Psychiatric Quarterly, Vol. 73, No. 2, Summer 2002 (© *2002*)

ADDICTIONS AND TRAUMA RECOVERY: AN INTEGRATED APPROACH

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The co-occurence of addiction with trauma-based mental health problems forms a toxic feedback loop, creating assessment and treatment challenges for consumers and their healthcare providers. Traditional separation of addiction and mental health treatment has contributed to a high level of recidivism among clients challenged by trauma and addiction problems. A new treatment model rooted in an understanding of trauma re-enactment, is described. ATRIUM integrates cognitive behavioral and relational treatment through an approach which stresses mind, body, and spiritual health.

KEY WORDS: trauma; addiction; co-occurring disorders; trauma reenactment; integrated treatment.

For survivors of childhood trauma and for those who want to support them, it has been frustrating that the co-occurrence of trauma-based mental health problems and addictions have rarely been addressed in an integrated treatment approach. While there has been more attention paid recently to the need for such treatment, few existing models have been specifically designed to intervene when trauma and addiction are concurrent. Najavits et al. (1), in a survey of cognitive

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0033-2720/02/0600-0157/0

behavioral interventions, found a startling absence of empirically validated comprehensive trauma and addiction models.

Yet there is a deadly logic to the interdependence of trauma and addiction. Addictions, mental health problems, and trauma seem to form a toxic feedback loop: the mental health symptoms caused by trauma-related distress continuously stimulate the addiction compulsion and the addictive behaviors then generate distress of mind, body and spirit. Just as the patterns of Borderline Personality Disorder are valid and logical responses to chronic patterns of childhood invalidation (2), addictions are valid and logical responses to the injuries inflicted to the abuse survivor's body, mind and spirit (3–5). Survivors of childhood trauma struggling with addictions—and the service systems working with them—have thus remained overwhelmed by the mental health and addiction problems resulting from interpersonal violence and abuse. It seems clear that addicted survivors have long been in need of accessible, empirically-validated treatment approaches that effectively address the co-occurrence of trauma-related mental health symptoms and trauma-related addictions as these impact mind, body and spirit.

The answer to why we have been so slow to develop an integrated treatment model may lie in the historical conflicts between treatment and recovery beliefs. It is common knowledge among those who participate in 12-step recovery programs that the addiction recovery community is suspicious of all treatment interventions straying from a clear and simple focus on addictive behaviors and their cognitive underpinnings. The primary focus is on staying sober and the assumption is that the addict/alcoholic will begin to feel healthier and more able to begin the lifelong task of creating a manageable life. Unfortunately for many who suffer the dual challenge of addiction and trauma-based mental health problems, it may seem impossible to sustain abstinence from addiction because of trauma-based physiological responses, emotions, thoughts and relationship patterns. Trauma-related distress continuously stimulates the addiction compulsion.

For the addicted trauma survivor there are several treatment paradoxes to contend with in attempting to achieve abstinence. How, for example, can the addict be expected to give up the addictive behavior (in order to address the underlying trauma issues) if it is the trauma issues themselves that create the compulsion to self-medicate? Who would choose to give up something that eases chronic emotional and physical pain, and then engage in therapy that stimulates that pain, without recourse to relief via self-medication?

Another dilemma for the addicted trauma survivor is to surrender to the "First Step" of recovery and admit powerlessness over the addiction when the addiction seems to be the only "power" she[1] has to fight the pervasive internal distress created by her trauma experiences. The central paradox of the 12-Step Program philosophy is that in the the battle to control the addiction, one must admit powerlessness in order to combat powerlessness of being a victim. This cognitive puzzle is difficult enough for the addict to comprehend, but it can be counter-intuitive and at worst extremely frightening for someone who has been victimized through childhood trauma and the loss of control it entails.

