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Guideline-based Programs in the Treatment of Complex PTSD

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Submitted in fulfillment of the requirements for the degree of Doctor of Health Science (DHSc)
Deakin University, Australia

February 2005
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ACKNOWLEDGEMENTS

The study is dedicated to my five children, who always inspire me to continue with learning about others, and my partner, Steve Cadman, for his assistance and support throughout the six years of my research and study.

The study is also dedicated to the ten individuals who participated in the treatment program evaluated in this study. All participants indicated enormous self-insight, as well as determination to become stronger and to move forward, despite their past suffering.

Acknowledgement is also due to fellow psychologist, Ms Celia Cronin, for her assistance with post-treatment interviews, and my principal supervisor, Dr Daryl Higgins, Deakin University, for his untiring support and encouragement over the past six years, and for the insight he has provided in guiding me with my research.
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Abstract

The term “post-traumatic stress disorder” (PTSD) is a relatively new diagnostic label, being formally recognized in 1980 in the Diagnostic Statistical Manual for Psychiatric Illness – Third Edition (DSM-III) of the American Psychiatric Association (APA, 1980). Complex Post-Traumatic Stress Disorder (CP) is a more recently discussed, and newly-classified, phenomenon, initially discussed in the early 1990s (Herman, 1992a). Thus, as research into effective treatments for CP is sparse, the treatment of CP is the topic of this study, in which a guideline-based treatment program developed by the researcher for the treatment of CP is implemented and evaluated.

Ten individuals participated in this study, undertaking individualized, guideline-based treatment programs spanning a period of six months. In providing background information relevant to this study, an explanation is provided regarding the nature of CP, and the reasons for its consideration as a separate phenomenon to PTSD. The adequacy of the PTSD formulation in enabling effective assessment and treatment of CP is also explored, with endorsement of previous researchers’ conclusions that the CP construct is more useful than the PTSD construct for assessing and treating survivors of long-term and multiple forms of abuse. The PTSD classification is restrictive, and not necessarily appropriate for certain forms of trauma (such as prolonged trauma, or multiple forms of trauma), as such trauma experiences may lead to specific effects that lay outside those formerly associated with PTSD. Such effects include alterations in affect regulation, consciousness, self-perception, interpersonal relationships, and in systems of meaning.

Following discussion regarding the PTSD/CP classification, an examination of treatment methods currently used in the treatment of PTSD, and a review of
treatment outcome studies, takes place. The adequacy of primary treatment methods in treating CP symptoms is then examined, with the conclusion that a range of treatment methods could potentially be useful in the treatment of CP symptoms. Individuals with a diagnosis of CP may benefit from the adoption of an eclectic approach, drawing on different treatment options for different symptoms, and constantly evaluating client progress and re-evaluating interventions.

This review of treatment approaches is followed by details of an initial study undertaken to obtain feedback from individuals who had suffered long-term/multiple trauma and who had received treatment. Participants in this initial study were asked open-ended questions regarding the treatment approach they had experienced, the most useful aspect of the treatment, the least useful aspect, and other strategies/treatment approaches that may have been useful – but which were not used. The feedback obtained from these individuals was used to inform the development of treatment guidelines for use in the main study, as were recommendations made by Chu (1998). The predominant focus of the treatment guidelines was “ego strengthening”, a term coined by Chu (1998) to describe the “initial (sometimes lengthy) period of developing fundamental skills in maintaining supportive relationships, developing self-care strategies, coping with symptomatology, improving functioning, and establishing a positive self identity” (p.75).

Using a case study approach, data are then presented relating to each of the ten individuals involved in the treatment program: details of his/her trauma experience(s) and the impact of the trauma (as perceived by each individual); details of each individual’s treatment program (as planned, and as implemented); post-treatment evaluation of the positive and negative aspects of the treatment program
(from the therapist’s perspective); and details of the symptoms reported by the individual post-treatment, via psychometric assessment and also during interview.

Analysis and discussion of the data relating to the ten participants in the study are the focal point of this study. The evaluation of the effectiveness of each individual’s treatment has been based predominantly on qualitative data, obtained from an analysis of language (discourse analysis) used by participants to describe their symptoms pre- and post-treatment. Both blatant and subtle changes in the language used by participants to describe themselves, their behaviour, and their relationships pre- and post-treatment have provided an insight into the possible changes that occurred as a result of the treatment program. The language used by participants has been a rich source of data, one that has enabled the researcher to obtain information that could not be obtained using psychometric assessment methods. Most of the participants in this study portrayed notable changes in many of the CP symptoms, including being more stable and having improved capacity to explore their early abuse.

Although no direct cause-effect relationship between the participants’ treatment program and the improvements described can be established from this study, the participants’ perception that the program assisted them with their symptoms, and reported many aspects of “ego strengthening”, is of major importance. Such self-perception of strength and empowerment is important if an individual is going to be able to deal with past trauma experiences. In fact, abreactive work may have a greater chance of succeeding if those who have experienced long-term or multiple trauma are feeling more empowered, and more stable, as were the participants in this study (post-intervention).
In concluding this study, recommendations have been made in regard to the use of guideline-based treatment programs in the responsible treatment of CP. Strengths and limitations of this study have also been highlighted, and recommendations have been made regarding possibilities for future research related to CP treatment. On the whole, this study has supported strongly other research that highlights the importance of focusing on “ego strengthening” in assisting those who have suffered long-term/multiple trauma experiences. Thus, a guideline-based program focusing on assisting sufferers of long-term trauma with some, or all, of the symptoms of CP, is recommended as an important first stage of any treatment of individuals who have experienced long-term/multiple trauma, allowing them to develop the emotional and psychological strength required to deal with past traumatic events. Clinicians who are treating patients whose history depicts long-term or multiple trauma experiences (either from their childhood, or at some stage in their adult life) need, therefore, to be mindful of assessing individuals for symptoms of CP – so that they can treat these symptoms prior to engaging in any work associated directly with the past traumatic experiences.
CHAPTER ONE

The purpose of this study was to describe a case series of ten adults with Complex PTSD (CP) who received treatment (according to procedural guidelines developed for the treatment of CP) over a six-month period. The study describes the way in which a guideline-based treatment program can be implemented, and also evaluates the usefulness of such treatment programs with individuals with CP. The following chapters provide a detailed account of this study.

Chapter 2 provides an insight into the nature of CP (and the reasons for considering it a separate phenomenon to PTSD). The adequacy of the PTSD formulation in enabling effective assessment and treatment of CP is also explored. Chapter 2 concludes with a review of assessment methods currently used to assess PTSD, and answers the question, “Are current assessment methods adequate for the assessment of Complex PTSD?” In Chapter 3, treatment methods currently used in the treatment of PTSD are discussed (with reference to relevant treatment outcome studies). The usefulness of these interventions in treating CP symptoms is also assessed. In Chapter 4, details are provided of an initial study undertaken to obtain feedback (via a questionnaire) from individuals who had suffered long-term/multiple trauma regarding the treatment they had received. The feedback obtained from these individuals was used to inform the development of the treatment guidelines for use in this study of the treatment of CP symptoms. Recommendations made by Chu (1998) were also used in the development of these guidelines. The process undertaken in developing the treatment guidelines for use in this study is outlined in Chapter 5. Following this, in Chapter 6, is an outline of the methodology used for the main study.
In Chapter 7 and using a case study approach, the researcher provides both qualitative and quantitative data for the individuals in the study, all of whom displayed numerous CP symptoms pre-treatment. The following were areas of focus in Chapter 7: details of each person’s trauma experience(s) and the impact of the trauma experience (as perceived by each individual), details of each person’s treatment program and the way in which it adhered to/departed from the suggested guidelines, positive and negative aspects of the treatment program (from the therapist’s perspective), and details of the symptoms experienced by each person post-treatment. A separate chapter (Chapter 8) has been devoted to a discussion on the other aspect of the program: group therapy.

Chapter 9 consists of an analysis and discussion of the data reported in Chapter 7 and 8. The evaluation of each individual’s treatment has been based predominantly on qualitative data, obtained from an analysis of language (discourse analysis) used by individuals involved in this study to describe their symptoms both pre- and post-treatment. Subtle changes in the language used by participants to describe themselves, their behaviour, and their relationships pre- and post-treatment provided an insight into the possible changes that had occurred as a result of the treatment program. Most of the participants in this study described notable changes in many of the CP symptoms, and reported being more stable and with improved capacity to explore and work through their early abuse.

Finally, in Chapter 10, recommendations have been made in regard to the use of guideline-based treatment programs in the responsible treatment of CP. Strengths and limitations of this study have also been highlighted, and recommendations have been made regarding possibilities for future research into CP treatment. Specifically, this study has provided support for the use of guideline-based treatment programs,
such as that used in this study, that cater specifically for the needs of those who have suffered long-term/multiple trauma experiences by targeting CP symptoms. Such programs focus on “ego strengthening” and are different to standard PTSD treatment programs that focus predominantly on core PTSD symptoms of re-experiencing, avoidance, and arousal, but may also assist indirectly with some CP symptoms. Randomised, controlled studies are needed to establish the relative efficacy of this approach, however.
CHAPTER TWO

POST-TRAUMATIC STRESS DISORDER (PTSD) AND COMPLEX POST-TRAUMATIC STRESS DISORDER (CP)

In this chapter, an examination of two constructs (PTSD and CP) takes place, forming the basis for a discussion as to which of these constructs is the most useful in providing a framework for the assessment and treatment of long-term, chronic forms of abuse. Also included in this chapter is an examination of the most commonly used methods for assessing PTSD and their usefulness in measuring long-term, chronic forms of abuse.

Many of those who have experienced trauma in their lives appear to have adapted to overwhelming and horrific life events, and to have survived without developing psychiatric disorder. This does not mean that they have not been affected in some way by the traumatic events, or that they will not have involuntary intrusive memories of them. In fact, such memories, and consequent replaying of the traumatic event, may assist them in modifying any emotions associated with the trauma and, in the large majority of cases, may lead to increased capacity to tolerate the information being remembered (Horowitz, 1978). There are many others, however, whose persistent intrusive memories do not lead to any modification of the emotions associated with them. For such individuals, there is a fixation on the trauma, with subsequent impairment in daily functioning. Van der Kolk and McFarlane (1996) argued that, despite humans’ great capacity to adapt and survive, “traumatic experiences can alter people’s psychological, biological and social equilibrium to such a degree that the memory of one particular event comes to taint all other experiences” (p. 4).
The Emergence of PTSD as a Diagnostic Category

Background

The term “post-traumatic stress disorder” (PTSD) is a relatively new diagnostic label. PTSD was formally recognised in the psychiatric nomenclature in 1980, in the Diagnostic Statistical Manual for Psychiatric Illness – Third Edition (DSM-III) of the American Psychiatric Association (APA, 1980). Van der Kolk and McFarlane (1996) claimed that this formal recognition of the category of PTSD was “a critical first step”, leading to detailed analysis of the effects of overwhelming experiences, and thereby opening up “the systematic investigation of how people come to be overwhelmed, how different people organise tragic experiences over time, and how their suffering can be alleviated” (p. 4). The APA’s acceptance of PTSD as a recognised diagnosis was closely related to the recognition of the effects of trauma on the veterans of the Vietnam War. In fact, it has been the interest and involvement of individuals who were themselves exposed to trauma, such as the Vietnam war veterans, and those working with traumatised individuals (for example, women and children who had experienced long-term or multiple forms of abuse – groups that had previously been neglected in research) that has led to an improved understanding in the field of post-traumareponses (van der Kolk, Weisaeth, & van der Hart, 1996).

History of the Study of Trauma

At the beginning of World War II, the existing system of classification and naming of conditions associated with trauma was inadequate for most of the patients seen by medical specialists. The classification system had no descriptive terminology to describe reactions to combat stress, neurotic symptoms, psychosomatic reactions and minor personality disturbances (Brett, 1996). Following World War II, however,
medical specialists dealing with psychiatric casualties recommended a revision of existing concepts of mental disorder. As a result, the American Armed Forces and the Veterans Administration each developed new diagnostic classifications. It was the Armed Forces’ categories that were used in 1948, when the World Health Organisation (WHO) decided to include mental disorders in the sixth edition of the International Statistical Classification of Diseases, Injuries and Causes of Death (ICD-6).

However, in 1952, three systems (the Armed Forces, Veteran’s Administration, and the ICD-6) were used when the APA revised its nosology (APA, 1952). Thus, both the International and American classifications were developed by psychiatrists with practical experience with patients suffering post-trauma responses. At this stage, however, both classifications defined traumatic reactions as short-lived responses in individuals with no pre-morbid or concurrent pathology. In ICD-6, PTSD prototypes were described as “acute situational maladjustments” (Brett, 1996, p. 118). There was no change to these descriptions in ICD-7 (World Health Organisation, 1954).

In the first edition of the DSM, produced by the APA in 1968, traumatic reactions were also described as short-lived responses: “transient situational personality disturbance” (Brett, 1996, p. 118). No change was seen in the description in the DSM-II, which was derived from the ICD-8 (World Health Organisation, 1969). Both manuals continued to use the term “transient situational disturbance”.

In 1970 in the US, psychiatrists, Shatan and Lifton, conducted “rap groups”, groups in which Vietnam veterans talked about their war experiences (Brett, 1996). Such sessions led to the growth of concern among professionals regarding the effects of war on psychological health. Shaton and Lifton referred to the literature on
Holocaust survivors (Kardiner, 1941) and compiled a list of the most common symptoms of “traumatic neuroses” reported in the literature. They concluded that there was a similarity between the symptoms described by the Vietnam veterans and those of the Holocaust survivors described by Kardiner in 1941.

At around the same time, Burgess and Holstrom (1974) first described the “rape trauma syndrome”. Burgess and Holstrom reported that the nightmares and frightening flashbacks experienced by women who had been raped appeared to be similar to the traumatic neuroses of war. Thus, the ICD-9 (WHO, 1977) used the term “acute reaction to stress” to encompass the overwhelming response to terrifying situations. Shortly after this, Kempe and Kempe (1978) published their work on battered children, and from that time on, research was undertaken on family violence and trauma. Then, in 1981, Herman began to document the widespread sexual abuse of children and the long-term destructive results of this abuse. Such work led to considerable changes in the way researchers conceptualised traumatic experiences and their effects.

In developing the DSM-III (APA, 1980), those involved in its development noted that traumatic experiences associated with childhood sexual abuse, adult rape, and war experiences all appeared to produce a similar set of symptoms – and so the new diagnosis of PTSD emerged (van der Kolk, 1996). The end-result of this process was the inclusion of PTSD in the DSM-III (APA, 1980). Thus, the classifications of post-traumatic stress reactions in both the DSM-III and the ICD-10 (WHO, 1992) represented a major change to previous classifications. The most important change was that traumatic stress disorders were no longer seen merely as acute responses in healthy individuals, but rather as chronic, often lifelong, conditions. The DSM-III thus placed post-traumatic reactions in the anxiety disorders section, instead of in the
adjustment and stress category. This was surprising, given that each of these syndromes had originally been defined differently to the eventual PTSD definition.

