

CASE REPORT

The “HEALTH” model – Part 2: case study of a guideline-based treatment program for Complex PTSD relating to childhood sexual abuse

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This study outlines some of the practical issues for practitioners in the use of a guideline-based treatment program: HEALTH (Connor & Higgins, 2008). Issues are explored using a case study of a 23-year-old woman who had multiple trauma experiences throughout her childhood and who was diagnosed with Complex PTSD (CP). The objective of the treatment program was “ego strengthening” and reduction of CP-specific symptomatology. Through this, the aim was to increase her capacity for eventual exploration and working through of her early abuse. The use of the HEALTH treatment guidelines with this case allowed for an individualised focus, with the program being tailored to meet the client’s needs. A major positive outcome of the treatment program was that the client reported improvements in all CP symptoms identified at the outset and reported being more capable of undertaking work directly related to the earlier abuse issues. A case study is used to explore issues for practitioners in implementing this guideline-based treatment program. The case study demonstrates that – in addition to focusing on core-PTSD symptoms undertaking therapeutic work to address directly the abuse issues – there are important the benefits for clients when CP-specific symptoms are addressed directly, as outlined in the HEALTH model.

Keywords: the HEALTH model; Complex PTSD; therapy; multiple traumas; childhood sexual abuse

Introduction

Complex PTSD (CP) is an emerging diagnostic category that is used to explain the symptoms seen in clients exposed to long-term, multiple experiences of abuse (Connor & Higgins, 2008). This paper outlines the efficacy of a guideline-based treatment program (the HEALTH program) focusing on “ego strengthening” and developed by the author for treating CP (Connor & Higgins, 2008). The program was used in the treatment of 10 adults with CP who received treatment over a six-month period. However, this paper focuses on the way in which this program was applied in the treatment of one of the participants, “Maria” who had experienced long-term childhood abuse. Over a period of six months, she received 24 individual treatment sessions and participated in concurrent group therapy, based on the HEALTH model (as outlined in Connor & Higgins, 2008). In this paper, we highlight the usefulness of using a guideline-based treatment program in early stage work with clients with long-term and multiple abuse experiences – particularly childhood sexual abuse.

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Maria***Childhood abuse***

“Maria” (not her real name) is a 26-year-old woman who, at the time of the therapy, lived with her partner of four years and worked as an administrative assistant. Maria is the eldest of three children. Her mother separated from her father when she was an infant. During Maria’s childhood her mother had two subsequent de facto relationships: first with Leslie, then Ian. Maria was sexually abused by both of her mother’s new partners over a period of approximately eight years. She reported that she was not aware of whether either of her siblings (a younger sister and brother) experienced similar abuse. Between the ages of five and eight, Maria was abused by her first stepfather, Leslie, who forced her to assist him masturbate. Maria reported that, although no aggression was involved, she was “gently encouraged” and shown the “correct technique”. She can remember feeling very uncomfortable, stating: “I felt that it was really wrong, but I shut myself off afterwards and pretended I was somewhere else.” She stated, “At the time, like, I was in two minds because I was thinking that I felt uncomfortable doing it. It felt really wrong but perhaps it’s OK because he seems OK with it”. Maria also stated, “I would look out the window and see nice sights outside . . . I didn’t want to see it. I wanted to pretend it wasn’t happening and that everything was OK. I used to switch off.” Maria reported that her mother was always absent from the home during the abuse (Maria was unable to explain her mother’s whereabouts). The abuse by Leslie ceased when the relationship ended between him and Maria’s mother. Maria was later also sexually abused between the ages of eight and twelve by her mother’s next partner, Ian. Maria reported that Ian “made me touch his penis – it happened a fair bit over time – but I just remember a few bits and pieces.” Ian also touched Maria inappropriately around the breasts. Maria also witnessed sexual behaviour between her mother and Ian. This occurred in a family area of Maria’s home, with no attempt by Maria’s mother at discretion, even after she became aware that Maria had entered the room. The abuse by Ian ceased when Maria became a teenager, Maria suspected that this was because he was concerned that she might inform others – and would be a more credible source of information than at an earlier age.

Maria also reported that her first stepfather, Leslie, was an alcoholic. She witnessed his behaviour when he had been drinking. There were many arguments between her mother and him and she witnessed him punch her mother in the face. She reported feeling extreme anxiety during these times. Because of the domestic violence experienced with Ian, Maria’s mother decided to leave him. Maria was involved in the precarious escape, during which her mother was driving with a migraine and Maria (only 12 years old) was requested to stay awake to ensure that her mother did not fall asleep at the wheel. Maria reported that this was also a very stressful experience.