MENTAL HEALTH PROFESSIONALS: UNEASINESS AND DENIAL

The mental health system has maintained similar barriers to recovery. Many mental health professionals feel unable to help the addicted trauma survivor because of their expectations regarding abstinence, and thus their confusion about the concept that links abstinence and the surrender to powerlessness. A lack of awareness of the dilemma created for addicted trauma survivors (or a resistance to its acknowledgement) parallels that of the addiction counselor who is impatient with the trauma survivor's reluctance to give up the practice of self-medication. Unfortunately, paralleling the addiction counselor's resistance and skepticism towards emotionally-charged psychotherapy, is the mental health professional's historical ignorance of the principles of addiction programs like Alcoholics Anonymous and other 12 Step programs. Too often, mental health professionals simply back away and refer the addicted trauma survivor into another addiction-based treatment program rather than trying to explore the survivor's account of previous treatment impasses in order to help link the trauma experience with addiction issues.

To work with addictions and trauma concurrently, it is essential to stay aware and respectful of the addicted survivor's tendency to self-medicate when the biological system is stimulated and to offer specific new body-based tools to replace the power of the addictive behavior. At the same time it is vital to build supportive relationships that allow for a more effective way of re-working the trauma material.

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[1]Although both males and females are affected by trauma and addiction, the author has chosen to use the female pronoun throughout the article.

INTRODUCING THE ATRIUM MODEL

The ATRIUM[2] model (5) is an assessment and treatment recovery model for adult and adolescent women and men who are survivors of childhood traumatic abuse. The ATRIUM approach is innovative in that it provides a model that simultaneously addresses the problems of trauma-related addictions and mental health challenges. It is a model that helps the addicted survivor find a useful bridge between addiction recovery and trauma treatment. Here the ATRIUM model is described, and the reasons for creating a much-needed integrated treatment approach are discussed. The ATRIUM Addictions and Recovery protocol is a three-fold process designed to assess and intervene at the three levels impacted by trauma and addiction, the body, mind and spirit. It is unique in its practical approach to healing the *body* and *spirit* as well as the mind. ATRIUM is designed to integrate cognitive-behavioral interventions appropriate to changing addiction-based patterns of behavior with a relational approach which assumes that all survivors have the resilience and capacity to heal. The emphasis on healing the spirit as well as the mind and body draws on the centrality of healing in community modeled by 12-Step Program philosophy and the healing principles of most indigenous cultures.

The ATRIUM protocol is the product of consumer/survivor experience as well as professional expertise. Because of the author's many years of experience as a client in the mental health system as well as her experience of substance abuse recovery, the ATRIUM approach speaks with a voice of consumer authority as well as professional knowledge. ATRIUM is designed to help both consumers and professionals find a bridge between addiction recovery and trauma-based mental health recovery, using the strength and wisdom of both professional and peer healing resources.

PRELIMINARY RESEARCH IMPLICATIONS

The ATRIUM model has been adopted by community-based programs and mental health settings serving adults with debilitating trauma histories. Some pilot research, both quantitative and qualitative, yielded positive results. Data using Briere's (6) Trauma Symptom Inventory with a small sample suggest significant improvement in areas of trauma symptomatology which do not improve without resolution of addiction. Group members were asked to complete the

[2]ATRIUM is the abbreviation for Addictions and Trauma Recovery Integrated Model.

Briere TSI prior to and at completion of the treatment groups. While this simple design was limited in its capacity to generalize the results, it did provide useful preliminary information regarding the potential efficacy of this integrated approach: The TSI is a 100-item measure that was designed to evaluate the sequelae of traumatic events. The TSI has 3 validity scales and 10 clinical scales which aim at assessing a broad range of psychological effects. Pre-test findings indicated that all group members were elevated above the level of significance ($T \geq 65$) on all scales with the exception of Defensive Avoidance and Dysfunctional Sexual Behavior. Post-treatment scores indicate that group members had dropped below the level of significance on all previously elevated scales. The two scales representing the greatest decrease were the Tension Reduction Behavior and the Intrusive Experiences scale. This indicates that group members experienced a decrease in externalized forms of self-soothing including self-harm, substance abuse, suicidality and aggression, as well as a decrease in intrusive symptoms (identified as a clinical marker and a highly treatment-resistant component of PTSD).

THE FOUR PRINCIPLES OF RECOVERY

The four basic principles of recovery in the ATRIUM model are: (1) recognizing and reinforcing resilience; (2) achieving abstinence from addiction; (3) recognizing and healing the wounds of nonprotection; and (4) creating a sacred connection to the world beyond the self-creating a "reverence for life" coupled with a sense of social purpose.