Thus, the DSM-III diagnostic criteria for PTSD was arrived at largely as a result of the knowledge gained through clinical experience. Scientific field trials were not conducted until the PTSD diagnosis was re-considered for the DSM-IV (APA, 1994), and most of the results of these trials were still not accepted as conclusive.

During the period in which the DSM-III was being developed, another group of researchers and psychiatrists suggested another diagnostic system for dissociative disorders (Nemiah, 1980). This group appeared to have no connection with the PTSD group, and there appeared to be no awareness of the relationship between dissociation and trauma. Thus, a separate classification was set up. Eventually, the two groups became aware that their systems had overlapping phenomena and agreed unanimously to combine the two groups and create a broader diagnostic system. These recommendations were tabled by both the DSM-III and DSM-IV Task Forces (van der Kolk, Weisaeth, and van der Hart, 1996). Van der Kolk and McFarlane (1996) claimed that

the development of post-traumatic stress disorder (PTSD) as a diagnosis has created an organised framework for understanding how people’s biology, conceptions of the world, and personalities are shaped by experience. The PTSD diagnosis has re-introduced the notion that many “neurotic” symptoms are not the results of some mysterious, well-nigh inexplicable, genetically-based irrationality, but of people’s inability to come to terms with real experiences that have overwhelmed their capacity to cope… the diagnosis of PTSD seems to have been received by victims as a legitimisation and
validation of their psychic distress. Having a recognizable psychiatric disorder can help people make sense of what they are going through, instead of feeling ‘crazy’ and forsaken. (pp. 4 - 5)

The Nature of PTSD

The DSM-IV Criteria

With the development of the DSM-IV (APA, 1994), diagnostic criteria for PTSD have been restricted to the presence of essential features. These are outlined in Table 1.

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<thead>
<tr>
<th>DSM-IV Criteria for PTSD</th>
<th>Symptom</th>
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<tr>
<td>A. The person has been exposed to a traumatic event in which two factors were present:</td>
<td>1) The person experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others.</td>
</tr>
<tr>
<td>1) The person experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others.</td>
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<tr>
<td>2) The person's response involved intense fear, helplessness, or horror.</td>
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<tr>
<td>B. The traumatic event is persistently re-experienced in one (or more) of the ways (seen in opposite column):</td>
<td>(1) recurrent and intrusive recollections of the event, including images, thoughts or perceptions.</td>
</tr>
<tr>
<td>(1) recurrent and intrusive recollections of the event, including images, thoughts or perceptions.</td>
<td></td>
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<tr>
<td>(2) recurrent distressing dreams of the event.</td>
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<tr>
<td>(3) acting or feeling as if the traumatic event were recurring (includes a sense of reliving the experience, illusions, hallucinations, and dissociative flashback episodes, including those that occur on awakening or when intoxicated).</td>
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<tr>
<td>(4) intense psychological distress or exposure to internal or external cues that symbolise or resemble an aspect of the traumatic event.</td>
<td></td>
</tr>
<tr>
<td>(5) physiological reactivity on exposure to internal or external cues that symbolise or resemble an aspect of the traumatic event.</td>
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Table 1 continued

C. Persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness (not present before the trauma) as indicated by three (or more) symptoms:

1) efforts to avoid thoughts, feelings, or conversations associated with the trauma.

2) efforts to avoid activities, places, or people that arouse recollections of the trauma.

3) inability to recall an important aspect of the trauma.

4) markedly diminished interest or participation in significant activities.

5) feeling detachment or estrangement from others.

6) restricted range of affect (eg. unable to have loving feelings).

7) sense of a foreshortened future (eg. does not expect to have a career, marriage, children, or a normal life span).

D. Persistent symptoms of increased arousal (not present before the trauma) as indicated by two (or more) of the following

E. Duration of the disturbance (symptoms in Criteria B, C, and D) is more than one month. The symptoms have lasted more than a month.

F. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

(Source: APA, 1994, p.434)

Van der Kolk and McFarlane (1996) reported that PTSD is a “very common disorder”, that “exposure to extreme distress is widespread”, and that “a substantial proportion of the population becomes symptomatic” (p. 5). Thus, several major responses have been determined for sufferers of PTSD: intrusions, avoidance and numbing, inability to modulate arousal, and lack of ability to concentrate and distractibility. A discussion of the nature of these PTSD symptoms follows.
Intrusions

After exposure to a traumatic event, many people become pre-occupied with the event, and experience persistent intrusions of memories related to it. Although these memories can interfere with other aspects of functioning, they also serve a more positive function, as this repeated replaying of distressing memories helps with modifying the emotions associated with the trauma, by creating a tolerance for the content of the memories (Horowitz, 1978). That is, the traumatic event becomes integrated in the memory among other life events and stored as a negative event belonging to the past.

For others, however, there is an inability – over time – to integrate the traumatic experience. In such cases, the replaying of the trauma leads to sensitisation, and in turn, an increasing level of distress (Hackmann, Ehlers, Speckens, & Clark, 2004). The traumatic event does not become integrated in the memory of other life events and begins to exist independently. The traumatic event also leads to secondary biological consequences that are difficult to reverse once the memories of the trauma are imprinted more and more powerfully onto the brain (Post, 1992; van der Kolk, & Greenberg, 1987, cited in van der Kolk & McFarlane, 1996). These biological “consequences” form the basis for the remaining PTSD symptoms (for example, difficulties with arousal and attention, psychological defences). Further, memories of past events evoke intense emotions and sensations that make victims feel that the event is happening again (van der Kolk & Fisler, 1995).

As people with PTSD have an impaired capacity to integrate their traumatic experiences with other life events, their traumatic memories are often incoherent,
and remembered more as intense emotions or somatosensory impressions. Intrusions can take the form of flashbacks/visual intrusions (Ehlers, Hackman, Steil, Clohessy, Wenninger, & Winter 2002), intense emotions, somatic sensations, nightmares, or interpersonal re-enactments (Laub & Auerhahn, 1993). Due to the intensity of these experiences, trauma victims report (many years after the event) that their relived experiences are as realistic and intense as when they first experienced the trauma, and have a “here and now” quality about them (Hackman et al., 2004; van der Kolk & Fisler, 1995). Thus, they become unable to accept the trauma as something belonging to their past.

In addition, the meaning that an individual attaches to a trauma will evolve over time, and in many instances, exposure to one traumatic event can activate memories of other traumas that had not previously bothered the individual. People may also experience sensory elements of the trauma without really understanding what is happening to them (van der Kolk & Fisler, 1995). Pitman, Orr, and Shalev (1993) reported that, over time, initial intrusive thoughts of the trauma may influence the individual’s responses to a range of other cues, and the individual will be reminded of the trauma, even by irrelevant stimuli. Further, people who suffer from PTSD may develop biased perception and respond more to trauma-related triggers at the expense of being able to respond to non trauma-related cues (van der Kolk & Ducey, 1989; McFarlane, Weber & Clarke, 1993). Total amnesia is also common for those who have experienced traumatic experiences (Krystal, 1968).

**Avoidance and Numbing**

Many traumatised individuals develop specific patterns of avoidance of the emotions that intrusions can evoke. Forms of avoidance include staying away from reminders, substance ingestion to numb the awareness of distressing states (for
example, drug/alcohol), or dissociating in order to keep unpleasant experiences from conscious awareness (van der Kolk & McFarlane, 1996). This avoidance of triggers appears to be accompanied by a generalised inability to respond emotionally to a whole range of emotional aspects of life (i.e., numbing). Van der Kolk and Fisler (1995) claimed that, although numbing and avoidance are grouped together in the DSM-IV, numbing possibly has a different underlying pathophysiology from avoidance. Many trauma sufferers describe a gradual withdrawal from everyday activities (Kardiner, 1941; Krystal, 1968; Titchener, 1986). In this way, PTSD sufferers actively avoid emotional arousal, but they experience increased withdrawal, to the extent that they avoid even pleasurable events that may set off an emotional response.

McFarlane, Yehuda, & Clark (in press, cited in Van der Kolk & McFarlane, 1996) proposed that, as intrusive memories predominate in the PTSD sufferers’ thinking, they will develop increased sensitivity to any stimuli that remind them of the trauma and, over time, reduced responsiveness to various stimuli that are necessary for everyday functioning. This, in turn, leads to a series of changes in the central nervous system that are similar to the effects of severe sensory deprivation. Litz, Schlenger, Weathers, Fairbank, Caddell, and LaVange (1997) have proposed that this lack of emotional responsivity leads to further physiological hyperarousal and to psychosomatic problems. Pennebaker (1993) also reported that low levels of emotional expression leads to impairment of immune functioning and to an increase in physical illness.

**Inability to Modulate Arousal**

PTSD sufferers experience conditioned autonomic arousal to both trauma-related stimuli and also to a wide variety of other stimuli (Bryant, Harvey, &
Guthrie, 2003; Schell, Marshall, & Jaycox, 2004). They suffer from hypervigilance, exaggerated startle response (hyper-reactivity), and restlessness (Kramer & Kinney, 2003; Palmer, 2002). Van der Kolk (1996) reported that people with PTSD tend to “move immediately from stimulus to response without often knowing what makes them so upset” (p. 13). They often experience intense negative emotions (for example anger or fear) in response to minor stimuli, or alternatively, they may shut down or freeze emotionally. These hyperarousal phenomena, based on anticipation of overwhelming threat, often cause difficulties with attention and concentration, and resulting distorted information processing. Such hyperarousal will often lead, in turn, to difficulties with sleep, as many are unable to relax themselves sufficiently in order to go to sleep – or perhaps they wake to avoid the trauma of possible nightmares (Franzen, 2004).

A major effect of hyperarousal is generalisation of threat (Van der Kolk, 1996), and somatic stress reactions are easily triggered – often by innocuous sounds and events. As a result, trauma sufferers are often soon unable to trust their own physical sensations. The consequent inability to interpret accurately messages from the autonomic nervous system leads to a sufferer responding to his/her environment with either inhibiting or exaggerated behaviours. Many individuals revert to earlier levels of coping with stress (children may be unable to take care of their own feeding and toileting needs; adults may become impulsive, excessively dependent and unable to make independent decisions).

**Inability To Concentrate; Difficulties with Stimulus Discrimination**

People with PTSD seem to lose the ability for decision-making through consideration of options. If they allow themselves to consider a range of options, they risk the possibility of connecting with possible reminders of the trauma. This
has been shown in studies of traumatised children (Rieder & Cicchetti, 1989) and traumatised adults (van der Kolk & Ducey, 1989). To prevent this from happening, traumatised individuals avoid considering the best options for responding to any emotionally arousing problems. They have difficulties in sorting out relevant stimuli from irrelevant, important information from unimportant (McFarlane et al., 1993). As a result, they become overstimulated, and will cope by failing to respond to their environment, subsequently losing involvement in everyday life. Deficits have also been seen in preservative learning and in the acquisition of new information (Yehuda, Keefe, Harvey, Levengood, Gerber, Geni, & Siever, 1995), as well as in conscious memory process generally (Brewin, 2001), and the ability to use and apply working memory within the environment (van der Kolk & Ducey, 1989; McFarlane et al., 1993).

Factors Influencing Post-Traumatic Stress Disorder

Subjective Interpretation of Trauma

The critical element that makes an event traumatic is the subjective appraisal by victims of how threatened and helpless they feel (McFarlane & Yehuda, 1996). The meaning that victims attach to a particular traumatic event is as important as the trauma itself. It is also important to remember that an individual’s interpretations of the meanings of traumatic events continue to evolve long after the trauma itself has ceased. Such interpretations will depend on a person’s prior experience and also on the many ways that their past has been incorporated into their current attitudes and beliefs. This can lead to a range of maladaptive responses in their current lives.
The Nature of the Stressor

The nature of the stressor is a central issue in traumatic stress studies, as is the role of the stressor as a primary factor in determining the typical pattern of symptoms. It is also important to note that differences will exist between different groups of trauma victims. For example, trauma following repeated combat (Beal, 1995) will be very different to that following a motor vehicle accident, which in comparison may last for one second and in which the victim has no control over the situation (Brom, Kleber, & Hofman, 1993). The trauma associated with child abuse is also unique as this trauma often continues over a long period of time, during which a child has to cope with being dependent on an abusive parent (Briere, 1992). The developmental stage of the child will also influence how the child understands the trauma and will influence the nature of possible psychological and behavioural responses (Finkelhor, 1990). Child abuse and related traumas have, therefore, much greater potential to disrupt stable relationships, and the development of appropriate ways of expressing affection and tolerating intense emotion, than a circumscribed traumatic event (Van der Kolk, 1996).

With all of the above, several factors will influence the outcome: the level of threat, the duration of the threat, whether there has been exposure to grotesque events or to fatalities/injuries, whether the event has been uncontrollable, or whether there has been property loss or re-location (Bryant, Harvey, & Guthrie, 2003).

Psycho-social factors

There are also a number of psycho-social factors influencing a person’s vulnerability to PTSD. Bryant et al. (2003) cite a number of such factors: degree of social support, individual’s coping style and capacity for help-seeking, ongoing stressors, prevalence of substance abuse, and existence of health issues.
Complex PTSD: Is Complex PTSD Different to PTSD?

Inadequacies in the Current Classification

Van der Kolk (1996) pointed to inadequacies in the current classification system, claiming that the current classification is restrictive, leaving out many of the characteristics of the disorder that have clinical and treatment relevance. He claimed that, using the current classification, clinicians may either miss the PTSD diagnosis because associated features dominate presentation, or overlook the associated features because of the strong presence of PTSD.

However, inadequacies were seen prior to 1996. As early as 1985, it was recognised that certain forms of trauma (especially prolonged or multi-faceted trauma) lead to specific long-term effects that lay outside those formerly associated with PTSD. For example, based on a study of 17 women (aged 24 - 44) who experienced childhood incest, Lindberg and Disttd (1985) suggested that the long-term effects of incest may be more than those associated with PTSD, with symptoms and symptom onset that closely matched the diagnostic criteria for a severe stress reaction. Lindberg et al. also suggested that there may be other long-term self-destructive behavioural patterns (including substance abuse, suicide or suicide attempts), feelings of worthlessness, isolation, and/or emotional numbing).