Throughout her childhood and adolescence, Maria’s mother verbally abused her. Maria acknowledged that her mother was experiencing considerable stress and would become angry over anything, blaming her daughter for many things (for example, ruining her relationship, hurting her siblings). The verbal abuse and blaming increased when her mother met Ian, as Ian would blame Maria for everything. At around the age of 12, Maria’s mother accused her of attempting to entice Ian by leaving her underpants in open areas of the home. She called Maria a “slut” regularly.

Maria was also beaten by her mother’s second partner, Ian, from the age of 8 until the age of 12, for seemingly trivial offences. Although Maria’s mother noted her daughter’s bruises in the shower, she did not pursue her for possible explanations.

For most of her childhood, Maria was also neglected emotionally and physically. Her mother was a heavy drug user and was also pre-occupied with the men in her life and her other children. Maria lived a life isolated from other children, and took on a “parenting role” in relation to her siblings, as well as some role-reversal in providing care for her mother. For example, when Maria was 12, her mother miscarried and Maria rode her bicycle a long distance to alert someone. This also added to her anxiety, as she feared her mother would die. During Maria’s adolescence, her mother experienced increasing stress and Maria described her mother’s “out of control” and angry behaviour. Maria’s mother asked her to leave home at the age of 16, leading to further feelings of rejection for Maria.

Trauma symptoms

Assessment of trauma-related symptoms was assessed via clinical interview with Maria and by asking her to complete two self-report psychometric scales: the Post Traumatic Stress Diagnostic Scale (PDS: Foa, 1995) and the Structured Interview for Disorders of Extreme Stress, Self-Report (SIDES-SR: van der Kolk, 1996) – a tool used to identify symptoms of Complex PTSD. This nomenclature is used in reference to individuals reporting a history of subjection to “totalitarian” systems (for example, survivors of child abuse) over a long period and who demonstrate a constellation of symptoms associated with alterations in affect regulation (which can include compulsive or inhibited sexuality, self-harming behaviour, aggression and depression), dysregulation or disturbance to self-concept, alterations in interpersonal relationships and dissociation. All of these symptoms are often prominent in survivors of long-term child abuse, particularly sexual abuse (Herman, 1992).

On the PDS, Maria identified 9 of the 17 symptoms commonly associated with PTSD: five in category A (Re-experiencing), one in category B (Avoidance) and three in category C (Arousal). Based on test norms, the intensity of her symptoms fell within the range categorised as Mild-Moderate (15/54), while her level of impairment was classified as Moderate. On the SIDES-SR, no clinically significant score was indicated on any of the main scales. However, clinically significant scores were indicated on the following sub-scales (all at a low level of intensity): Modulation of Anger, Suicidal Pre-occupation and Difficulty Modulating Sexual Involvement (i.e. elements of Alterations in Affect Regulation); Amnesia and Transient Dissociative Episodes (i.e. Alterations in Consciousness); Guilt and Responsibility (Alterations in Self-Perception); Victimising Others (Alterations in Interpersonal Relations); Somatisation (conversion, sexual and cardio symptoms); and Loss of Previously Sustaining Beliefs.

Based on the published normative data, the above results of self-report inventories indicate that Maria satisfied the DSM-IV Criteria for a diagnosis of PTSD and her symptoms were reported to be at a mild-moderate level. This was also the case for CP symptoms. However, as the treatment program progressed, Maria’s symptoms of both PTSD and CP appeared more prominent than had been indicated by the initial self-report measures. Specifically, Maria experienced severe problems with loss of consciousness, which appeared to be a manifestation of her dissociative episodes. The discrepancy noted between Maria’s symptoms observed during therapy (and her reported symptoms on inventories and formal diagnostic interviews) highlights the need for multi-faceted assessment approaches. It is important to draw together information from structured patient self-report inventories, as well as ongoing assessment and review as part of the therapeutic process, as the full range of clinical issues may not be revealed using a standard psychometric assessment.