Anyone who is familiar with the co-occurrence of trauma and addiction can no doubt agree that the first principle—recognizing and supporting resilience—is relatively self-explanatory. The second principle—abstinence from addictive behaviors—while not easy to achieve, is also self-evident, generally uncontested by those whose lives have become unmanageable because of their addictions.

Atrium's third principle—recognizing and healing the wounds of *nonprotection*—may not seem as self-explanatory. This recovery principle is concerned with the pervasive experience of *nonprotection* in the survivor's life, the lack of protection she experienced in childhood *and* the reenactment of nonprotection in her adult experience of healing systems and community. The primacy of this focus on protection is both unique to the ATRIUM model and central to its theoretical foundation.

Although the ATRIUM Model approaches the remembering of childhood abuse very cautiously, there is room for survivors to review

the painful legacy of abuse through a concept named the Triadic Self, unique to this model and directly related to the issue of nonprotection. This is a concept from the author's earlier trauma and addictions Trauma Reenactment model (3,4). Linked to all three levels of trauma as it is re-enacted in mind, body and spirit, the Triadic Self is a vehicle for telling the story of being abused and not being protected. In this construct, the victim is seen as internalizing all three of the usual actors in most childhood trauma scenarios—the Victim, the Abuser and the Non-Protecting Bystander. The Triadic Self is central to the treatment model, and is revisited throughout the 12-week protocol, deepening the understanding of how trauma and addictions are enacted and then transformed through exercises designed to help change the survivor's relationship with mind, body and spirit.

PROTECTION AS THE CENTRAL THEME OF THE TRIADIC SELF

The cycle of Trauma Reenactment, enacted in the fluid internal relationships of the Triadic Self, is a story about the Victim, the Abuser and the Non-Protecting Bystander. This internal representation of earlier trauma dynamics is enacted in a variety of ways, including the survivor's active self-harming behaviors (or addictions), her abusive relationship with a partner, or even her repetitive chronic pain.

A bulimic trauma survivor, for example, may be enacting these dynamics when she binges and purges. As she begins the binge part of the cycle, she is simultaneously saying "I have to eat this whole cake' (the voice of the Abuser) and "no, I don't want to do this to myself" (the voice of the child Victim). When she says to herself, "but I can't help it, I have to do it, I just can't stop myself," she is also speaking the role of the Non-Protecting Bystander, replicating the position of the person/s who didn't protect her in childhood.

THE TRIADIC SELF AND THE PROTECTIVE PRESENCE

In working to interrupt the deadly impact of these three internalized voices, we must understand that the Triadic Self is a central component of the addicted trauma survivor's experience, presenting itself as an internal conversation acted out through using the woman's body to tell the story of earlier traumatic experience. First the survivor needs to understand that she, not the Triadic Self, is in control of her body. Then

she is helped to identify the elements of her unique Triadic Self, the voices she has internalized, and how these voices direct her to engage in self-harming behavior. Eventually she will be able to work with her helping community to develop an internalized sense of "the Protective Presence," (3), a construct which will work to help her fight back against the power of the destructive Triadic Self.

The development of the Protective Presence is one of the most important tasks addressed in the ATRIUM model. Somewhat akin to the "Higher Power" of the 12-step Program, the Protective Presence can be whatever amalgam of protective relationships the individual chooses for herself. When the survivor is able to fully develop and internalize the Protective Presence, she has the resource available to her which allows her to achieve the recovery principles of recognizing and reinforcing her own resilience, transcending fear, and letting go of her addictive behaviors.

A BRIEF INTRODUCTION TO TRAUMA REENACTMENT

The concept of "Trauma Reenactment," like the construct of the Triadic Self, is another foundation of the ATRIUM model. Trauma Reenactment (TR) has been variously described by a number of experts on childhood trauma and its sequelae (7–9). It has been used to refer to a victim of childhood abuse who subsequently abuses another child (8), to describe psychoanalytic introjects (7), and to describe behavioral manifestations of reenacting traumatic experience (9).

