treatment. Specifically, the therapists explain that the goal of treatment is to help patients manage symptoms, but that the skills will not eradicate all difficulties immediately. The therapists also emphasize the need for consistent practice of skills. To that end, the therapists reinforce completion of homework assignments and practice of affect-management skills. The rationale for a focus on current affect and problems, rather than a focus on traumatic material itself, is explicitly discussed with patients. In addition, the group leaders emphasize the importance of not triggering other group members with detailed descriptions of traumatic events. The therapists validate the importance of traumatic experiences, but highlight the current focus on skills.

It is the therapists' responsibility to maintain the structure and safety of the group. This includes informing group members that the focus should remain on each person's own recovery rather than on "caretaking" for others in the group. Patients are presented with guidelines regarding how to proceed if another patient calls and reports or threatens self-harm or suicidal behavior (e.g., to remind the patient in crisis that such contact is discouraged and to rely on a mental health professional under these circumstances, and to direct the patient in crisis back to the therapist or emergency room). Within sessions, the therapists aim to preserve safe levels of affect by modeling skills and guiding patients in the use of skills.

Content of Sessions

There are several goals of affect-management treatment. First, this treatment aims to teach patients to manage intense distress without the use of maladaptive behaviors. Second, affect-management treatment aims to help patients control destructive behaviors that arise from disrupted affect regulation (e.g., self-mutilation, dissociation). Finally, the treatment seeks to restore for patients a sense of control and mastery over their trauma-related symptoms.

The group consists of fifteen 90-minute sessions that each follow the same structure. First, previous homework is reviewed. Then, there is a short psychoeducational component (a "mini-lecture") that provides patients with information and/or guidelines regarding how to use a skill. This is followed by the rehearsal of skills. Each group ends with the assignment of new homework. Homework includes assignments such as implementing a safe sleep plan (for Session 2: Sleeping Problems) and practicing execution of a crisis plan (for Session 11: A Crisis Plan). The topic of each session is provided in Table 1. Next, we discuss two sessions in greater detail.

Session 14: Anger-Management Skills. In this session, the focus is on education and discussion, as well as integration of skills learned in previous sessions. The objectives of this session are to teach patients to recognize their anger triggers, to learn to discriminate problematic anger from adaptive anger, to identify "hot thinking" related to anger, to use appropriate coping skills to deal with anger, and to review the model for identifying and managing feelings using anger as an example. To address these objectives, the mini-lecture for this session includes general information related to anger, discussion points, and a description of specific skills aimed at managing anger adaptively.

First, patients are provided with information regarding the role of anger in PTSD. Specifically, the experience of anger in response to sexual abuse, as well as difficulties with anger management, is normalized. Group leaders explain that survivors of child-

Table 1
Affect-Management Group Sessions

Session Number	Session Topic
1	Posttraumatic Stress Disorder
2	Sleeping Problems
3	Dissociation
4	Identification of Feelings
5	Model for Describing Emotions
6	Distraction Skills
7	Self-Soothing Skills
8	Improving the Moment–Part I
9	Improving the Moment–Part II
10	Improving the Moment–Part III
11	A Crisis Plan
12	Twisted Beliefs
13	Stinking Thinking
14	Anger-Management Skills
15	Review & Termination

hood sexual abuse tend to "stuff" or "escalate" angry feelings, and potential reasons for using each approach are provided. Discussion regarding why these approaches may be problematic is encouraged. For example, a patient may hold feelings inside because of the fear that a partner will respond with abandonment or retaliation, because of doubts about the right to those feelings, or because of a belief that the feelings will not be respected. This may result in a pattern of suppressing feelings of anger until they become overwhelming. At that point, the patient may become extremely emotional and is less likely to be able communicate needs effectively. The therapist works to convey that by addressing anger as it arises at lower intensities, the patient may more effectively cope with it.