Between 1991 and 1992, several investigators specialising in the treatment of trauma-related disorders collaborated on the DSM-IV Post-Traumatic Stress Disorder (PTSD) Field Trial to investigate (among other aspects) alternative versions of the PTSD criterion and potential changes in the minimum required PTSD symptoms. Such researchers suggested that there was a constellation of trauma-related symptoms not addressed by the PTSD diagnosis and questioned the reliability of a structured interview to measure this constellation.
Herman (1992b) discussed the inadequacies of the current diagnostic categories for describing survivors of extreme situations. She claimed,

The persistent anxiety, phobias, and panic or survivors are not the same as ordinary anxiety disorders. The somatic symptoms of survivors are not the same as ordinary psychosomatic disorders. Their depression is not the same as ordinary depression. And the degradation of their identity and relational life is not the same as ordinary personality disorder… The lack of an accurate and comprehensive diagnostic concept has serious consequences for treatment, because the connection between the patient’s present symptoms and the traumatic experience is frequently lost. Attempts to fit the patient into the mould of existing diagnostic constructs generally result, at best, in a partial understanding of the problem and a fragmented approach to treatment. (p. 118)

Herman recommended that it was time for the disorder to have an official, recognised name: “complex post-traumatic syndrome” (p. 119).

Herman (1992a) identified three broad areas of disturbance that, she claimed, transcended simple PTSD. The first was symptomatic, the symptom picture in survivors of prolonged trauma often appearing to be “more complex, diffuse and tenacious” (p. 379) than in simple PTSD. Categories of symptoms that did not readily fall within the classic diagnostic criteria for PTSD were the somatic, dissociative and affective sequelae of prolonged trauma. The second was characterological, survivors of prolonged abuse developing recognisable personality changes, including “deformations of relatedness and identity” (p. 379). The third area involved the survivor’s vulnerability to repeated harm, both self-inflicted and that received by others. Herman (1992a) concluded that there was “unsystematised
but extensive empirical support for the concept of a complex post-traumatic syndrome in survivors of prolonged, repeated victimisation. This previously undefined syndrome may co-exist with simple PTSD, but extends beyond it” (p. 387).

The symptom constellation described by Herman has since been referred to under a variety of names, including Complex PTSD (CP, Herman, 1992a), disorders of extreme stress (DES, DSM-IV classification) and disorders of extreme stress not otherwise specified (DESNOS).

Recognition of Complex PTSD as a Disorder

Herman (1992a) reported that, at the time of writing, complex post-traumatic stress disorder was under consideration for inclusion in the fourth edition of the DSM. The seven criteria for CP are listed in Table 2 on the following page.
### Table 2

**Seven Criteria for Complex PTSD (Herman, 1992a)**

<table>
<thead>
<tr>
<th>Criterion</th>
<th>Symptoms</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>A history of subjection to totalitarian control over a long period (examples include those subjected to totalitarian systems in sexual and domestic life, including survivors of domestic abuse, childhood physical and sexual abuse, or childhood battering).</td>
</tr>
<tr>
<td>2</td>
<td>Alterations in affect regulation (including persistent dysphoria, chronic suicidal pre-occupation, self-injury, explosive or extremely inhibited anger, compulsive or extremely inhibited sexuality).</td>
</tr>
<tr>
<td>3</td>
<td>Alterations in consciousness (including amnesia or hypermnesia for traumatic events, transient dissociative episodes, depersonalization/derealisation, reliving experiences).</td>
</tr>
<tr>
<td>4</td>
<td>Alterations in self-perception (including sense of helplessness or paralysis of initiative, shame and guilt, self-blame, sense of stigma, sense of complete difference from others).</td>
</tr>
<tr>
<td>5</td>
<td>Alterations in perception of perpetrator, including pre-occupation with relationship with perpetrator, unrealistic attribution of total power to the perpetrator, idealization of paradoxical gratitude, sense of special or supernatural relationship, acceptance of belief system or rationalizations of perpetrator.</td>
</tr>
<tr>
<td>6</td>
<td>Alterations in relations with others (including isolation and withdrawal, disruption in intimate relationships, repeated search for rescuer, persistent distrust, repeated failures of self-protection).</td>
</tr>
<tr>
<td>7</td>
<td>Alterations in systems of meaning (loss of sustaining faith, sense of hopelessness and despair).</td>
</tr>
</tbody>
</table>

(Source: Herman, 1992a, p. 121)

Herman (1992a) explained that the complexity and severity of symptoms in adults was related to a number of factors, including prolonged duration and/or repetitiveness, early age of onset, and interpersonal rather than environmental stressors. The working group for DSM-IV chose the designation “disorder of extreme stress not otherwise specified (DES-NOS).” This naming of the syndrome
of complex post-traumatic stress represented a major step toward providing appropriate treatment for those who have been victimized over a long period of time. It must be noted, however, that the DES-NOS designation was not included in the DSM-IV (APA, 1994). By contrast, the ICD-10 (WHO, 1992) does include personality change after traumatic experience (van der Kolk, 1996). Preliminary results from the field trial demonstrate that CP is specific to trauma, since it was rarely found among non-trauma exposed survivors. In addition, CP was typically co-morbid with a PTSD diagnosis.

**Support for the CP Construct**

There is now wide agreement regarding the CP/DES construct, and several studies/writings support the clinical utility of the CP nomenclature: a study of predictors of Complex PTSD in women who were sexually abused as children (Brun, 2002); a study of two female adult survivors of childhood neglect and abuse who met the criteria for Complex PTSD (Korn & Leeds, 2002); a study of CP symptoms among battered women (Pelcovitz & Kaplan, 1995, cited in Roth, Newman, Pelcovitz, van der Kolk, & Mandel, 1997); a treatise on strategies for the comprehensive treatment of simple and complex post-traumatic stress disorder (van der Kolk, van der Hart, & Burbridge, 2003); an outline of short-term treatment of simple and Complex PTSD (Tinnin, Bills, & Gantt, 2003); a study of CP symptoms among combat veterans (Newman, Orsillo, Herman, Niles, & Litz, 1995); and a study of CP symptoms in response to fluoxetine (van der Kolk, Dreyfuss, Michaels, Shera, Berkowitz, Fisler, & Saxe, 1994).
Adequacy of a PTSD Formulation in Understanding the Psychological Problems Reported by Child Abuse Victims

The PTSD formulation appears to be most inadequate in providing an understanding of the problems associated with long-term or repeated abuse, in particular, during childhood. Maynes and Feinauer (1994) refer to these inadequacies in the PTSD formulation when applied to the problems associated with child sexual abuse. Although PTSD provides an organising framework for many of the reactions common to victims of sexual abuse, it is not adequate as it fails to account for all symptoms and all victims of sexual abuse (Finkelhor, 1990). Finkelhor argued that the theoretical basis of PTSD is inconsistent with sexual abuse and that some victims do not show evidence of PTSD symptoms. Such conclusions were at variance with those of Wolfe, Gentil, and Wolfe (1989) who suggested that the impact of child abuse was a variant of PTSD. In their research, Wolfe et al. reported substantial differences on a scale of PTSD items from the Child Behaviour Checklist (CBCL, Achenbach, 1991) between sexually abused girls and the CBCL normative sample, with abused girls showing higher rates of PTSD symptoms.

However, there is much more support for the usefulness and necessity of the CP construct in understanding survivors of long-term abuse and traumatic experiences. For example, Kendall-Tackett, Williams, and Finkelhor (1993) argued for the development of a psychiatric nomenclature that accounted for the complex syndrome resulting from “the multiple dynamics and associated adaptations present in situations of interpersonal exploitation” (p. 177). Their review of 45 studies of child victims of sexual abuse (all participants being 18 years or younger), indicated that sexually abused children had more symptoms than non-abused children, with abuse accounting for 15-45% of the variance, and that the impact of sexual abuse
could manifest itself in a variety of symptomatic and pathological behaviours, rather than one dominant set of symptoms. They concluded that the impact of sexual abuse was very complicated and that the PTSD formulation did not account for all the effects seen. The review undertaken by Kendall-Tackett et al. discussed research that relied on evidence provided by children and young persons, rather than on adults and retrospective reporting, and as such, is an extremely useful document in furthering understanding of those who have suffered long-term abuse. The strength of this review also stems from the breadth of research it draws on, crossing diverse nationalities and age groups.

In another study indicating the utility of the CP nomenclature, van der Kolk, Pelcovitz, Roth, Mandel, McFarlane, and Herman (1996) focused exclusively on the CP symptom clusters of affect regulation, dissociation, and somatization. Results of the study (involving 264 participants) indicated that significantly more of those who had suffered early interpersonal trauma endorsed all three symptom clusters. Specifically, more of those with early interpersonal trauma endorsed items indicating problems with anger modulation, self-destructiveness, suicidal behaviour, dissociative symptoms, and somatisation, as compared with those with later onset interpersonal trauma of other form of trauma. On the basis of the results of this study, van der Kolk (1996) argued that chronic, early trauma (such as sexual or physical abuse) could lead to personality or characterological changes that reached beyond the three primary symptom groups which comprise PTSD (intrusive symptoms, avoidance/numbing and arousal). This study used reliable assessment instruments, was methodologically sound, and drew on a sufficiently large population (both clinical and non-clinical) to enable generalisation. It is a significant
study, drawing attention to the inadequacy of the PTSD formulation for sufferers of long-term abuse as children.

Further support for the utility of the CP construct, and for claims regarding the impact of multi-faceted abuse, was provided in a study by Roth, Newman, Pelcovitz, van der Kolk, and Mandel (1997). Roth et al. concluded that “the constellation of symptoms subsumed under the CP nomenclature is consistent with empirical findings and developmental models regarding the long-term impact of childhood abuse” (p. 540). Their study assessed the risk of developing CP, characterised by dissociation, somatisation, chronic self-destructiveness, problematic cognitive and affective constructions of the self, world and others, and health problems of unknown etiology. It involved 234 participants, (ranging in age from 12 to 75, and with 189 of the sample being women, and 45 men) and indicated that sexually abused women, especially those who had experienced physical abuse, had a higher risk of developing CP than those who had suffered only physical abuse. This study was methodologically sound, involving large numbers from both community and clinical populations and crossing a broad age group. It also used reliable assessment methods, and rigorous analysis. The study is important in highlighting the severe impact of multiple forms of abuse during childhood.

More recently, Putnam (1998) has discussed the degree to which the diagnosis of PTSD inadequately accounted for many important symptoms and behaviours associated with maltreatment and victimisation in children and adults. Hall’s (1999) explanation for the inadequacy of the PTSD formulation is also relevant. Hall noted that PTSD (as described in DSM-IV) “had its origins in the battlefield and best describes the vivid symptomatology seen in adult male soldiers responding to the horrors of war” (p. 52). Hall also claimed that the diagnostic
classification of PTSD “failed to capture the symptomatology reported by adult victims of childhood maltreatment or other interpersonal trauma” (p. 52).

In an attempt to determine the appropriateness of characterising children’s responses to early and repeated traumatic experiences utilising the CP framework, Hall (1999) drew on the records of 100 sexually abused boys and girls (aged three to seven years), who were allotted to one of three groups: full-PTSD, partial PTSD and non-PTSD. These groups were compared on seven CP indices. Hall’s results indicated that children with PTSD exhibited more CP symptoms within a greater number of CP categories than partial or non-PTSD groups. The relationship between cumulative trauma and total number of CP symptoms revealed that as the cumulative number of types of trauma increased, the number of CP symptoms rose. Hall (1999) concluded that the CP framework was highly appropriate in characterising sexually-abused children, especially those who have been multiply maltreated, and offered “a more developmentally-appropriate framework for assessment and treatment than PTSD” (p. 51).

Thus, the CP framework appears to be particularly useful for assessing individuals who have experienced multiple forms of maltreatment, in particular, for those who have experienced child sexual abuse, or child sexual and physical abuse, given that many sufferers of long-term child abuse do not necessarily report the core PTSD symptoms, yet exhibit a range of other symptoms.

**Studies Describing Symptoms Observed Among Survivors of Child Abuse: Are The Symptoms Described Covered by the PTSD Formulation?**

In determining psychological symptoms, researchers have focused on the areas of psychological problems (including depression, impaired self reference, difficulties in effective interpersonal relationships, dissociation), inappropriate
sexual behaviour and health problems of unknown etiology. Their research is reported on the following pages.

**Psychological Problems**

*General.* The psychological and emotional responses expected of those who have been traumatically abused as children have been identified by numerous researchers (Baynard, Williams, & Siegel, 2001; Briere & Runtz, 1988; Haj-Yahia, 2001; Higgins & McCabe, 2000; Mannarino & Cohen, 1986; Molnar, Buka, & Kessler, 2001; Nixon, Resick, & Griffin, 2004; Trocki, 2003). These responses include re-experiencing, avoidance and arousal (primary responses, cited in DSM-IV), and depression, aggression toward self and others, poor affect regulation/panic attacks, decreased self-esteem, disturbances in identity, difficulties in interpersonal relationships, guilt and shame (secondary and associated responses, not noted in DSM-IV PTSD diagnosis).

*Symptoms of depression: self-harm and suicide ideation.* Childhood psychological abuse has been shown to be significantly related to adult depression and lifetime suicidal behaviour, as well as to all other forms of abuse (Bifulco, Moran, Baines, Bunn, & Stanford, 2002). The results of this study support earlier research suggesting an association between childhood abuse and later self-destructive behaviour. Boudewyn and Liem (1995) described retrospective self-reported depression and self-destructive behaviour in adults (173 college men and 265 women) who had been victims of childhood sexual abuse. The researchers found that childhood sexual abuse was a consistently significant predictor of depression, chronic self-destructiveness, self-harm ideation, acts of self-harm, suicide ideation, and suicide attempts for both men and women. The more frequent and severe the sexual abuse, and the longer its duration, the more depression and self-
destructiveness was reported in adulthood. For this population, the CP construct provides a more useful framework than the PTSD framework, for assessing individuals who report difficulties in affect regulation. The PTSD framework, while allowing for the assessment of some symptoms of depression, does not cover all symptoms of depression, in particular, self harm/suicidal ideation or attempts. The CP construct ("alterations in affect regulation, including persistent dysphoria, chronic suicidal pre-occupation, self injury…", Herman, 1992a) more adequately covers this.

Symptoms of impaired self identity/self reference. Long-term, multiple traumatic experiences may have a profound impact on self-regulation, self-definition, interpersonal functioning, and adaptational style (Pelcovitz, van der Kolk, Roth, Mandel, Kaplan, & Resick, 1997). One form of child abuse, incest, has its unique negative effects in the domains of self and social functioning (Cole & Putman, 1992):

We regard the specific effects of the pervasive, sustained stress of incest to be most pronounced in domains of self-development, specifically in terms of the physical and physiological self integrity, and the development of self-regulatory processes, particularly regulation of affect and impulse control.