In the author's own writing, (3–5) Trauma Reenactment refers to a pattern of addictive behavior developed to cope with the legacy of trauma. Trauma Reenactment causes survivors of childhood trauma to engage in self-harmful patterns of behavior, including addictions, eating problems, and/or self-sabotage through abusive relationships; and sometimes TR even causes the survivor to suffer chronic somatic complaints.

Trauma Reenactment is a central construct in the ATRIUM model, underlying the interdepence of trauma problems and addiction. The experience of childhood trauma presents major mental health and addiction challenges in both the mind and the body, and causes deep spiritual pain: therefore TR includes an awareness of these three levels, the physical, mental and spiritual problems of daily living. The author's experience of training and supervising mental health professionals, addiction counselors and peer advocates indicates that they often grasp the complexities of Trauma Reenactment or understand its roots.

Survivors struggling with the various self-harming manifestations of addiction are often blamed for their own despair, even their own death, because the "fatal wounds" are inflicted by their own hands: "she's killing herself . . . why doesn't she just eat" (or) "stop drinking or drugging?" Or if the survivor reenacts trauma through abusive relationships, she may be blamed for her injuries: "she should have known better . . . why didn't she leave him?" if she suffers trauma-related somatic pain: "it's all in her head . . . she's just making herself sick." Yet these wounds are a consequence of earlier injuries, wounds that never heal and for many prove devastating. These trauma survivors are caught in the cycle of Trauma Reenactment. Prisoners of TR—they tell the painful story of childhood physical and sexual abuse through their drug and alcohol addiction, anorexia, bulimia, self-injuries, somatic complaints, and abusive relationships.

TRAUMA REENACTMENT AS NARRATIVE

Trauma Reenactment can be understood as the telling of a story. TR tells the story of the harm done in childhood (3). It reinforces the deeply rooted belief that the woman is incapable of protecting herself because she was not protected in childhood. For many survivors of childhood trauma, it feels impossible to stop self-harming patterns like drug abuse or self-mutilation as they recreate the destruction of their abuser. Survivors may inexplicably fail to interrupt the violent cycle of returning to an abusive partner over and over again as they re-experience the process of victimization. And trauma survivors who experience chronic somatic distress of ambiguous origins may also be reenacting their search for protection from the pain of abuse, protection that eluded them in childhood. Their pain, like their early experience of trauma is real, not imagined. It gives credence to their search for protection which may originate from earlier unmet needs.

Whatever pattern of distress prevails, when someone cannot "just say no," and the cycle of self-harm, self-destruction and self-sabotage seems to repeat despite help from psychotherapy, 12-Step programs, battered women's organizations, medication or surgery, then she is very likely the victim of a debilitating struggle with Trauma Reenactment (3–5).

TR involves excessive secrecy. Just as the abused child lived with dangerous secrets, so does the adult (or adolescent) who is struggling with TR. She holds fast to secrets which she may keep even from herself. Although it seems like a paradox, these behavioral manifestations often provide relief because it gives the survivor the illusion of being the

one in control of her own body. Strange as it may seem, patterns of TR behavior often become the woman's "best friend" because Trauma Reenactment fools her into thinking that these ways of being are her best defense.

The ATRIUM approach helps the survivor understand her addictions as having been the best way she has found to express the painful dynamics of her trauma experience. At the same time, the ATRIUM Model helps the survivor gradually let go of these addictive behaviors and helps her find better ways to connect with a healing community and experience empowerment.

Understanding the logical and functional reasons for these manifestations of Trauma Reenactment behavior allows the addicted survivor and those who care about her to approach the problem of TR from a position of respect. Many survivors feel that their connection to bulimia, addiction, or an abusive partner, is more "safe" than the offerings of helping, protective relationships. For others, the somatic expression of their pain in the form of a medical condition can become a paradoxically comforting companion as well as the means to legitimize their search for protection and healing. It's also the best way the survivor has found, so far, to tell the story of her pain.