Second, group leaders present information regarding the identification of anger. The experience of anger is validated, and distinctions between angry feelings and destructive actions are made. Patients are presented with strategies for ascertaining whether angry feelings are adaptive or problematic. For example, they are encouraged to evaluate the extent to which their angry feelings are a signal of *current* (as opposed to past) danger and whether the magnitude of their response is consistent with the current situation. Patients may enlist the help of trusted others to assist in this evaluation. In addition, information regarding situations and thoughts that may trigger anger, or predispose patients to angry feelings, is provided. The leaders encourage group members to discuss examples of adaptive and problematic anger from their own lives, and to identify personal anger triggers. In this area, patients often discuss anger related to feeling taken advantage of, feeling that their needs are not being met, or feeling that someone has failed to follow through on an agreement. Patients are encouraged to reflect on underlying expectations, assumptions, and automatic thoughts that may leave them vulnerable to angry feelings.

Third, leaders explain the process by which anger builds from tension and frustration. Group leaders ask patients to identify physical signals that may serve as indications that they are feeling tense (e.g., tight muscles, headaches) or as warning signs that anger is approaching (e.g., increased heart rate, perspiration, muscle tension). Although group leaders discuss the connections between angry feelings and both maladaptive and adaptive responses, the emphasis remains on the link between anger and impulses for maladaptive action (e.g., self-harm behaviors).

Finally, group leaders present specific information on adaptive coping skills that patients can use to replace impulsive responses to anger. Coping skills described in this session include time-out, relaxation exercises, imagery, challenging hot cognitions (i.e., cognitions that elicit extreme anger), cheerleading (i.e., self-affirming statements), and distraction. Handouts are provided to remind patients of the information provided and to facilitate the use of these coping strategies. Homework for this session involves each group member selecting two anger management strategies discussed in session, practicing those skills, and preparing to discuss them during the next group. Patients are encouraged to use an anger-management skill that they have never used or one that they have found difficult to use.

A few of the techniques and issues addressed in Session 14 are illustrated in the following interaction. Please note that all examples of therapist/patient exchanges in this article are only illustrations and are not actual accounts of interactions.

PATIENT: (*in a pressured voice*) I get so angry at my boyfriend. Sometimes I just want to hit him. He always expects me to take care of everything around the house. It really bothers me. I don't see why he can't pull more of his own weight.

THERAPIST: It sounds like it makes you angry to even think about it.

PATIENT: I don't know, I guess if I'm not screaming I don't notice if I'm angry.

THERAPIST: Yes, it can be difficult to recognize some feelings when they first start. Do you have any ideas why I might think you're angry right now?
PATIENT: Well, I'm talking pretty loud.
THERAPIST: Yes, that's true. Does that happen to you when you're feeling angry?
PATIENT: Uh-huh . . . and I also get really hot. I notice sometimes I'm burning up in the middle of winter. Like I'm about to blow up or something.
THERAPIST: Are there any other signals that you notice when you're feeling angry?
PATIENT: Well, my muscles tighten up. Mostly in my neck and back . . . and my jaw. Like I'm having to stop myself from doing something, but I don't know what.
THERAPIST: Okay. When you're feeling angry with your boyfriend like this, what do you usually do?
PATIENT: Nothing, really. I never actually hit him or anything. I usually just storm around the house, and wait for him to ask me what's wrong. Then I start screaming at him, and he usually ends up leaving for a while.
THERAPIST: That sounds very stressful.
PATIENT: It is.
THERAPIST: Why do you think you don't tell him more directly that you're angry?
PATIENT: Well, I just figure he'll leave. That's what he always does when I get angry.
THERAPIST: Sounds like you're used to people ignoring or punishing you for your feelings.
PATIENT: Yes. That's how it's always been. Ever since I was little with my father and what he did.
THERAPIST: Often women who have been sexually abused as children give up on trying to get people to understand what they are feeling.
PATIENT: Yeah, and then I just get so mad that it's too late. And it's like I explode. Before I know what's even happened, I'm screaming at the top of my lungs. No wonder he leaves.
THERAPIST: It can be very hard not to yell at someone when you've been angry at them for a long time. What do you think might happen if you told him you were getting frustrated with him at the very beginning, when you first started to feel that way?
PATIENT: I don't know.
THERAPIST: It's hard to imagine doing that?
PATIENT: Yes.
THERAPIST: Well, take a minute to imagine it. What if you told him right away that you were frustrated with the situation? Do you think that might make it easier to tell him how you feel without screaming at him?
PATIENT: Probably. I've never really tried it.
THERAPIST: How do you think he might respond if you told him clearly how you were feeling, without screaming at him?
PATIENT: Well, he probably wouldn't leave so fast. Maybe he'd even stick around. I don't know.
THERAPIST: Okay. Do you have any idea what you might want to say to him? How could you tell him what you told us?