(p. 175)

Cole and Putman also reported that the development of self is integrally related to social development and a sense of others, and that sexual abuse by a parent violates the child’s basic beliefs about trust and safety in relationships, disturbing the ability to have satisfying relationships in which one feels loved and protected. Problematic affective and cognitive constructions of the self, world and others among incest survivors have also been reported (Roth and Newman, 1991). Roth and Newman
claimed that sexual trauma confronted individuals with emotional reactions (such as rage, helplessness, fear, loss, shame, guilt and some of a diffuse nature – pain, discomfort and hurt) and challenged their systems of meanings (e.g., self blame, challenges to the ability to trust). Tong, Oates, and McDowell (1987) found that young persons (37 girls and 12 boys) who had been sexually abused displayed reduced confidence, with aggressive behaviour, difficulty with friendships and poor school performance. When compared with control children, the sexually abused children were lower in self-esteem and had a significantly greater number of personality profiles in the clinical range on the Child Behaviour Checklist (parents), Teachers’ Report Form and self- report (Achenbach, 1991). Tong et al.’s study suggests that this group of children have persisting problems with their behaviour, the way they are perceived by others, and the way they feel about themselves. If untreated, these may persist until adult years. Steele (1986) also reported on psychological residues of early childhood abuse. In his paper, he discussed the persistence for many years of low self-esteem, problems with identity, and a significant sensitivity or vulnerability to crises of all sorts. On the whole, the PTSD diagnosis does not cover symptoms related to self and self perception, as does the CP construct (“alterations in self perception” and “alterations in systems of Meaning”). Such “alterations” are, as the above studies indicate, a common outcome of child sexual abuse, and thus, the CP construct is a more appropriate framework for use with those who have suffered from long-term child abuse, and whose self-perception has been eroded.

Symptoms of impaired interpersonal relationships. Women survivors of childhood sexual abuse often experience difficulties in parenting, as well as difficulties in the mother-child relationship (Hooper & Koprowski, 2004). Child
maltreatment has also been associated with a reduced interpersonal sense of empowerment, and self-report of lower levels of community connections, even after controlling for the effects of negative family of origin and environment (Banyard & LaPlant, 2002). Trauma has also been reported to affect attachment behaviour and interpersonal relationships (McFarlane & Bookless, 2001). In this study, McFarlane et al. claimed that the traumatic experience can become embedded in the memory structure of the individual, causing a progressive avoidance of interpersonal triggers. They further claimed that the traumatic experience may also have detrimental effects on self-awareness, intimacy, sexuality and communication, all key elements in healthy interpersonal relationships. These psychological sequelae are not well-defined by PTSD, but have been noted frequently among treatment-seeking trauma survivors. In a review of studies focusing on attachment theory and maltreated samples, Cole-Detke and Kobak (1998) also reported that there is a link between maltreatment/multiple abuse experiences and difficulties in interpersonal relationships. Their review lead them to conclude that that the experience of abuse leaves victims vulnerable to lapses in organised behaviour, lapses that may include violent or frightening experiences that disrupt close interpersonal relationships. This review was based on numerous studies, and the conclusions drawn from it appear well founded. As with other psychological dimensions, the PTSD construct does not incorporate difficulties with interpersonal relationships, which are a frequently identified correlate of long-term childhood maltreatment/abuse. This is more adequately covered in the CP construct under “alterations in interpersonal relations”.

**Symptoms of dissociation.** Several researchers have examined the relationship between dissociative symptoms in adulthood and a history of physical or sexual abuse. Chu and Dill (1990) studied a female inpatient population to determine
whether a history of physical or sexual abuse was associated with dissociative symptoms. They found that early physical abuse and early sexual abuse each independently predicted dissociative symptoms in adulthood, and that dissociative symptoms were particularly severe in patients with histories of both physical and sexual abuse. In another study within a clinical population of 47 hospitalised adolescents, Sanders and Giolas (1991) found that dissociation was positively and significantly correlated with self-reported histories of physical and sexual abuse in childhood. Despite some limitations (small numbers, based purely on a clinical population) the studies by Chu et al. and Sanders et al. both indicate a strong association between dissociative symptoms and childhood abuse experiences. Other authors (Higgins & McCabe, 1994 & 2000) have shown that childhood sexual abuse (CSA) victims have higher levels of dissociation than non-CSA individuals.

Dissociative symptoms are more adequately covered by the CP construct (“alternations in consciousness”, including transient dissociative episodes, depersonalization/derealisation) than by the PTSD construct – which has historically excluded dissociation officially from its criteria.

**Difficulties with Sexual Functioning**

Several recent studies indicate a strong negative relationship between childhood sexual abuse and adult sexual functioning. Cobia, Sobansky, and Ingram (2004) reported that couples where one partner is a survivor of childhood sexual abuse are at increased risk for a variety of relationship problems that accompany or result in unsatisfying or dysfunctional sexual relationships. This study provided some strong indicators of potential difficulties for couples, where one partner has survived childhood sexual abuse.
Other research has indicated that the more types of childhood maltreatment to which an individual had been exposed, the more likely they were to have problems with risky sexual behaviours and substance abuse in adulthood (Rodgers, Lang, Laffaye, Satz, Dresselhaus, & Stein, 2004). Rodger et al’s study involved a large number of females (n = 221), and although these were drawn from a purely clinical setting, the study used reliable measures and sound methodology, and as such, has provided reliable and useful information regarding the effect of multiple forms of maltreatment on later sexual adjustment.

In a study involving 362 middle-aged women, Dennerstein, Guthrie, and Alford (2004) concluded that the major impact of childhood sexual abuse was on the quality of relationship, with feelings for partner being significantly affected. Women who had experienced penetrative childhood sexual abuse had, on average, shorter current relationships. However, women who had experienced both childhood physical and sexual abuse reported a lower frequency of sexual activities. As this study involved large numbers of women, across a range of socio-economic groups, the results have important implications when considering treatment programs for adult survivors of childhood sexual abuse.

Other studies indicate that survivors of child sexual assault often exhibit inappropriate sexual behaviour. Gray, Pithers, Busconi, & Houchens (1999) concluded that developmentally unexpected sexual behaviours were often the result of having been abused, physically and sexually. Their study involved teacher, caregiver, and self-report questionnaires concerning 127 six to twelve-year old children who had engaged in developmentally unexpected sexual behaviours. Gray et al. (1999) found that more than half of the children engaging in developmentally unexpected sexual behaviours had been abused both physically and sexually by two
different perpetrators. These children had acted out against an average of two other children, and high levels of distress were evident across a number of psychometric and historical variables. Gray et al. concluded that children with sexual behavioural problems commonly exhibited a number of functional impairments commonly associated with maltreatment. The results of this study appear reliable, as the children’s behaviours were assessed across settings, and using a comprehensive battery of psychometric devices as well as a structured interview.

Kendall-Tackett, Williams, and Finkelhor (1993) noted that inappropriate sexualised behaviours were common in pre-school children, remitted during adolescence, but then re-emerged. This is in accordance with the views of Widom (1995), cited in Gray et al. (1999), who concluded that “people victimised by sexual abuse as children are also significantly more likely (4.7 times) than non-victims to be arrested for a sex crime” (p. 6). In a sample of 87 hospitalised children (41 females and 46 males), ranging in age from 3 to 13 years old, Deblinger, McLeer, Atkins, Ralphe, and Foa (1989) found that significantly higher rates of inappropriate sexual behaviours and more avoidant/dissociative symptoms were present in sexually-abused children when compared with physically- and non-abused children. However, interpretation of the data of this study may be limited, as the data were based on a retrospective chart review. Further, the findings of this study may be specific to psychiatrically hospitalised children and thus may not be generalisable to all child abuse sufferers.

In a comparison of behavioural and emotional indicators of child sexual abuse in 103 sexually-abused and physically-abused children, Kolko, Moser, and Weldy (1988) found that sexually abused children exhibited greater sexual behaviour, fear/mistrust/anxiety, and withdrawal at home, and greater sexual
behaviour, fear, anxiety, and sadness in the hospital, than non-abused children. In contrast, there was no significant difference between physically abused and non-abused children. In interpreting the data of this study, caution must be exercised, however, as certain categories (for example sexual abuse only) yielded small cell sizes, and this may have lead to unstable results. Further, as the study was based on hospitalised children, it is not clear whether the results are applicable to abused children who are not hospitalised.

Other studies have examined the long-term effects of childhood abuse on sexual behaviour. In an examination of the long-term correlates of sexual abuse in college men, Fromuth and Burkhart (1989) found that those men who were sexually abused were only slightly less well-adjusted than the non-abused men. Very few significant correlations emerged between a history of sexual abuse and later sexual adjustment and behaviour. It must also be noted, however, that the definition of sexual abuse for this study was broad, and included contact and non-contact experiences. Further, in this study, the majority of the perpetrators of abuse were female, and the abuse experience did not appear to be perceived negatively by the men in the study. Although this study drew on a large sample ($n = 582$), the generalisability of the results is limited by the use of a purely college sample. Additionally, the young age of the sample may have masked those sexual adjustment difficulties that emerge later in life. It would thus be inappropriate to extend these findings to all male victims of abuse. The findings are also at variance with earlier results of Fromuth (1986), who in exploring the relationship of childhood sexual abuse and later psychological and sexual adjustment in 383 female college students, reported a number of small, but significant, relationships between a history of childhood sexual abuse and measures of later psychological and sexual adjustment.
Again, however, interpretation must be cautious, as generalisability is limited to a college population.

Although there is some disagreement between researchers in this area, there appears sufficient evidence to indicate that those who have suffered long-term child abuse experience some difficulties in terms of later sexual behaviour. As with other psychological dimensions, the PTSD construct does not incorporate sexual dysfunction or sexually inappropriate behaviours, which are a frequently identified correlate of child sexual abuse. This is more adequately covered in the CP construct under “Alterations in Affect Regulation”, which includes compulsive or extremely inhibited sexuality.

**Health Problems of Unknown Etiology**

Numerous studies have been undertaken to determine the impact of child maltreatment on later health. Available retrospective and longitudinal data suggest that child maltreatment appears to have an indirect effect on women’s physical and mental health by increasing the risk for victimisation, which in turn, has a direct negative impact on health (Arias, 2004). A history of childhood abuse has also been related to increased neuroendocrine stress reactivity, which is further enhanced when additional trauma is experienced in adulthood (Helm, Newport, Wagner, Wilcox, Miller, and Nemeroff, 2002). Helm et al’s study involved 49 women who had experienced childhood abuse, and although this study was based on relatively small numbers, it used reliable measures, involved a control group, and was in other ways methodologically sound. As such, it provided some support for other research indicating a relationship between adult health problems and long-term child maltreatment.
Van Ommeren, Sharma, Sharma, Ivan, Cardena, and de Jong (2002) reported a strong relationship between somatic and PTSD symptoms (independent of depression and anxiety symptoms) in a random, community sample of 526 tortured and 526 non-tortured Bhutanese refugees living in United Nations refugee camps in Nepal. As this interview-based study involved such large numbers, it provides some strong support for the relationship between trauma experiences and health concerns.

Leserman, Drossman, Li, Toomey, Nachman, and Glogau (1996) concluded that health problems of unknown etiology have been associated with incest survivors. Their study included 239 female patients from a gastroenterology clinic who were interviewed to assess sexual and physical abuse history. Leserman et al. found that 66.5% of patients experienced some type of sexual and/or physical abuse; that women with sexual abuse history had more pain, non gastro-intestinal somatic symptoms, days in bed, lifetime surgeries, psychological distress, and functional disability, compared to those without sexual abuse; that women with physical abuse also had worse health outcome on most health status indicators; that rape (intercourse) and life-threatening physical abuse seem to have worse health effects than either less serious physical violence or sexual abuse involving attempts and touch; and that those with first abuse in childhood did not appear to differ in health from those whose first abuse was as an adult. The findings of Leserman et al. supported earlier findings with gastroenterology patients.

Walker, Gelfand, Gelfand, Koss, and Katon (1995) classified a sample of 89 gastroenterology patients by severity of sexual trauma and studied differences in lifetime psychiatric diagnoses, physical abuse, and medically unexplained symptom patterns. Compared with women who had experienced less severe or no prior sexual trauma, the gastroenterology patients with severe sexual victimisation had
significantly higher lifetime and current rates of several selected psychiatric
disorders (major depression, dysthymic disorder, somatisation disorder, generalised
anxiety disorder, obsessive-compulsive disorder, as well as alcohol abuse and adult
physical assault). They also had a significantly higher mean number of psychiatric
disorders, medically unexplained physical and anxiety symptoms, greater harm
avoidance and dissociation scores, and increased functional disability. Several
limitations need to be taken into consideration when evaluating these data, however.
Firstly, the participants were sampled from a tertiary care medical centre, which
tends to over-represent patients with psychopathology. Thus the prevalence rates of
lifetime psychiatric disorders, sexual victimisation and levels of functional disability
and dissociation, may limit the generalisability to tertiary care samples only.

An earlier study by Rimsza, Berg, and Locke (1988) found symptoms similar
to the “rape trauma syndrome” (Burgess & Holstrom, 1974) in 48 of the 72 female
sexual abuse victims (2-17 years), and only 26 of the matched control group.
Common somatic complaints in the sexual abuse patients included dysuria,
gastrointestinal problems, skeletal muscular tension, vaginal discharge and chronic
abdominal pain. Some of the emotional and behavioural problems noted during the
follow-up period among the sexual abuse patients included depression, fearfulness,
sleep problems, oppositional behaviour, runaway behaviour and suicide attempts.

Neither the PTSD construct nor the CP construct adequately covers health-
related symptoms. However, it is important that clinicians are careful when patients
present with such symptoms, as these may be important indicators of a trauma
history.
Usefulness of CP Framework

As the above research indicates, survivors of long-term child abuse present with a constellation of symptoms that are certainly more complex and diffuse than those seen in patients with PTSD: symptoms of a psychological (in particular, affective), sexual, and somatic nature. Such symptomatology falls outside the boundaries of the symptoms covered by the PTSD diagnosis.

The CP construct (see p. 20) is thus more useful in providing a framework for such symptomatology. The criteria presented by Herman (1992a) for PTSD refer to individuals who have experienced a history of subjection to “totalitarian” systems (for example, survivors of child abuse) over a long period. The CP construct also includes alterations in affect regulation (which can include compulsive or inhibited sexuality, self-harming behaviour, aggression, and depression), disregulation or disturbance to self concept, alterations in interpersonal relationships, inappropriate sexual behaviour, and dissociation, all of which are prominent in survivors of long-term child abuse. Such symptoms are not essential features of PTSD, according to DSM-IV criteria.