The key to recognizing Trauma Reenactment is to understand the connection between the TR behavior and the person's unique story of childhood trauma. A typical survivor suffering from Trauma Reenactment may cut or burn herself when relationships end. This may be understood as her reenactment of an extensive trauma history, including sadistic physical and sexual abuse. She may also have been abandoned for long periods of time by her caretakers. Thus, her self-injuring replicates the physical and emotional violence inflicted on her in childhood and her inability to self-protect represents the abandonment by childhood caretakers.

A bulimic teenager might hesitantly identify herself as a trauma survivor but qualify the label by claiming "it was really no big thing, some inappropriate stuff between my older brother and me, some creepy touching by my step dad." Her bulimia can be seen as representing the enactment of disgust she experienced through being molested.

Others may be telling the story of the relationships they experienced and how they have created a core internal relationship template. For example, a survivor abusing alcohol and prescription drugs might be retelling the trauma of being verbally abused and emotionally abandoned by her parent. Another example might be the woman who experiences chronic pain considered to have no clear organic basis by the medical providers who have examined her. She, like the other

women imprisoned by TR, is often mistreated and invalidated by professionals who think she should be able to overcome her pain. Once again she finds no protection, no safety and no healing from those who are supposed to care for her.

THE FOUNDATION OF THE ATRIUM APPROACH

ATRIUM seeks to build a bridge between past history (the "trauma story") and current functioning within a context that progressively acknowledges, validates and then effectively re-constructs the multiple pathways of Trauma Reenactment. Furthermore, by actively identifying and exploring the mind/body/spirit interface in relation to trauma, a more holistic understanding of trauma is cultivated. As such, the ATRIUM model provides an effective bio-psycho-social frame that is responsive to the interrelated and often complex treatment needs of survivors.

ATRIUM works well at various junctures in a person's recovery process. It can be used in conjunction with other trauma recovery models, especially when addictions and self-harm are involved. ATRIUM can also be used in partnership with other addiction models, often helping someone to more successfully engage in a Twelve Step program or other intervention aimed primarily at achieving sobriety/abstinence. It can be used exclusively when someone is fearful, mistrustful, or otherwise unable to engage in addiction recovery programs—the goal in such a case would be to help the person become more comfortable about subsequently engaging in addiction recovery after graduating from the 12-week ATRIUM protocol. The ATRIUM protocol, although primarily designed for groups, can be used by a therapist or counselor as a structured format for advancing a client's individual work when the more traditional psychotherapy path seems to be at a standstill.

The ATRIUM model has been developed from the following assumptions: Survivors are experts concerning their own problems. Survivors are competent healers for themselves and their peer community. They are very capable of establishing communities of care. Like other peer-based healing models, this is a non-pathologizing model: Trauma Reenactment is a description, not a diagnosis.

HEALING THE MIND, BODY, AND SPIRIT

ATRIUM has a strong emphasis on working with the body as well as the mind. Survivors not only re-enact their early abuse by engaging

in addictive, self-harming behavior and/or by re-creating abusive and toxic relationships, but the legacy of early abuse can also emerge and be re-created within the biological (i.e., body-based) domains as well. Some of the most promising research in the development of trauma treatment can be found in the resurgent interest in treating the impact of trauma on the survivor's somatic functioning (10), validating what trauma survivors themselves have been telling us for a long time: trauma affects *both* the mind and the body in significant ways. The effect of trauma on the central nervous system and the neurohormonal system is considered as important as impaired cognitive functioning and compromised relationships; all, in fact, are now seen as salient, interrelated factors in understanding and treating the impact of trauma.

Trauma experts are also beginning to look at the effects of trauma on the survivor's spiritual life as well (11–13), emphasizing how important it is to repair disrupted connections to community and shattered trust in spiritual dimensions of the survivor's life. Working with the impact of trauma and addictions at the level of spiritual violation mandates a focus on building safe supportive relationships and developing a healing community in which trust can be re-established.

ATRIUM also emphasizes the importance of connecting to natural support systems: healing in relationship becomes a primary intervention in healing the spirit. Because survivors of childhood trauma often have negative associations with religious institutions and practices due to experiences of betrayal within religious institutions, the emphasis is on spiritual, not religious, connection. ATRIUM participants are helped to understand trauma's injuries to the spirit as disconnection from the human community and the natural environment.