Pre-treatment evaluation

Alterations in self-perception

Maria reported self-confidence issues (“I have no confidence in myself at all – mostly, I feel ugly and that I don’t have any good qualities”), stating that her mother’s use of derogatory words (“fat” and “slut”) remained with her and she felt this had contributed to the development of an eating disorder (symptoms of which were no longer current at the time of therapy). Maria also reported that she had always experienced problems believing she was intelligent, as she was never given any positive feedback. (“I always thought I was dumb as no-one at school or at home ever praised me for anything I did”). It was only recently that she had started to believe that she might be intelligent, due to the fact that her partner had reassured her of her capabilities.

Overall, Maria described a great deal of self-doubt in her life. Although she was also able to recognize her positive attributes, she did not report a strong sense of self (“Even though I do know I can do some things well, I still don’t believe in myself”). Maria also reported feelings of self-blame and guilt regarding relationships with her mother and her siblings and sometimes felt that she could have been more pro-active in maintaining the relationships and protecting her siblings (“I should have made more effort with them”).

Alterations in affect regulation

Maria explained that she had difficulties modulating her anger and that she could be quite “moody”. She also explained that, when she first met her current partner, she “tested” him regularly with her anger, to see how much he would accept without leaving. She stated, “Sometimes I yelled at him, fully aware of what I was doing, and it was like a kind of test for him”. Maria explained that, although she has undertaken some work with counsellors around her anger management, there was still some work to do (“There are many times I just can’t control my anger”).

Maria also reported suffering from depression about five years ago: “It lasted for about a year but I think the worst was for six months, and there was a secret dark cave that I was in.” Maria stated that during this period she was “getting up in the morning and crying, “coz life was just not worth it”. However, she reported, “I don’t get that anymore. I’m really happy.” Although this description appeared somewhat incongruous with Maria’s traumatic background, it is possible that Maria’s understanding of “happy” was somewhat different to that of someone who had not experienced childhood abuse. It is possible that she was comparing her current mood state – or her current life events – with those experienced in previous periods of her life and the contrast was sufficiently noticeable to cause her to assess that she must now feel “happy”.

Maria also reported panic attacks – periods when she became dizzy, weak and would collapse on the floor. Sometimes, these attacks were accompanied by screaming or calling out (these were later identified as dissociative episodes). Often, there was no particular trigger for these attacks.

Sexual dysfunction

Maria reported that her past experiences had impacted on the way she viewed sex (“I feel guilty and ashamed when I am having sex”) and led to confusion in her thinking about sex. She also reported current difficulties in her own sexual relationship, dissociating during the experience (“I take myself away to somewhere else in my mind”) and not

wanting to participate. Maria reported a dislike for being touched in the genital area and stated an awareness that she needed to work on sexual intimacy issues.

Alterations in interpersonal relationships

Maria reported that she generally forms relationships with others easily. However, she reported some problems with her closest relationship – that with her partner. “He is patient and kind with me – but I am often nasty and mean in return. It is like I need to take my anger out on someone.” There was also a sense, however, that she may see him as a “rescuer”: “He is always there for me, no matter what I do – and I feel that he saves me from getting worse a lot”. Maria worried most about her lost relationship with her mother and siblings, stating, “I should have made more effort with them”.

Alterations in belief systems

Maria reported changes in her belief systems over the years (“My beliefs have changed a lot since I left home”). At 16, when searching for answers and needing support, Maria turned to Christianity. She explained that she had recently started to question why she was involved with the church, explaining that she would prefer to direct her compassion and energies toward helping other people. Thus, for Maria, there has been a move away from a formal, structured kind of religion to a more humanitarian-centred approach to life – wanting to do things for people in society.

In summary, although formal psychometric assessment indicated mild-to-moderate symptoms of PTSD and CP, Maria indicated throughout her therapy that she did have quite marked PTSD symptomatology (dissociative symptoms) as well as some specific CP symptoms. Maria thus satisfied the second criteria for inclusion in this program.

Treatment program: HEALTH

The treatment guidelines used in Maria’s treatment were based on a 6-stage model (Connor & Higgins, 2008). The six stages form the acronym ‘HEALTH’:

- Having a supportive therapist
- Ensuring personal safety
- Assisting with daily functioning
- Learning to manage core PTSD symptoms
- Treating complex PTSD symptoms
- Having patience and persistence to enable “ego strengthening”

Ego strengthening (or strengthening of the self) is central to working with patients in the early stage of treatment of CP. A guideline-based program provides the therapist with a pathway for achieving this, but also allows for some flexibility – both at the outset when negotiating a treatment program and throughout the program (see Connor & Higgins, 2008).