There is also a particularly strong association between CP and multi-type maltreatment. Roth, Newman, Pelcovitz, van der Kolk, and Mandel (1997) concluded that “sexual abuse, particularly when in combination with physical abuse, “appears to be a greater risk [for CP] than physical abuse alone” (p. 549). They explained that both physical and sexual abuse shared several characteristics that could increase the likelihood of problems with self-regulation, self-definition, interpersonal functioning, and adaptational style “consistent with CP nomenclature”. Roth et al. suggested that their conclusions could result from either the doubly harmful impact of two forms of abuse on an individual or the relative greater
chronicity of sexual and physical abuse compared to sexual abuse alone or physical abuse alone. Higgins and McCabe (2000) also reported that, “multi-type maltreatment was associated with significantly higher levels of trauma symptomatology [for example depression, dissociation, anxiety, sexual problems, sleep problems] and self-depreciation than single-type maltreatment” (p. 8). Such problems are more consistent with the CP construct.

However, it is important to recognise that the PTSD construct provides the clinician with a useful basis for assessing and treating any individual who has experienced trauma, as it allows for assessment according to the criteria outlined in DSM-IV for PTSD. More specifically, it allows for assessment to be made of an individual not only in regard to the nature of the trauma experienced, and the overall degree of disturbance for the individual, but also in regard to the presence of persistent re-experiencing of the traumatic event, avoidant behaviours, and increased arousal.

As van der Kolk (1996) has indicated, this classification is restrictive, and is not necessarily appropriate for certain forms of trauma (such as prolonged trauma, or multiple forms of trauma), as such trauma may lead to specific effects which lay outside those formerly associated with PTSD. Such effects include alterations in affect regulation, consciousness, self-perception, interpersonal relationships, and in systems of meaning. It is important that assessment procedures used with sufferers of prolonged, or multiple forms of, trauma take account of these additional “special effects” – and enable therapists to identify more easily Complex Post-Traumatic Stress Disorder.
Measurement of Complex PTSD

This section involves an examination of currently available PTSD measurement instruments, and an evaluation of their application and suitability in measuring symptoms CP. Two broad approaches are adopted for measuring PTSD: structured interview techniques and self-report measures. Within each of these approaches, the focus may differ, with some measures focussing on the traumatic experiences themselves, others on the trauma responses, and yet others incorporating an assessment of both the traumatic experience and the response.

Structured Clinical Interviews

A structured clinical interview is “a formalised interview process that has internally logical or consistent rules that govern the content of questions asked of an interviewee, the order in which the topics are covered, and the specific kinds of information sought” (Weiss, 1997, p. 494). Structured clinical interviews are intended for administration by individuals with clinical training and experience. There are a variety of structured interviews that can be used in the PTSD diagnostic process. Most are focused solely on PTSD, although several have broader application: Structured Interview for PTSD (Davidson, Smith, & Kudler, 1989); The PTSD Interview (PTSD-I, Watson, Juba, Manifold, Kucala, & Anderson, 1991); and Clinician-Administered PTSD Scale (CAPS-I, Blake et al., 1995).

Using a structured clinical interview enables a clinician to have high quality, reliable information. At the same time, it does not prevent interviewees from presenting their story in their own words, a very important aspect of working with sufferers of post-traumatic stress. The structured clinical interview also ensures thorough examination of the complete set of signs and symptoms of PTSD. However, structured interviews do not easily accommodate indices of severity and/or
duration of signs and symptoms. Although most clinicians would consider that the use of a structured interview is essential, criticisms have been made of assessments that rely too heavily on an interview. Keane, Wolfe, and Taylor (1987) reflect this view:

> Most professionals agree that for diagnostic purposes, the skilfully administered clinical interview remains the gold standard by which we must judge all methods of diagnosis. Yet problems of diagnostic reliability and validity exist when the clinician places exclusive reliance upon the clinical interview. (p. 4)

These researchers, therefore, recommend a multi-axial approach for the assessment of PTSD. This approach includes the use of structured interview, psychometrics, and a psychophysiological assessment procedure.

A major difficulty in measuring PTSD is that the diagnostic criteria are being continually modified. This occurred between 1980 and 1987, with the conversion from DSM-III to DSM-III-R, and again between 1987 and 1994, with the conversion to DSM-IV. Thus research relating to particular structured interview techniques always seems to be a little behind such modifications. However, the choice of which interview to use should be dictated by the goals and circumstances under which an assessment is being conducted. Personal preference, administration time available, training/expertise of the clinician, and research evidence will all influence which schedule will be administered. However, for additional precision, all clinical assessment should include the use of one of the available structured clinical interviews.

In the assessment of Complex PTSD, it is important to determine whether a patient satisfies those criteria that Herman (1992a) claimed were present in sufferers
of CP: a history of subjection to “totalitarian control over a long period”; alterations
in affect regulation, alterations in consciousness, alterations in self-perception;
alterations in perception of the perpetrator; alterations in relations with others;
alterations in systems of meaning. To date, the only structured interview that
attempts to do this in a systematic manner is the Structured Interview for Disorder of
Extreme Stress (SIDES-SR, van der Kolk, 1996). The SIDES is a 48-item
questionnaire which asks patients to describe their past and current functioning on
seven dimensions: disorders of affect regulation, amnesia and dissociation,
somatization, disorders of self, disorders in relationships to abusers, disorders in
relationships to others, and disorders of meaning. Thus, it assesses for the DSM-IV
Associated Features of PTSD. In the DSM-IV Field trials, in which it was used, the
Interview version of the SIDES demonstrated good inter-rater reliability, internal
consistency and construct validity (Pelcovitz et al., 1996; van der Kolk et al., 1996).
This interview is particularly useful in the assessment of Complex Post-Traumatic
Stress as it seeks information on the presence of those symptoms that Herman
(1992a) explained were associated Complex Post-Traumatic Stress Disorder.

**Self-Report Measures**

There are several generic self-report measures of psychopathology that are
often applied to PTSD sufferers, despite their lack of focus on the effects of trauma.
In using such tests, an assessor must be mindful of the fact that the data derived from
such tests have the potential to under-assess or distort symptoms, although it can also
be valid and useful. Space does not permit a detailed report on these assessment
tools. However, the following have been found to be useful by clinicians to provide
general information about a patient’s psychological status: Personality Assessment
Inventory (PAI, Morey, 1991); MMPI (Butcher, Dahlstrom, Graham, Tellegen, & Kaemmer, 1989); The MCMI-I (Millon, 1983) and the MCMI-II (Millon, 1987).

Important and useful information may be gained from measures such as those listed above. Such measures have been fully standardised, and now often include PTSD-specific scales and scoring systems. They also allow for the assessment of a wide range of symptoms, many of which are relevant to abuse survivors. However, such instruments may misinterpret trauma or abuse-related symptomatology as evidence of other disorders. Such misinterpretation can arise from a number of factors: the pervasiveness of trauma-related symptoms, many of which may relate to several other psychological disturbances; the potential for PTSD symptomatology to be tapped by measures of psychosis and personality disorder; and the fact that most of these generic measures were developed without reference to post-traumatic phenomena – and thus, may not be sensitive to abuse-related distress (Wilson & Keane, 1997). The inclusion of trauma scales on the MMPI-2 and MCMI-III (Millon, 1994) provides, however, some more reliable mode of assessing trauma.

A number of other self-report measures have been developed to assess more specifically the traumatic event itself and also specific symptoms of trauma. Self-report measures often perform the function of allowing for a brief screen of experiences and/or responses. They may also provide supporting or additional information, as well as information on symptom severity, often not obtained via clinical interview.
Measures of PTSD Experiences and Symptoms: Appropriateness with CP Experiences and Symptoms?

On the following pages, a selection of structured clinical interview schedules and self-report measures, used in measuring PTSD experiences and symptoms, will be described.

Measures of Traumatic Experiences (i.e. DSM-IV Diagnostic Criterion A)

Diagnostic Criterion A requires that the person has been exposed to a traumatic event in which both of the following were present: the person experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others; the person's response involved intense fear, helplessness, or horror. The following are examples of measures that assess for Criterion A: Traumatic Stress Schedule (TSS – Norris, 1990); Traumatic Events Questionnaire (TEQ – Vrana & Lauterbach, 1994); Trauma History Questionnaire (THQ, Green, 1995); Traumatic Life Events Questionnaire (TLEQ - Kubany, 1995); and Childhood Trauma Interview (CTI – Fink, Bernstein, Handelsman, Foote, & Lovejoy, 1995). While some of these measures (THQ, TEQ, TLEQ) are self-report measures, others (TSS, CTI) are based on an interview schedule. With the exception of the Childhood Trauma Inventory, these scales screen for the occurrence of potentially traumatic events more broadly, rather than the experiences of specific trauma populations. A comparison of some components of these measures is seen in Table 3 on the following page.
Table 3.

Comparison of Tests for Assessing Criterion A-1 (PTSD)

<table>
<thead>
<tr>
<th>Test</th>
<th>Recommended Use</th>
<th>Time to Administer</th>
<th>No. of Event Items</th>
<th>Additional Probes</th>
<th>Evidence of Stability</th>
<th>Test Format</th>
</tr>
</thead>
<tbody>
<tr>
<td>TSS</td>
<td>Brief Screening.</td>
<td>5-30 mins.</td>
<td>10</td>
<td>Yes</td>
<td>T-R (Eng.-Span.) $r = .88$</td>
<td>Interview.</td>
</tr>
<tr>
<td>CTI</td>
<td>Comprehensive Assessment.</td>
<td>20-40 mins.</td>
<td>49</td>
<td>Yes</td>
<td>T-R $r = .73 - 1.0$</td>
<td>Interview.</td>
</tr>
<tr>
<td>TEQ</td>
<td>Brief Screening.</td>
<td>5-30 mins.</td>
<td>11</td>
<td>Yes</td>
<td>T-R $r = .91$</td>
<td>Self Report.</td>
</tr>
<tr>
<td>THQ</td>
<td>Comprehensive Screening.</td>
<td>10-30- mins.</td>
<td>24</td>
<td>Yes</td>
<td>T-R $r = .54 -.92$</td>
<td>Self Report.</td>
</tr>
<tr>
<td>TLEQ</td>
<td>Comprehensive Screening.</td>
<td>10-30 mins.</td>
<td>17</td>
<td>Yes</td>
<td>na</td>
<td>Self Report.</td>
</tr>
</tbody>
</table>

T-R = Test – Re-test;
$r = $ correlation co-efficient (Pearson’s).
Note, n/a = data not available.
In summary, each of the above measures asks about the occurrence of certain events, and probes affirmative responses for more detail. All scales probe for subjective experiences of life threat and/or injury following any affirmative response. All reviewed scales also use the use of “catch-all” events, providing the respondent with an opportunity to report on events important to her/him, although the content of these events needs to be examined carefully. However, the scales serve different purposes: the TSS is a brief screen for traumatic stress, whereas the THQ and TLEQ aim to provide comprehensive trauma histories. Each scale measures different events, reflecting differences in the definitional boundaries of the relevant events. The TSS has the most restricted definition; THQ has the broadest. The measures also differ in regard to their attention to sexual trauma, with the TSS the least detailed.

Perhaps the most useful of these scales in assessment of past traumatic events for sufferers of CP would be the THQ and the CTI, the THQ because of the broadness of their scope, which would allow the clinician to obtain information about multiple trauma experiences, which may have lead to CP symptoms; the CTI because it assesses experiences that have been found to be associated with Complex PTSD symptoms.

Measures of Trauma Responses (DSM-IV Criteria B: Intrusion, Avoidance and Arousal)

There are many scales that aim to measure symptomatic criteria for PTSD or very closely related constructs. To satisfy DSM-IV criteria for PTSD, the person must show at least one intrusion symptom, three avoidance symptoms, and two arousal symptoms. The following are some of the more well-known scales used to
measure symptomatic criteria for PTSD: Reaction Index (RI - Fredrick, 1985, revised 1987); National Women’s Study PTSD Module – (NWS) PTSD Module (Kilpatrick, Resnick, Saunders, & Best, 1989); PTSD Symptom Scale and Modified PTSD Symptom Scale (PSS – SR, Foa, Riggs, Dancu, & Rothbaum, 1993); The Modified PTSD Symptom Scale - MPSS-SR (Falsetti, Resnick, Resick, & Kilpatrick, 1993); Impact of Events Scale (IES, Horowitz, Wilner, & Alvarez, 1979); IES-Revised (Marmar, Weiss, Metzler, Ronfeldt, & Foreman, 1996; Weiss, Marmar, Metzler, & Ronfeldt, 1995); Trauma Symptom Checklist-40 (TSC, Briere & Runtz, 1989); The Trauma Symptom Inventory (TSI, Briere, 1995); Purdue-PTSD Scale – Revised (Lauterbach & Vrana, 1996); Civilian Mississippi Scale (Keane, Caddell & Taylor, 1988); The Revised Civilian Mississippi Scale (Norris & Perilla, 1996); Penn Inventory for PTSD (Hammarberg, 1992); MMPI-PTSD (PK) Scale (Keane, Malloy, & Fairbank,1984); Symptom Checklist 90 PTSD Scales; SCL-PTSD (Saunders, Arata, & Kilpatrick, 1990); SCL-Supplemented PTSD (Ursano, Fullerton, Kao, & Bhariya, 1995); Harvard Trauma Questionnaire (HTQ, Mollica et al., 1992).

A comparison of some components of the above scales is provided in Table 4 (pp.47-48). An examination of the summary details provided in the table indicates that the scales provide a wide range of choices for measuring post-traumatic stress responses. Some scales adhere closely to DSM-IV criteria; others are broader in their focus. Some are short; others are long. Some take advantage of available clinical data; most require additional assessment materials. With a few exceptions, all of the scales listed above show acceptable reliability and validity, although some researchers have provided more detail regarding their psychometric properties.