SUMMARY OF THE ATRIUM PROTOCOL

While it is beyond the scope of this article to describe the entire ATRIUM protocol, the following is a very brief description of the structure. The model is organized into 12 sessions, each including a didactic component, a process section which allows the participants to share their own experience pertaining to the topic, an experiential component teaching the participants new ways of responding to the issues addressed, and a "homework" assignment guided by a handout that reviews both the didactic and the experiential content of each session and gives the participant a sort of workbook to keep for her own use.

The ATRIUM protocol is organized in four sections that flow through the three stages of the original Trauma Reenactment model (the Outer, Middle and Inner Circle—representing a progression to the most painful heart of the survivor's trauma experience) (3,4). These four sections are to be used in a twelve-week sequence, either in a group or individual-oriented format.

The four sections include: (1) An introduction to Trauma Reenactment and Addictions: three sessions used to orient the user to the theory of Trauma Reenactment; the role of traumatic stress in connecting the problems of trauma, addiction and mental health; and an introduction to the construct of the Triadic Self and the Protective Presence; (2) Trauma Reenactment and the Mind: this 3-part segment covers the major mental health conditions of depression and grief, anger, fear and anxiety and their connection with addictions, framed by the principles of Trauma Reenactment; (3) Trauma Reenactment and the Body: three sessions focusing on how Trauma Reenactment is expressed in the body through somatic distress, body image, and the ways survivors experience touch and physical intimacy; (4) Trauma Reenactment and the Spirit: spiritual well-being is addressed in relationship to community, Nature, and the Protective Presence.

Moving sequentially through these stages of treatment, the model provides a multilevel approach. Behaviors, cognitions and relational capacities are equally important. The model respects the many levels at which the survivor's "symptoms" and relational issues tell the story of her traumatic experiences. The primary goal for treatment is to help survivors find less painful, non-addictive avenues to express their life stories so that they may leave Trauma Reenactment behind. When the work of the ATRIUM Model is completed, the survivor is able to call upon a strongly-felt internal experience of her own unique Protective Presence and also to operationalize this in her mission to support other survivors in their recovery.

In reviewing the basic principles of recovery in the ATRIUM approach, we can illustrate the ways that the ATRIUM model is able to bridge the gap between addiction recovery and relational psychotherapy:

- Principle 1—Recognizing and reinforcing resilience. Through celebrating resilience, ATRIUM models the 12-Step philosophy that addicts, alcoholics (and all others who engage in self-sabotage), can achieve a manageable and productive life; at the same time the emphasis on resilience directs the survivor towards investigating the trauma story with a emphasis on how her trauma

history has created strengths and resources for her rather than focusing on her story of being victimized.

- Principle 2—achieving abstinence from addiction. This principle honors the wisdom of addiction treatment models while at the same time teaching ATRIUM participants new skills, borrowed from expressive therapies, movement therapies, and meditation practices, skills which allow her to experience relief at all three levels of suffering—body, mind and spirit—which she previously tried to numb through the addictive behavior.
- Principle 3—recognizing and healing the wounds of nonprotection. This is the component of the ATRIUM model most closely aligned with the various trauma-informed psychotherapy models that help the participant to re-work the painful memories of childhood and replace those with current supportive relationships modeling care, acceptance and protection. Here the importance of supportive, accepting relationships parallels both the use of the sponsor in 12-Step recovery, and the value of therapeutic relationships in mental health domains.
- Principle 4—creating a sacred connection to the world beyond the self; creating a "reverence for life" coupled with a sense of social purpose. Becoming aware of a connection to her community, both local and global, is at the heart of the author's own recovery and it has guided her work with survivors. It has made clear the importance of healing body, mind and spirit as practiced in the 12 Step recovery model, in feminist models like the Stone Center "Relational Model" (14) and in healing practices of indigenous cultures such as Native American, Maori, and South Pacific Islanders. While the ATRIUM model cannot claim to erase the painful legacy of trauma (nor can it—if used without other long-term recovery programs like 12-Step—permanently eradicate addictive behavior), it can help the addicted trauma survivor to create new understandings of the connection between trauma and addiction and help her to engage with new communities of support.

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