This exchange illustrates a number of therapeutic interventions. Initially, the therapist focuses on identification of the situation triggering the patient's anger and the physical signs that accompany that anger. The therapist assists that patient in labeling her emotional response, and also validates both the emotional response itself and the patient's difficulty in identifying that response. The clinician then is able to probe for potential links between the patient's history of abuse and her current feelings and attempts at coping. Her responses are normalized within the context of her abuse history. Finally, the

therapist helps the patient generate alternative adaptive coping responses and begins to discuss specific ways to integrate those responses into her behavioral repertoire.

Session 11: A Crisis Plan. This session focuses extensively on in-session planning and feedback. During this session, patients are guided through the development of a personalized, detailed crisis plan. Developing a crisis plan requires patients to identify ten specific activities in which they may readily engage when faced with overwhelming distress. Activities represent examples of affect-management skills taught in the group (e.g., listen to a favorite song as a form of adaptive distraction, take a bubble bath as a way to self-soothe, use of relaxation skills). In session, group leaders provide feedback to patients regarding each crisis plan. Patients are encouraged to post the plan in several places (e.g., in the car, on the refrigerator) and to insure that they have all required "equipment" to implement the plan (e.g., a recording of the song). Patients then are asked to engage in several "dry runs" of their plan. That is, they are asked to practice the plan in non-crisis situations before implementing it in a crisis. In addition, patients are asked to create a list of "supportive" contacts with phone numbers.

Early development of a crisis plan is illustrated by the following interaction.

PATIENT: Once I'm upset, that's it. There's nothing I can do. I just sit on the floor and chain smoke.

THERAPIST: Then what?

PATIENT: I usually end up bingeing. If it's really bad, I burn myself with a cigarette.

THERAPIST: Does that work for you?

PATIENT: Kind of. I mean, it does usually stop me from doing something more drastic. But I'm getting fat, and I'm sick of all these little scars. I end up feeling worse the next day because I did it again.

THERAPIST: Yes, that's hard. I think it's important for you to have other options for feeling better when you are in crisis. Something that could help you feel better in the moment, and also longer term. What do you think?

PATIENT: Well, it *sounds* okay.

THERAPIST: One thing that can be very important at those times is to have a plan of healthy things you could do. If you have a crisis plan, then you don't have to come up with other options when you're upset; it's already done for you. Does that make sense?

PATIENT: Yes.

THERAPIST: Okay, good. So what kinds of things could you do in a crisis instead of hurting yourself?

PATIENT: I could get away. Take a trip. That would really help. To be able to just get on a plane and go visit a friend.

THERAPIST: Yes, visiting friends is a great idea. It can really help deal with stress. But I'm concerned that you might not always be able to do that in a crisis. And for a crisis plan to work, we need to focus on things you could do any time. Does that make sense?

PATIENT: I guess.

THERAPIST: So what could you do that would help you to feel better any time you were in crisis? What do you enjoy doing?

PATIENT: I like to go for walks in the park near my house. There are some beautiful trees in that park. And I like to give my dog a bath. He loves the water, so it's fun.

THERAPIST: Those are great ideas. Do you think that would help if you were in crisis?

PATIENT: Yes. They're both distracting, and they get me out of the house, which is good.