Maria’s program

The program negotiated with Maria demonstrated the way in which the guidelines can be used flexibly for individual clients. For Maria, development of a safety plan was not a

major focus of the initial work. Although Maria had referred to previous suicidal ideation in the initial self-report inventories she completed, by the time that therapy commenced, Maria was reporting no likelihood of self-harm and no current suicidal ideation. She also referred to safety networks of a supportive partner and close friends, it was therefore agreed that this would not be necessary. Similarly, she described adequate daily functioning; therefore – as suggested in the HEALTH guidelines (Connor & Higgins, 2008) – a flexible approach to treatment meant that these aspects were not a major focus of treatment. It was important to respect the views of the client and to build rapport (and provide a sense of personal success and achievement) by focusing on the areas of greatest concern to her. Therefore, Maria's program focused on the control of PTSD symptoms (in this case dissociation) prior to treating those CP symptoms identified during assessment: Alterations in Affect Regulation, Alterations in Self-Perception and Alterations in Relationships with Others. No work was indicated as necessary for Alterations in Systems of Meaning.

Individual sessions were devoted to working with Maria, using a number of different treatment approaches (e.g. Cognitive Behavioural Therapy, Interpersonal Psychotherapy, Gestalt approaches). During some sessions, skills (e.g. breathing and relaxation skills, strategies for managing panic attacks) were rehearsed. At the end of each session, Maria was provided with "homework" to complete (sometimes written, sometimes practical, such as practising breathing techniques) prior to her next session. Each session built on the work of the previous session.

Positive and negative aspects of program

Maria was reliable, attending every session – including most group sessions. She reported looking forward to every session. Further, Maria was diligent in undertaking additional reading and in doing her "homework", often involving experimenting with different techniques, writing and self-analysis.

There were few problems encountered with this client. However, during some sessions, Maria experienced dissociative episodes when reference was made to her experiences of childhood sexual abuse and, at the conclusion of her episode, was usually so exhausted that the session had to be abandoned. Further, although Maria was better able to manage her dissociative episodes as a result of learning strategies to manage these (e.g. grounding; see Connor & Higgins, 2008), they were still evident at the end of the 24 sessions (although not as frequent or severe).

Post-treatment evaluation

Psychometric assessment: comparison with pre-treatment assessment

On the PDS (Foa, 1995), Maria identified seven of the 17 core PTSD symptoms, as compared with nine in the pre-treatment assessment. Specifically, this comprised two symptoms (compared with five pre-treatment in category A [Re-experiencing]; two (compared with one pre-treatment) in category B [Avoidance]; and three [no change] in category C [Arousal]. Intensity of symptoms was rated in the Mild range (7/54), compared with the Mild-Moderate range (15/54) pre-treatment, while level of impairment was Very Mild (c.f. Moderate, pre-treatment). On the SIDES-SR, no elevated score was indicated on any of the main scales. However, the following sub-scale symptoms were still noted to be present (all at a low level of intensity): Modulation of Anger (i.e. sub-scale of Alterations in Affect Regulation); Transient Dissociative Episodes (i.e. sub-scale of

Alterations in Consciousness); Guilt and Responsibility (sub-scale of Alterations in Self-Perception); and Somatisation (conversion, cardio symptoms). Additional symptoms noted (again at a low level of intensity) were as follows: Permanent Damage and Nobody Can Understand (sub-scales of Alterations in Self-Perception) and Inability to Trust.

Those symptoms no longer noted were: Suicidal Pre-occupation and Difficulty Modulating Sexual Involvement (both are from the sub-scale of Alterations in Affect Regulation); Amnesia (sub-scale of Alterations in Consciousness); Victimising Others (sub-scale of Alterations in Relations with others); and Loss of Previously Sustaining Beliefs (sub-scale of Alterations in Belief Systems).

From the results of the psychometric assessment, it was apparent that there had been a reduction in a number of PTSD symptoms (especially Re-experiencing) as well as a reduction in the intensity of PTSD symptoms overall. The increase in score on the Avoidance scale of the PDS was perhaps related to greater awareness of avoidance symptoms. There was also a reduction in intensity of CP symptoms. However, it is difficult to compare results of pre- and post-treatment SIDES-SR results as her scores on this measure indicated only mild-to-moderate CP symptoms at the pre-treatment assessment and it is possible that Maria was under-reporting at this time. Perhaps the most meaningful information can thus be obtained from the client's comments at her final interview.