In terms of the suitability of the above measures for assessing CP, most of the tests, if used alone, would be inadequate in providing an assessment of CP. This is
because most adhere very strictly to assessment of the core PTSD criteria (as described in DSM-IV). Few assess for symptoms that fall outside this diagnosis, such as those identified by Herman (1992a) for CP.
Table 4

<table>
<thead>
<tr>
<th>Test</th>
<th>Number of Items</th>
<th>Evidence of Stability</th>
<th>Evidence of Internal Consistency</th>
<th>Validity</th>
<th>Data Provided</th>
<th>Suitability for Measuring CP Symptoms</th>
</tr>
</thead>
<tbody>
<tr>
<td>RI</td>
<td>20</td>
<td>Interrater</td>
<td>Moderate</td>
<td>Core PTSD symptoms, onset, duration, symptom severity.</td>
<td>Limited Use: PTSD symptoms only.</td>
<td></td>
</tr>
<tr>
<td>NWS (PTSD Module)</td>
<td>20</td>
<td>T-R</td>
<td>Strong</td>
<td>Core PTSD symptoms, period of symptomatology.</td>
<td>Limited Use: PTSD symptoms only.</td>
<td></td>
</tr>
<tr>
<td>PSS-SR</td>
<td>17</td>
<td>T-R</td>
<td>.85-.91</td>
<td>Core PTSD symptoms, symptom severity, impairment of functioning.</td>
<td>Limited Use: PTSD symptoms only.</td>
<td></td>
</tr>
<tr>
<td>MPSS-SR</td>
<td>34</td>
<td>.96</td>
<td>Only for Females - Good</td>
<td>Core PTSD symptoms, symptom severity, impairment of functioning, frequency of symptoms.</td>
<td>Limited Use: PTSD symptoms only.</td>
<td></td>
</tr>
<tr>
<td>IES</td>
<td>15</td>
<td>T-R</td>
<td>.79-.92</td>
<td>B and C criteria of PTSD – for previous 7 days, symptom frequency.</td>
<td>Limited Use – PTSD symptoms only.</td>
<td></td>
</tr>
<tr>
<td>IES-Revised</td>
<td>22</td>
<td>T-R</td>
<td>High internal consistency</td>
<td>B, C and D criteria of PTSD.</td>
<td>Limited Use: PTSD symptoms only.</td>
<td></td>
</tr>
<tr>
<td>Purdue PTSD Scale</td>
<td>17</td>
<td>T-R</td>
<td>.91</td>
<td>Core PTSD criteria.</td>
<td>Limited Use: PTSD symptoms only.</td>
<td></td>
</tr>
<tr>
<td>CMS</td>
<td>35</td>
<td></td>
<td>.86</td>
<td>Core PTSD symptoms.</td>
<td>Limited Use: PTSD symptoms only.</td>
<td></td>
</tr>
</tbody>
</table>
**Table 4 (continued).**

**Comparison of Tests for Assessing Criterion B-D (PTSD)**

<table>
<thead>
<tr>
<th>Test</th>
<th>Number of Items</th>
<th>Evidence of Stability</th>
<th>Evidence of Consistency</th>
<th>Validity</th>
<th>Data Provided</th>
<th>Suitability for Measuring CP Symptoms</th>
</tr>
</thead>
<tbody>
<tr>
<td>Revised CMS</td>
<td>30</td>
<td>T-R</td>
<td>.86 - .92</td>
<td>Moderate</td>
<td>Core PTSD symptoms.</td>
<td>Limited Use: PTSD symptoms only.</td>
</tr>
<tr>
<td>Penn Inventory</td>
<td>26</td>
<td>T-R</td>
<td>.94</td>
<td>Moderate-Strong</td>
<td>Feelings associated with symptoms.</td>
<td>Limited Use: PTSD symptoms only.</td>
</tr>
<tr>
<td>MMPI-PTSD (PK)</td>
<td>46</td>
<td>T-R</td>
<td>.95</td>
<td>Strong</td>
<td>Some core PTSD symptoms only.</td>
<td>Limited Use: PTSD symptoms only</td>
</tr>
<tr>
<td>SCL-PTSD</td>
<td>28</td>
<td></td>
<td>.93</td>
<td>Moderate</td>
<td>Some core PTSD symptoms, other symptoms not part of PTSD sub-scale:</td>
<td>Possibilities for use.</td>
</tr>
<tr>
<td>SCL-Supplemented PTSD</td>
<td>43</td>
<td></td>
<td></td>
<td>Moderate</td>
<td>Core PTSD symptoms, other symptoms – not part of PTSD sub-scale.</td>
<td>Possibilities for use, but unlikely to be used, given development of more appropriate tests available.</td>
</tr>
<tr>
<td>TSC-40</td>
<td>40</td>
<td></td>
<td>.90 - .92</td>
<td>Moderate</td>
<td>Core PTSD Symptoms, some other symptoms.</td>
<td>Possibilities for use, but unlikely to be used, given development of more appropriate tests available.</td>
</tr>
<tr>
<td>TSI</td>
<td>100</td>
<td>Int. consistency</td>
<td>.74 - .90</td>
<td>Moderate-Strong</td>
<td>Core PTSD symptoms. Other symptoms (e.g impaired self reference, dysfunctional sexual behaviour).</td>
<td>Possibilities for use, but unlikely to be used, given development of more appropriate tests available.</td>
</tr>
<tr>
<td>HTQ</td>
<td>16+14</td>
<td>T-R</td>
<td>.96</td>
<td>Moderate-Strong</td>
<td>Stressors experienced PTSD core symptoms, other symptoms of distress.</td>
<td>Has been developed specifically for use with refugees – may not be sensitive to symptoms in other populations.</td>
</tr>
</tbody>
</table>

\( r = \) correlation co-efficient; \( \alpha = \) Cronbach’s alpha
Measures of Childhood Maltreatment Experiences and Responses

There are numerous concerns facing the clinician who assesses adult survivors of child abuse: the relative accuracy of the client’s retrospective abuse report, and the possibility of “false memories” of abuse; the systematic assessment of the specific details of the victimization experience, including its type (i.e. sexual, physical, psychological), frequency, duration, the victim’s age at onset of abuse; and the accurate assessment of the specific nature and extent of any abuse-related symptomatology or dysfunction that might be present.

Debates regarding the issue of the validity of truthfulness of a given abuse report are common. Dube, Williamson, Thompson, Felitti, and Anda (2004), after undertaking The Adverse Childhood Experiences (ACE) Study, a large epidemiological study using data from 658 participants, concluded that retrospective responses to childhood abuse and related forms of serious household dysfunction are generally stable over time. Further, Kendall-Tackett and Becker-Blease (2004), although claiming that prospective studies provide a number of advantages over retrospective designs, indicate that the findings from retrospective studies should not be disregarded. Clinical experience also suggests that most reports of past abuse are accurate in their major details, although it is possible that a small minority of abuse reports are significantly distorted or confabulated. It has been suggested that specific abuse allegations may stem from psychopathology, vindictiveness, or be related to a therapist implanting (intentionally or inadvertently) “false memories” of abuse in a client who has no abuse history. Thus, despite the claims of such researchers as Dube et al. (2004), the possibility of inaccurate reporting of abuse must be considered during the assessment process.
Another issue relates to the exploration of the specific nature of a given individual’s abuse history during an unstructured clinical interview. Such evaluations may be subject to error or oversight. Fortunately, however, the last several years have seen the development of a number of more structured and comprehensive abuse history measures.

A final concern relates to the accurate and sensitive assessment of abuse effects. In the past, clinicians and researchers have tended to use generic measures of global phenomena such as anxiety, depression, and personality disorder, when assessing clients who present with trauma histories. Unfortunately, such measures may overlook or misinterpret specific, abuse-related psychological disturbance. The pervasiveness of symptoms associated with child maltreatment may also lead to difficulties in assessment. A number of disturbances may be noted: in the parent-child attachment bond; in psychological development; in neuro-physiological development; dissociative experiences (such as psychogenic amnesia and dissociative identity disorder). Also found in some adults abused as children, however, are less trauma-specific symptoms and disorders such as helplessness, guilt, and low self-esteem; anxiety, depression or anger; anxiety mediated responses such as sexual dysfunction; somatisation; drug and alcohol abuse; externalising behaviours such as compulsive and indiscriminate sexual activity; bingeing or chronic over-eating; aggression, suicidal behaviour; and self mutilation. Because of the variety of abuse-related responses, psychological assessment can be incomplete if, for example, only a PAI or MMPI, a PTSD measure, or a test of borderline traits is administered. Instead, a comprehensive assessment of abuse-related difficulties should involve multiple measures that encompass not only the usual tests of anxiety or depression, but also instruments that tap, for example, post traumatic stress,
dissociation, somatisation, sexual difficulties, and enduring personality traits.

Assessment of abuse-related difficulties must also include evaluation of both the circumstances of the abuse and the psychological disturbance arising from it.

**Measures to Evaluate Child Abuse Experiences**

There are several scales that specifically examine childhood maltreatment history: Assessing Environments III, Form SD (AE-SD – Rausch & Knutson, 1991); Childhood Trauma Questionnaire (CTQ, Bernstein et al., 1994); Child Maltreatment Interview Schedule (CMIS, Briere, 1992); Child Maltreatment Questionnaire (CMQ, Demare, 1993); Traumatic Events Scale (TES, Elliott, 1992); and the Comprehensive Child Maltreatment Scales (CCMS, Higgins & McCabe, 2001).

These scales vary considerably in terms of the number of forms of abuse or neglect they assess and the amount of abuse specific detail they offer. Table 5 on the following page provides a comparison of some components of these scales.
<table>
<thead>
<tr>
<th>Measure</th>
<th>No. of Items</th>
<th>Stability</th>
<th>Data Provided</th>
<th>Usefulness with CP Sufferers</th>
</tr>
</thead>
<tbody>
<tr>
<td>AE III (SD)</td>
<td>170</td>
<td>.68-.74</td>
<td>Physical punishment, sibling physical punishment, perceptions of punishment (self and sibling).</td>
<td>Too limited in scope.</td>
</tr>
<tr>
<td>CTQ</td>
<td>70</td>
<td>T-R: $r = .80 - .83$ Int. con $\alpha = .79 - .94$</td>
<td>Physical, sexual and emotional abuse, physical and emotional neglect, family dysfunction.</td>
<td>May be useful in determining nature of trauma experience. Some limitations.</td>
</tr>
<tr>
<td>CMIS</td>
<td>46 (and sub-items)</td>
<td></td>
<td>Multiple facets of abuse (psychological, physical, emotional, sexual, ritualistic), perception of abuse, age of onset, severity of maltreatment, relationship to abuser.</td>
<td>May be useful- but lack of psychometric data a concern.</td>
</tr>
<tr>
<td>CMQ</td>
<td>Three scales: 14 sub-scales / items</td>
<td>High internal consistency.</td>
<td>Psychological abuse and neglect, scales for sexual and physical maltreatment.</td>
<td>Limited in scope. Scales for sexual and physical maltreatment limited.</td>
</tr>
<tr>
<td>TES</td>
<td>30 items</td>
<td>T-R data not available.</td>
<td>Thirty traumas - 10 specific to children (details re abuse, age, relationship to perpetrator, and level of distress).</td>
<td>Could be useful in assessment of CP – but no data on psychometric properties.</td>
</tr>
<tr>
<td>CCMS</td>
<td>5 types; 21 items x 3 perpetrators for most</td>
<td>Int. cons. ($\alpha = .76-.88$) T-R $r = .62 - .95$</td>
<td>Five types of maltreatment (sexual, physical, psychological, neglect and witnessing violence), and multi-maltreatment.</td>
<td>Could be useful in assessment of CP, due to assessment of multi-forms of childhood maltreatment.</td>
</tr>
</tbody>
</table>

R = correlation co-efficient; $\alpha$ = Chronbach’s alpha
The above measures provide the practitioner with a means to examine child abuse histories in detail and in a structured manner. All measures except the Assessing Environments Scale assess for different forms of child abuse. However, some scales (CMIS, CMQ & CCMS) allow for obtaining more specific details of the nature of the abuse. Others (CTQ) do not allow for this. Several scales (CMIS, TES, CCMS) ask questions regarding the age at which the abuse was experienced. Others (such as the Assessing Environments Scale & the CTP) do not. Some have reported good psychometric properties (CTQ & CCMS) while others (CMIS, CMQ & TES) do not have adequate reliability/validity data available.

Perhaps the most useful scale for assessment of childhood maltreatment is the CCMS, as it assesses for a wide range of child maltreatment forms, it allows the patient to report on specific details of the abuse, and it has good psychometric properties.

**Measures of Symptoms of Child Abuse**

Having discussed the measurement of experiences of child maltreatment, it is now important to discuss the measurement of its effects, and the capacity of measurement tools to account for CP symptoms. A major difficulty in measuring symptoms of child abuse is that most current trauma measures were developed solely for research applications, and thus have insufficient normative or validity data to fully justify their use as clinical instruments. Furthermore, of these measures, few have been used in the study of abuse survivors. Thus, only a small number of abuse-relevant tests are available to researchers. As a result, the clinician is forced to choose between standardised, but insensitive, generic tests, and specific but typically non-standardised psychological measures in the evaluation of abuse effects. It seems that our growing understanding of the incidence and impact of childhood abuse far
outstrips the measurement technology currently available to assess such phenomena. Thus, the practitioner must proceed with all caution. The following tests are available to clinicians, however, although as most of these have been used largely in abuse research, they must be treated as experimental: Impact of Event Scale (IES; Horowitz, Wilner, & Alvarez, 1979); Dissociative Experiences Scale (DES, Bernstein & Putnam, 1986); Los Angeles Symptom Checklist (LASC, Foy, Sipprelle, Rueger, & Carroll, 1984); Trauma Symptom Checklist-40 (TSC-40 – Briere & Runtz, 1989; Elliott & Briere, 1992; and Trauma Symptom Inventory (TSI) (Briere, 1995). Prime components of these measures have already been outlined in Table 4. Given the information available regarding CP, it is clear that current measurement instruments are not adequate in assessing the range of symptoms associated with Complex Post-Traumatic Stress Disorder.

**Appropriate Measurement of CP**

Van der Kolk (1996) has addressed this issue with the construction of the Self-Report Inventory for Disorders of Extreme Stress (SRI-DES, van der Kolk, 1996). This self-report inventory is based on the SIDES (Structured Interview for Disorders of Extreme Stress), a 48-item questionnaire which asks patients to describe their past and current functioning on seven dimensions: disorders of affect regulation, amnesia and dissociation, somatization, disorders of self, disorders in relationships to abusers, disorders in relationships to others, and disorders of meaning. Thus, it assesses for the DSM-IV Associated Features of PTSD.

As reported earlier, in the DSM-IV Field trials, the interview version of the SIDES demonstrated high reliability and validity (Pelcovitz, van der Kolk, Roth, Mandel, Kaplan, & Resick, 1997). The inter-rater reliabilities for lifetime and current symptoms were Kappa co-efficients of .81 and .67 respectively. In terms of the
subscales’ internal consistency, co-efficient alphas ranged from .53 to .96. Construct validity was obtained as well.