THERAPIST: Excellent. Now, if you needed to do something else, what else could you do?

PATIENT: I could call a friend and let her know how I'm feeling.
THERAPIST: Okay, do you have someone specific in mind?

This exchange highlights several components of developing a crisis plan. First, the therapist helps the patient identify the usual coping responses in a crisis situation, and examines the immediate and longer-term consequences associated with those responses. Although validating feelings, the therapist challenges the patient's usual approach and advocates for a more adaptive response to crisis. The therapist ensures that the rationale for developing a crisis plan is clear to the patient. Of particular importance is the therapist's focus on a plan that is *specific* and can be *readily implemented*. The therapist genuinely praises the patient's ideas, but highlights potential difficulties with them and shapes the patient's responses appropriately. This discussion would continue until the patient had a list of ten possible adaptive coping strategies.

At the end of treatment, termination of the group is guided by the reinforcement and sincere praise of learning and adaptive interacting that was present throughout the previous sessions. The importance of continued use of adaptive affect-management skills is emphasized, and discussion focuses on ways in which patients can continue using skills in daily life (e.g., setting aside time when the group usually met to review notes). Patients are given bibliographies for further reading, and presented with certificates of completion.

Therapist Challenges

Therapists may face many challenges while implementing this treatment. For example, prior to group participation, patients may have given little thought to their patterns of experiencing and coping with distress or to their styles of interacting with others. Therefore, it is imperative that therapists raise patient awareness of these phenomena. In addition, despite clear guidelines provided to minimize vivid disclosure of traumatic material and emphasize containment of distress, patients may begin to describe details of traumatic experience(s). In response, therapists should acknowledge and validate the pain and importance of the traumatic material but limit the information disclosed. Specifically, the therapist can remind the patient of the rationale for not discussing trauma in this group and redirect her to current issues (To prevent this situation from arising, a similar reminder is provided to all patients at the beginning of each session.)

Furthermore, detailed disclosure of traumatic material may trigger strong emotional responses in patients. At its most extreme, this may result in dissociation within the session. Such instances may be addressed by reorienting to current surroundings by focusing the patient's attention on concrete elements such as colors or objects in the room. If this does not adequately de-escalate the situation, one therapist may leave the room with the patient and return once the patient's distress has decreased. Finally, if risk for suicide increases during a patient's participation in group, the therapist should address that risk individually with the patient. Because the group is an adjunct to individual treatment, the therapist should encourage discussion of suicidal risk with the patient's primary therapist. However, the therapist is responsible for the safety of the patient, as necessary.

Summary

This affect-management group is based on a stage approach to the treatment of trauma survivors. It is a time-limited, structured, first-stage treatment for adult survivors of childhood sexual abuse that emphasizes the learning of coping skills, symptom reduction, and

patient stabilization and safety. A wide variety of affect-management strategies are presented to patients, including skills such as mindfulness (i.e., nonjudgmental awareness of a situation or feeling), distraction, self-soothing, crisis planning, relaxation, time-out, and challenging distorted thinking.

To investigate the efficacy of this treatment, 48 female survivors of childhood sexual abuse who met criteria for PTSD and complex PTSD were evaluated. All participants received individual treatment for at least one month before being randomly assigned to either the affect-management group or to a wait-list control condition, and continued in individual treatment during the study. Participants also received psychotropic medications throughout the investigation. There were no differences between participants in each condition regarding demographic characteristics, pretreatment PTSD symptoms, depression, or dissociation. Results indicated that participants in the affect-management group reported significantly greater improvement in symptoms of PTSD, depression, and dissociation at posttreatment than the wait-list controls (Zlotnick et al., 1997). This study provides preliminary empirical support for the use of an adjunctive affect-management group with adult survivors of childhood sexual abuse. However, empirically based treatments of abuse-related PTSD are still in their infancy. Additional research that has a solid foundation in theory is needed to further refine the understanding and treatment of the complex PTSD reactions of survivors of childhood sexual abuse.

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