Also, while there were reductions in a number of major symptom areas, the presence of three new symptoms was noted at the post-treatment interview: Permanent Damage; Nobody Can Understand; and Inability to Trust. It is important to note that these were rated at a low-level of intensity. It may be that as some of the major debilitating symptoms are addressed in therapy, that other areas of self-perception and interpersonal behaviours are raised for clients. This suggests that assessment of symptoms needs to be an iterative process throughout therapy, with opportunities for recognising and focusing on new issues that emerge once other major milestones have been achieved for clients.

Qualitative data: symptoms identified post-treatment

Post-treatment interviews were conducted by another registered psychologist who acted as an independent evaluator for the 6-stage HEALTH model for treating CP. The purpose of an independent evaluator was to enable participants to feel speak freely about positive and negative aspects of their experience of therapy. Maria reported positive improvements in each of the seven areas identified by Herman (1992).

Alterations in self-perception

Maria reported increased self-confidence and self-knowledge ("I feel very confident now because I know more about myself"). She also reported a greater sense of comfort with herself ("I like myself much more than I did before").

Alterations in affect regulation

According to Maria, she had developed effective strategies to assist her manage her anger more effectively ("I had a lot of problems with anger before, but I have been dealing with that better and using different approaches that are more conciliatory and help me to relax more"). She reported being calmer and more in control of her emotions and stated that her partner had noted the changes in her behaviour. However, she reported that there was still

some instability, as she was still collapsing (having “panic attacks”) at least once per week. However, Maria reported a decrease in the frequency of dissociation and the intensity of her attacks (“It occurs with less intensity than before and I can see the intensity decreasing over time”).

Maria explained that the knowledge she had gained about panic attacks and the strategies she had learned had reduced her fear about her collapsing greatly. She stated, “At first I thought I was going to die, but now it’s just, ‘I’m going to relax for a little while’ – so I’m less fearful”. Maria felt sufficiently confident of her capacity to manage her attacks to go on a trip overseas alone. Maria also appeared more optimistic, reporting that she was looking to the future with hope. She explained, “I’m looking forward to learning more about myself and challenging myself with different things, so that I can become more dependent on myself.”

Alterations in interpersonal relationships

Maria reported improvements in her relationship with her partner (“I am not feeling a need to be negative towards him any more”). She stated that she did not have as much anxiety over her relationship with her mother (“Her actions and what she said to me in the past are sitting more comfortably with me and my negativity towards her has lessened”). She reported that she did not think about her mother as much following some work undertaken in sessions.

Alteration in perception of perpetrator of abuse

Maria stated that she thought differently about her mother and was able to recall positive aspects of their relationship. She reported that her mother no longer had the same “hold” on her (“She’s more on the fringe now”) and reported positive emotions towards both her mother and her siblings.

Summary of impact of treatment program

Overall, Maria reported improvements in those CP symptoms that had been treated: Alterations in Self-Perception, Alterations in Affect Regulation (anger, anxiety and panic attacks) and Alterations in Interpersonal Relationships. There was a reduction in one core PTSD symptom (Re-experiencing) and dissociative aspects of Avoidance. There was also a reduction in the intensity of PTSD symptoms overall, although other than Dissociation, core PTSD symptoms were not specifically dealt with. In commenting on the program, Maria reported that she liked weekly sessions:

It was good to have that regular contact. She [the therapist] knew what happened last week and she knew what happened a month ago – so it was like a puzzle, and it was putting pieces together. If the sessions were monthly, you forget important snatches of stuff that now make things clearer.

Discussion

Overall, this program was highly appropriate for this early-stage treatment of Maria’s symptoms. Use of the HEALTH treatment guidelines with Maria allowed for an individualised focus, with Maria’s program being tailored to meet her needs. Thus, the guidelines allowed for flexibility in approach, but still keeping the main objectives in sight.

A major positive outcome of the program was that Maria reported improvements in terms of CP symptoms and discourse analysis (as outlined in Connor & Higgins, 2008) of information provided in the final interview indicated that “ego strengthening” had taken place. Specifically, Maria reported improvement in all CP symptoms identified at the outset. The improvements described by Maria lend support to the claims made by Chu (1998) in relation to therapy focused on ego strengthening and CP-specific symptomatology: “This kind of therapy . . . has the best chance of helping patients achieve stability and the capacity for eventual exploration and working through of their early abuse” (p. 77).