Summary

In measuring trauma experiences and responses associated with long-term childhood maltreatment, a multi-faceted approach needs to be taken, involving the use of an appropriate structured interview (such as the Structured Interview for Disorders of Extreme Stress [SIDES] (van der Kolk, 1996) in combination with self-report measures – a standard psychological measure such as the PAI, augmented with a self-report measure of core PTSD symptoms (such as the PDS-Foa, 1995) and another measure for assessment of CP symptoms (such as the Self-Report Inventory for Disorders of Extreme Stress (SRI-DES, van der Kolk, 1996). Detailed and thorough assessment is imperative if the clinician is to obtain adequate information related to both the trauma experience, and also the symptoms being experienced.
CHAPTER 3
TREATMENT MODALITIES

Development of Treatment Guidelines for PTSD

In November 1997, the Board of Directors of the International Society for Traumatic Stress Studies (ISTSS) developed a practice guideline under the auspices of the PTSD Treatment Guidelines Task Force. This guideline was intended to inform the clinician on the treatment of individuals with a diagnosis of post-traumatic stress disorder (PTSD).

Although the members of the Task Force recognised that traumatic experiences can lead to the development of several different disorders (including depression, specific phobias, personality disorders such as borderline personality disorder, and panic disorder), the focus of this guideline was specifically on the treatment of PTSD and its symptoms as defined in the Diagnostic and Statistical Manual (DSM) of the American Psychiatric Association (4th edition, 1994). Recommendations for treating associated symptoms were not made.

In this chapter, standard interventions commonly used by therapists in the treatment of PTSD will be described, with reference to the trauma symptoms for which they are most effective. The relevance of standard interventions in dealing with Complex PTSD symptoms will also be discussed. In examining standard interventions, reference will be made to recent efficacy data. Over the past two decades, a substantial body of research has been undertaken, such research evaluating a range of PTSD treatment methods with diverse populations. A valuable reference for clinicians is “Effective Treatments for PTSD: Practice Guidelines from the International Society for Traumatic Stress Studies” (Foa, Keane, & Friedman, 2000), a collaborative effort of experts in the various treatment modalities. The
contributors have provided complete descriptions of a number of standard treatment methods, including theoretical considerations and reviews of supporting clinical and experimental literature. Since its publication, Foa et al.’s book has been reviewed positively by several authors, including Francis (2003) and Smith (2003).

Given the large number of treatment outcome studies available, it is not feasible to refer to all such research. The focus in this chapter will, therefore, be on more recent research. Further, in examining recent treatment efficacy studies, a central goal has been to determine which interventions may be applicable in the treatment of specific symptoms of Complex PTSD. The researcher has been less concerned with critiquing (and determining inadequacies in) past PTSD treatment outcome studies, many of which are well-designed studies, undertaken by experts in the field. However, with most standard interventions appearing to have an extensive and adequate research base, as well as broad applications, it is not unrealistic to anticipate that recommendations for the treatment of Complex PTSD may incorporate a range of these well-researched treatment methods. For the purposes of this study, no analysis of pharmacological methods will take place, as these are of less direct relevance to the practice of psychologists working in this field.

**Efficacy of Approaches to Treating PTSD**

The following treatments have been used with victims of PTSD: Cognitive Behavioural Therapy (CBT), including exposure techniques (systematic desensitization and flooding/implosion), and stress inoculation/anxiety management training; EMDR – a specific form of CBT; hypnosis; psychoanalytic or psychodynamic approaches (including art, music and play therapy); psychopharmacological methods; group psychotherapy; and hospitalisation.
In examining treatment methods, it must be remembered that therapeutic goals for different treatments are not necessarily the same. Some treatments (e.g., CBT, EMDR, pharmacotherapy) target PTSD symptom reduction as the major clinical outcome by which efficacy should be judged. Other treatments (e.g., hypnosis, group psychotherapy, art therapy, music therapy, and psychoanalysis) emphasise the capacity to enrich the assessment or therapeutic process rather than the ability to improve PTSD symptom reduction. Still other treatments (e.g., psychosocial rehabilitation) emphasise functional improvement with or without PTSD symptoms. Finally, some interventions (e.g., hospitalisation, substance abuse treatment) focus primarily on disruptive behaviours or co-morbid disorders that must be controlled before PTSD treatment *per se* can be initiated. In most cases, however, the criterion for treatment efficacy is reduction of PTSD symptoms – either core or associated symptoms.

**Cognitive Behavioural Therapy**

Cognitive behavioural treatment for anxiety disorders can be divided into two categories. The first is comprised of *exposure-based therapies*, such as systematic desensitisation and flooding – therapies that primarily target memories of traumatic events and focus on reduction of arousal to cues of the traumatic experience. Such therapies help the client confront fear situations, as the successful processing of traumatic events involves emotional engagement with the trauma memory, and organisation of the trauma narrative, so that dysfunctional cognitions that follow the trauma can then be corrected (Hembree & Foa, 2000).

The other approach consists of a variety of *anxiety management procedures* that focus on acquisition and maintenance of skills for coping with symptoms of
PTSD (intense anxiety) and trauma-related problems (Kilpatrick, Veronen, & Resick, 1982).

**Exposure-Based Therapies (Systematic Desensitisation and Flooding)**

*The process.* Systematic desensitization (Wolpe, 1958) generally involves first establishing a desirable behaviour (relaxation) that is incompatible with the undesired fear or anxiety responses. The individual is then gradually exposed to a hierarchy of feared stimuli or images so that he or she can ultimately tolerate full exposure to the entire range of (real or imagined) fear stimuli. Thus, the individual remains relaxed while imagining/remembering increasingly greater amounts of the feared/traumatic imagery, effectively replacing reactive distress with relative calmness. In flooding or implosive therapy (Stampfl & Levis, 1967, cited in Follette, Ruzek, & Abueg, 1998), the therapist directs the individual repeatedly and systematically to imagine all (sensory, imaginal, thematic) aspects of traumatic incidents. The individual being treated is often asked to recall the event as vividly as he or she can and to involve as many senses (visual, auditory, gustatory, olfactory, tactile) as possible during the imagery. Implosive therapy involves encouraging the individual to experience the undesired fear responses that are associated with the fear-provoking stimuli. The fear responses are deliberately maintained until they are eliminated via the natural extinction process. The individual gradually becomes less fearful since, unlike during the traumatic event, the trauma and its tragic accompaniments do not occur in recall.

**Studies on the Efficacy of Exposure-based Therapies with PTSD**

Recent studies have indicated some positive outcomes for exposure therapy when used with PTSD patients. Foa and Rauch (2004) reported clinically significant, reliable and lasting reductions in negative cognitions about self, world and self-
blame in 54 female survivors of sexual and non-sexual assault with chronic PTSD, who completed prolonged exposure therapy over a 9-12 week period. The addition of cognitive restructuring did not significantly increase the cognitive changes.

Taylor, Thordarson, Maxfield, Fedoroff, Lovell and Ogrodniczuk (2003) compared exposure therapy, EMDR and relaxation training. They found that exposure therapy produced significantly larger reductions in avoidance and re-experiencing symptoms, tended to be faster at reducing avoidance symptoms, and tended to yield a greater proportion of participants who no longer met criteria for PTSD after treatment, than either EMDR or relaxation treatments. In their study, 45 participants were assigned randomly to one of the three treatment groups, and treatment occurred over eight weeks. This study was a methodologically sound treatment outcome study, using clearly defined target symptoms, reliable and valid measures, blind evaluators, adequately trained assessors, replicable and specific treatments, unbiased assignment to treatment, and evaluation of treatment adherence. Although there were some identified limitations to the study (the sample was small, and tended to have chronic, severe PTSD and its findings may not be applicable to milder symptoms), on the whole, this study provides strong support for the use of exposure therapy with PTSD symptoms.

Resick, Nishith, Weaver, Astin and Feuer (2002), in a comparison of cognitive processing therapy with prolonged exposure and a waiting-list condition (minimal attention condition) for the treatment of PTSD and depression, reported that both cognitive processing therapy and prolonged exposure were highly efficacious and superior to the minimal attention condition in terms of reduction of PTSD symptoms, depression, and trauma-related guilt. The two therapies had similar results, although cognitive processing therapy produced better scores on two of the
four guilt scales. This study, a randomized control study, involved 171 female rape victims, 120 of whom completed treatment.

Other studies have indicated that prolonged exposure therapy may be effective for a wide range of populations and samples with chronic PTSD, including female assault survivors (Foa, Dancu, Hembree, Jaycox, Meadows, & Street, 1999; Foa, Rothbaum, Riggs, & Murdoch, 1991; Weaver, Nishith, & Resick, 1999, in a study of one thirty-four year old female with rape-related PTSD; male combat veterans (Keane, Fairbank, Caddell & Zimmering, 1989; Rothbaum et al., 1999, using ‘Virtual Reality’ therapy); refugees (Paunovic & Ost, 2001); individuals with concurrent PTSD and cocaine-dependence (Brady, Dansky, Bonnie, Back, Foa, & Carroll, 2001); victims of traffic accident with a PTSD diagnosis (Fectau, 2000); and PTSD outpatients (Lovell, Marks, Noshirvani, Thrasher, & Livanou, 2001).

Other researchers have pointed to potential difficulties with exposure therapy. Ehlers, Clark, Dunmore, Jaycox, Meadows, and Foa (1998) claimed that patients who experienced mental defeat, alienation, or permanent change may not benefit from exposure therapy, and may require cognitive restructuring in addition to exposure. Scott and Stradling (1997) claimed that exposure-based treatments are not the treatment of choice for clients, who do not wish to ‘relive’ their trauma. Other clinicians have reported high levels of anxiety often experienced by patients and have abandoned the use of exposure in favour of a variety of imaginal exposure procedures involving confrontation with moderate to high levels of anxiety.

Several studies have also investigated the efficacy of imaginal exposure therapy. Researchers have differed in their findings regarding whether imaginal exposure is more effective when used alone, or in combination with other therapies. In a randomized control study of 58 civilian survivors of trauma with PTSD, Bryant,
Harvey and Guthrie (2003) reported that participants who received a combination of imaginal exposure and cognitive restructuring had greater reductions in PTSD and maladaptive cognitive styles than those who received imaginal exposure alone.

However, Abrahams (2000) recently reported successful outcomes in the treatment of post-traumatic stress disorder using imaginal and in-vivo exposure with an 11-year old boy, who developed PTSD after witnessing a violent incident that culminated in the death of a relative. Treatment involved a combination of imaginal exposure to scenes from the traumatic incident and in vivo exposure to associated feared situations. The intervention resulted in considerable improvement to the three key features of PTSD: re-experiencing of the event (intrusive thoughts, nightmares, flashbacks), avoidance of associated stimuli, and levels of arousal. Although the results of this study cannot be generalised to the broader population, it is worthy of inclusion here, given the lack of support for imaginal exposure in other studies.

Two studies have indicated moderate success for imaginal exposure in the treatment of post-traumatic stress disorder (Tarrier, Pilgrim, Sommerfield, Faragher, Reynolds, Graham, & Barrowclough, 1999; Tarrier, Sommerfield, Pilgrim, & Humphreys, 1999). However, methodological problems in the studies have led to little support for these studies (Cahill, Zoellner, Feeny, & Riggs, 2002; Taylor, Thodarson, Maxfield, Fedoroff, Lovell, & Ogrodniczuk, 2003).

Some limited support for imaginal exposure therapy was provided in a study by Tarrier, Pilgrim, Sommerfield, Faragher, Reynolds, Graham, and Barrowclough (1999). In this study with 72 PTSD patients, a randomised trial was performed in which imaginal exposure and cognitive therapy were compared in the treatment of chronic post-traumatic stress disorder. Results indicated significant improvement in all measures over treatment and at follow-up, although there was no significant
difference between the two treatments at any assessment. Terrier et al. concluded that either exposure or a challenge to cognition could result in symptom reduction, although neither resulted in complete improvement. The results of this study do not provide strong support for the efficacy of imaginal exposure, as there is also the possibility that patients’ improvements were related to natural improvements over the course of time.

More recently, Foa, Zoellner, Feeny, Hembree, and Alvarez-Conrad (2002) tested whether initiation of imaginal exposure caused significant symptom exacerbation during therapy, and whether such exacerbation was related to eventual drop-out and outcome. Results indicated that, although a minority of participants displayed symptom exacerbation, this was often associated with the onset of intrusive experiences and was only temporary, and was not associated with eventual dropout – or significantly worse outcome at post-treatment assessment.

Other recent studies have examined the efficacy of ‘Virtual Reality’ exposure therapy. Difede and Hoffman (2002) described the treatment of a 26-year old survivor of the World Trade Centre (WTC) attack of 9 September, 2001, who had developed PTSD. After she failed to improve with traditional imaginal exposure therapy, virtual reality exposure therapy was used. The patient was exposed over six one-hour sessions, to virtual planes flying over the World Trade Centre, jets crashing into the same Centre, with animated explosions and sound effects, virtual people jumping to their deaths from burning buildings, towers collapsing, and dust clouds. Virtual reality exposure therapy was successful for reducing PTSD symptoms and depression. Although case reports are scientifically inconclusive by nature, these strong preliminary findings suggest that virtual reality exposure therapy has potential for the treatment of acute PTSD.
Other studies have investigated the use of a relatively new exposure therapy treatment, ‘Narrative Exposure’ therapy. Neuner, Schauer, Kaschik, and Elbert (2004) evaluated narrative exposure therapy, a short-term cognitive-behavioural therapy, including a narrative testimony of past trauma events. The evaluation was undertaken in a randomised controlled trial with Sudanaese refugees living in a Ugandan refugee settlement and diagnosed as suffering from PTSD. They received either four sessions of narrative exposure therapy, four sessions of supportive counselling, or psycho-education, completed in one session. One year after treatment, only 29% of the narrative exposure therapy group, but 79% of the supportive counselling group, and 90% of the psycho-education group still fulfilled PTSD criteria. Although a small trial, this study indicates promise for narrative exposure therapy for refugees living in unsafe conditions.

Research has also been undertaken on one other form of exposure therapy, systematic desensitisation. Sugden (1998) reported positive outcomes using systematic desensitization in the treatment of PTSD. The client in this study was a middle-aged female, who presented five months following a violent assault. The Beck Anxiety Inventory (BAI) was administered post-treatment, and at six-month and eighteen-month follow-up. Results of data analysis showed significant reductions in anxiety post-treatment that were maintained at eighteen-month follow-up. Results were supported by psychometric testing, which measured overall PTSD symptomatology across measures from PTSD-positive levels at pre-treatment to PTSD-negative levels at eighteen-month follow-up. Again, although generalising from this case report is not possible, Sugden’s findings suggest that VR systematic desensitization has potential for the treatment of acute PTSD.
Several earlier and uncontrolled studies demonstrated that systematic desensitisation is also effective with rape victims in reducing fear, anxiety, depression, and social maladjustment (Frank & Stewart, 1983; Turner, 1979). The successful outcome of systematic desensitization was also reported in two early studies with war veterans (Peniston, 1986; Bowen & Lambert, 1986). In these studies, the treatment was effective when compared to a no-treatment control condition, but required a large number of sessions over an extended period of time. However, few conclusions can be drawn from these studies due to the lack of methodological rigour and the absence of PTSD diagnosis and measures in most of the studies. Further, Shapiro (1989) referred to some drawbacks with this method. Firstly, many relaxation and desensitization sessions are necessary, and this has perhaps led to the method not being used widely. Also, the traumatic cues associated with rape and many Vietnam War incidents are not amenable to hierarchical arrangement.