Maria also indicated some improvement in core-PTSD symptoms (both number and intensity). It appears that there was some “carry-over” effect from the direct focus of treatment on her specific CP symptoms to the core-PTSD symptoms. Although the use of a standard PTSD treatment program may have resulted in greater focus on core PTSD symptoms of Re-experiencing, Avoidance and Arousal and may have led to a subsequent reduction in the number and intensity of these symptoms as well as some associated symptoms, such a program would not have been appropriate for addressing the symptoms of CP. Complex PTSD-focused therapy was needed to address CP symptoms such as Alterations in Affect Modulation, Self Concept, Relations with Others, Consciousness and Systems of Meaning. Had the focus been solely on core PTSD symptoms, the presence of CP symptoms may have undermined effective treatment anyway.

Maria appeared to understand intuitively that she needed to be stronger before she could address some of the core PTSD symptoms and past trauma events. Her interest in dealing predominantly with CP symptoms also indicates that she felt vulnerable in these areas and required assistance. The need to focus on CP symptoms has been referred to by Chu (1998) and van der Kolk, McFarlane, & Weisaeth (1996), who have emphasised the importance of dealing with some of the “associated” symptoms of PTSD (when working with sufferers of long-term or multiple abuse experiences) prior to helping them deal with core PTSD symptoms. Courtois’ statement (1998, cited in Chu, 1998) that “this treatment [CP] is . . . a process of life reconstruction and enhancement” is one about focusing on those CP symptoms identified by participants in this program.

Although no long-term follow-up has been possible, Maria’s improvements (as reported immediately after the six months of treatment) were promising and consistent with the claims of Chu (1998) and Herman (1992) that treating CP symptoms is of major importance in any program dealing with sufferers of long-term and/or multiple trauma experiences. This is essential if further abreactive work is to be undertaken, as the individual undertaking this work needs to be emotionally and psychologically stable, with skills to manage the strong emotions that may arise when reminded of past trauma experiences. As survivors of long-term trauma are often highly emotionally responsive (as in this case study) and as resistance to change appears to be a major factor standing in the way of recovery (as occurred with other participants in this study; see Connor & Higgins, 2008), therapists undertaking work with sufferers of long-term/multiple abuse experiences will need to be patient, skilful and encouraging. Therapists may also need to be creative in their approach to therapy, given that many individuals with CP are difficult to engage in therapeutic processes and are likely to avoid homework and conscientious work between sessions.

Maria’s case also demonstrates the flexibility that this guideline-based program affords (both at the outset when negotiating a treatment program and throughout the program) when working with sufferers of long-term/multiple abuse experiences. It is possible that, as many individuals displaying CP symptoms will not be expressing suicidal ideation at the time of commencement of therapy, less work around safety issues may be necessary in

regard to safety in the initial stages and there is a need to be flexible in regard to this issue. Careful screening and ongoing monitoring around safety issues is important. Further, as many individuals with CP may not require work to assist with aspects of daily functioning (as was the case for Maria), the guidelines also afford the opportunity to be flexible here, allowing the opportunity to work on, issues of daily functioning as they arise. Alternatively, it may be more appropriate to integrate this aspect of treatment into every “topic” of treatment. It may also be necessary to be flexible with regard to treatment of core PTSD symptoms. Therapists should be prepared to work on core PTSD symptoms as they are identified, given that many individuals may not, at the outset, identify or understand the nature of the PTSD symptoms (as in the case of three individuals in this program, who had not realised that they were often in a dissociated state).

Finally, it is important to note that, as recovery from the effects of long-term/multiple abuse experiences often involves years of therapy, six months of treatment may not be sufficient to effect lasting changes. For further information about the HEALTH model and data supporting its usefulness, see Connor and Higgins (2008). It may also be the case that this set of treatment guidelines may not achieve the desired result with everyone. However, for many sufferers of long-term and multiple trauma experiences, similar outcomes to those experienced by Maria, may be possible.

Notes on contributors

Pam Connor is a Registered Psychologist, who has worked in both government agencies and in private practice in Canberra, Australia over the past ten years. Pam has undertaken extensive therapeutic work with clients suffering from a range of mental health conditions, many of these being individuals who have suffered long-term childhood or adult abuse. The research was conducted as part of her doctoral dissertation, under the supervision of Daryl Higgins, who at the time the data were collected was a Senior Lecturer in the School of Psychology at Deakin University. Dr Higgins is now General Manager (Research) at the Australian Institute of Family Studies. The views expressed in this article are those of the individual authors and may not reflect Australian Government or Institute policy or the opinions of the Director.

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