In general, it appears that exposure therapy is most appropriate for use with the PTSD symptom of re-experiencing and avoidance, although King (2002) suggested that detrimental consequences may result if exposure therapy is used with patients with head injury and mild dysexecutive impairment. King reported that, in such cases, the re-experiencing of a traumatic event may become a perseverated response. King based his conclusions on a single case study, and although the results are limited to this case, the study has significant implications for the treatment of PTSD in such circumstances.

It is reasonable to predict that exposure therapy would be less likely to be beneficial for those who have suffered multiple and long-term abuse, as the traumatic cues associated with multiple forms of abuse over long periods of time are
not particularly amenable to hierarchical arrangement. However, as the above research indicates, the use of exposure therapy has been shown to have some benefits in altering negative cognitions related to self, the world and others, and in the treatment of symptoms of fear and guilt, (related to memories of the trauma, or perception of the perpetrator). It is thus relevant in working with “Alterations in Self Perception” and “Alterations in Relations with Others” (Criteria 4 & 6, CP symptoms, Herman 1992a). Exposure therapy has also been indicated to assist in reducing symptoms of anxiety and depression (Criterion 4, “Alterations in Affect Regulation”). In assisting with avoidance systems, it is also relevant in the treatment of “Alterations in Consciousness” (Criterion 3). The use of imaginal exposure therapy to assist with these symptoms may also be possible, while virtual reality exposure therapy and systematic desensitization appear to show promise in assisting with anxiety (“Alterations in Affect Regulation”, Criterion 4).

**Anxiety Management Training**

Anxiety management training involves teaching the client how to control intense anxiety by using specific skills. Anxiety management typically includes a variety of procedures, including cognitive therapy, cognitive restructuring, cognitive-behavioural therapy, stress inoculation training, and often accompanying these, relaxation and biofeedback.

*Cognitive therapy.* Cognitive therapy is used successfully in the treatment of anxiety, depression, and insomnia – all of which are experienced by victims of trauma. Cognitive treatments can be delivered in both group and individual contexts but tend to have more of a pedagogical/educative flavour. Treatment often involves providing information to the survivor about the trauma (for example, sexual assault victims may be given information regarding the national incidence of rape) as well
as information about PTSD, its theories and its treatment. These educative efforts add to the patient’s knowledge about trauma and his or her PTSD symptoms. This treatment may involve educating the survivor about learning theory or about how cognitions affect mood and behaviour. The trauma victim is often taught to monitor and record information about his or her thoughts or behaviour. In both group and individual settings, therapists can augment the treatment with handouts, audiotapes, videotapes, role-play exercises, behavioural rehearsal, and between session “homework”. Two approaches have been employed with trauma survivors. The first approach involves helping the individual identify and replace cognitive distortions (Beck, 1976; Burns, 1992) or irrational beliefs (Ellis, 1994; Ellis & Grieger, 1986). The second approach involves helping the individual identify themes, constructions (stories), or narrative memories, and persuading them in some fashion to adopt more flexible and less punitive ones. In practice, CBT is almost always a blend of these interventions. Positive results have been reported when using cognitive therapy with bettered women with PTSD (Kubany, Hill, Owens, Lannce-Spencer, McCaig & Tremayne, 2004). Their treatment-outcome study involved 125 ethnically diverse battered women with PTSD. They reported that PTSD remitted in 87% of women who completed Cognitive Trauma Therapy, with large reductions in depression and guilt and substantial increases in self-esteem. The gains were maintained at three- and six-month follow-ups. The therapy involved trauma history exploration, PTSD education, stress management, exposure to abuse and abuse reminders, self monitoring of negative self-talk, cognitive therapy for guilt, and modules on self advocacy, assertiveness, and identification of perpetrators. Positive results (reduced PTSD symptoms) when cognitive therapy is used with those exposed to terrorist activities have also been reported by Gillespie, Duffy, Hackmann, and Clark (2002)
in another population. Their study involved 91 patients (aged 17-73 years) with PTSD resulting from a car bomb that exploded in the centre of Omagh, Northern Ireland in 1998. Gillespie et al. concluded that the positive changes observed in research settings generalised well in a community, non-selective service. Positive results have also been reported for cognitive restructuring (CR) when used with PTSD sufferers (Marks, Lovell, Noshirvani, Livanou, & Thrasher, 1998). Marks et al. examined the efficacy of cognitive restructuring and prolonged exposure in treating 87 patients suffering from post-traumatic stress disorder (PTSD) and found positive effects (reduced PTSD symptoms) for both methods. However, results indicated that both prolonged exposure and cognitive restructuring were therapeutic only when used on their own, not when combined. Both techniques were more effective than relaxation. However, in a later study (Lovell, Marks, Noshirvani, Thrasher, & Livanou, 2001), cognitive restructuring, when combined with exposure treatment, also produced outcomes for some PTSD patients. Lovell et al. indicated that cognitive restructuring and exposure combined were superior to relaxation in improving clusters of PTSD symptoms and associated features, and some, but not all, individual symptoms of PTSD. Cognitive restructuring (as with exposure) improved all individual symptoms similarly. Although no research has been carried out to date specifically examining the efficacy of cognitive therapy with identified Complex PTSD patients, cognitive therapy could potentially have broad applications in the treatment of Complex PTSD: in addressing CP Criterion 2, “Alterations in Affect Regulation” (identifying and replacing cognitive distortions or irrational beliefs underlying depression, anxiety and anger); Criterion 4, “Alterations in Self-Perception” (identifying and replacing cognitive distortions or irrational beliefs related to ‘self’; reducing sense of helplessness, shame, guilt, self-blame); Criterion
5, “Alterations in the Perception of the Perpetrator” (identifying and replacing unrealistic attributions, idealisation, and pre-occupations with thoughts of the perpetrator); Criterion 6, “Alterations in Relations with Others” (influenced by improvements in other symptoms); and Criterion 7, “Alterations in Systems of Meaning” (assisting with feelings of hopelessness and despair).

**Stress inoculation training.** Stress inoculation training teaches both physical and cognitive coping skills, and can thus be used successfully with trauma sufferers. The procedure was developed by Meichenbaum and Cameron (1983) who used it to assist clients with severe phobic reactions to manage anxiety in stressful situations. Meichenbaum and Turk (1976) described stress inoculation as a type of psychological protection that functioned in the same way as medical inoculation in providing protection from disease. Stress inoculation, according to Meichenbaum (1993), “helps clients acquire sufficient knowledge, self-understanding, and coping skills to facilitate better ways of handling expected stressful encounters” (p. 381). Cormier and Cormier (1998) outlined the main components of this technique: educating the client about the nature of stressful reactions, helping the client acquire and rehearse various physical and cognitive skills, helping the client apply these skills during exposure to stressful situations. Indirect effects of stress inoculation training are that the increased perception of control may allow the victim to tolerate the trauma memories for longer periods of time, which may serve as self-directed prolonged exposure. Also, the perception of self as an adequate coper will allow the individual to be better able to avert potential dangers (Rothbaum & Foa, 1996). Trzepacz & Luiselli (2004) evaluated stress inoculation training in a 27-year old who experienced emergency gynaecological surgery three weeks after delivering her first child, and displayed symptoms of sleep disturbance, flashbacks, avoidance of
landmarks associated with the surgery, prolonged crying and chronic distress in response to multiple environmental stimuli. Stress inoculation training was instituted in eight treatment sessions in which she was taught progressive muscle relaxation, deep breathing, guided imagery, covert modelling, thought stopping, and thought replacement procedures. The effects of the treatment were that the woman no longer had stress-inducing experiences, and her level of discomfort in the presence of identified environmental triggers were mostly eliminated. Although the results of this study cannot be generalised to the broader population, the study provides some promising results regarding the efficacy of stress inoculation. In a study of 96 female victims of PTSD comparing stress inoculation training, prolonged exposure, combined treatment and wait-list control, all three active treatments reduced the severity of PTSD and depression compared with the waiting list group, but did not differ significantly from one another (Foa, Dancu, Hembree, Jaycox, Meadows, & Street, 1999). The gains were maintained through the follow-up period. Successful outcomes for stress inoculation therapy were also indicated in earlier studies (Foa, Rothbaum, Riggs, & Murdoch, 1991; Foa & Riggs, 1993), who examined the efficacy of stress inoculation training with female victims of rape and non-sexual assault who met the criteria for PTSD. The studies reported above indicate that stress inoculation training produces positive changes on measures of fear and depression. The limited research available suggests that Stress Inoculation Therapy could be useful not only in addressing PTSD symptoms, but also in addressing CP symptoms relating to “Alterations in Affect Regulation” (CP Criterion 2).

Relaxation. Trauma sufferers may also discover that they have difficulty relaxing, and that they suffer from anxiety, panic attacks, depression, and insomnia. There are many different relaxation programs/methods that may assist such sufferers.
Progressive muscle relaxation is one of these methods. In muscle relaxation, a person is taught to relax by becoming aware of the sensations of tensing and relaxing major muscle groups. Jacobsen (1929) developed a technique called “progressive relaxation” (p. 40). In this procedure, an individual is taught to relax muscle groups one at a time. This technique is based on the assumption that muscular relaxation was effective in bringing about emotional relaxation. According to Jacobsen, practising an ordered sequence of muscle tension and relaxation exercises could help an individual recognise when muscles are tense and take steps to try to relax them.

The long-range goal of muscle relaxation is for the body “to monitor instantaneously all of its numerous control signals, and automatically relieve tensions that are not desired” (McGuigan, 1993, p. 21). This technique is not new, however. Wolpe (1958) also used muscle relaxation, as part of his systematic desensitisation procedure, in order to reduce anxiety. Later, Bernstein and Borkovec (1973) outlined the procedures for conducting this anxiety-reducing procedure. In recent years, many studies have been undertaken, assessing the effectiveness of muscle relaxation training with a range of problems often associated with PTSD. Muscle relaxation has proven to be successfully used with clients’ depression (Broota & Dhir, 1990); headache (Applebaum, Blanchard, Nicholson, & Radnitz, 1990; Arena, Bruno, Hannah, & Meador, 1995; Blanchard, Applebaum, Radnitz, & Michultka, 1990; Blanchard, Kim, Hermann, & Steffeck, 1993; Blanchard, Nicholson, Taylor, & Steffeck, 1991); hypertension (Broota, Varma, & Singh, 1995; Haaga, Davison, Williams, & Dolezal, 1994; Larkin, Knowlton, & D’Alessandri, 1990); insomnia (Gustafson, 1992) and panic disorder (Ost, Westling, & Hellstrom, 1993). Muscle relaxation may not be successful with some survivors of severe trauma, as many such individuals may need to maintain a degree of vigilance in order to feel safe.
However, the method does have certain advantages over other methods of relaxation: one of the main advantages is that it can increase a client’s sense of control over his/her own relaxation process. Further, progressive muscle relaxation can be practised independently, once learned (Cormier & Cormier, 1998), and without expensive equipment (other than a CD/cassette recorder). Pre-recorded relaxation tapes are available in many stores or can be self-recorded by any individual. As indicated, the main application of muscle relaxation for PTSD sufferers is in the reduction of symptoms of insomnia, anxiety and stress. This is also true for sufferers of Complex PTSD, and thus relevant to symptoms of “Alterations in Affect Regulation” (CP Criterion 2). The applications, therefore, are still important.

**Biofeedback.** Biofeedback refers to “the use of electronic instruments to mirror psychophysiological processes of which the individual is not readily aware and which can be brought under voluntary control” (Fuller, 1978, cited in Scartelli, 1984, p. 39). In this way, the electronic sensor provides clients with information about the state of their bodily processes (Elton, Stanley, & Burrows, 1983). Individuals are thus trained to develop voluntary control of their own biological activities, such as muscle tension, skin surface temperature, brain waves, blood pressure and heart rate. A client can test specific muscle/body areas for tension levels and a sensor gives instant and ongoing feedback (Davis, Eshelman, & McKay, 1998). Biofeedback thus uses the operant conditioning principle of systematic response shaping as the individual learns to use tension and relaxation exercises to observe what techniques work best for him to reduce the tension. Electromyographic biofeedback (Scartelli, 1984) is one specific form of biofeedback that provides immediate information about muscle activity. With electromyographic biofeedback, clients receive audio and visual feedback of muscle tension taken from the frontalis
Whenever they experience tension, patients are usually asked to use whatever technique they have found effective in reducing tension during biofeedback. Thus, the stimulus is the feedback from the biofeedback mechanism, and the response is the resulting physiological adjustment. Biofeedback is potentially an effective strategy to adopt in the treatment of PTSD. This process has been widely used as a relaxation training/anxiety reduction procedure over the past twenty years, and there is abundant literature that supports its use.

Biofeedback can also be used successfully with sufferers of trauma to help reduce tension and symptoms of anxiety. Baddeley (1999) concluded that electromyographic biofeedback can enhance treatment and can be used to train clients to induce, deepen and maintain theta brain states, as it is only during theta states that programming is downloaded.

Wenck, Leu, and D’Amato (1996) found the combined use of electromyographic biofeedback and thermal biofeedback techniques achieved success in reducing the anxiety of 150 seventh to eighth-grade anxious children over a six-week period. The children showed a significant reduction in both state and trait anxiety, and biofeedback was, as a result, suggested as a viable intervention that might be coordinated and provided by psychologists. Some earlier studies have indicated that biofeedback is effective in reducing situation specific anxiety (Shellman, 1982); generalised anxiety disorder (Rice, Blanchard, & Purcell, 1993; Spencer, 1986); and in response to anxiety-provoking films (Falkowksi & Steptoe, 1983). Although biofeedback is a very effective and popular method of anxiety reduction, it needs to be administered by trained practitioners and also requires technical equipment. It is, therefore, not one that can be used independently by untrained people in the comfort of their own home. However, the main advantage in using biofeedback in preference to other techniques (such as meditation, hypnosis, progressive muscle relaxation) is
its ability to objectively measure and guide changes in anxiety levels. As with other forms of relaxation therapy, the application of Biofeedback in the treatment of PTSD (and also Complex PTSD) sufferers is limited to its use in the reduction of stress and anxiety conditions. However, it could play an important part in the treatment of either of these conditions.

**Combined Treatments**

In a study that evaluated gender differences in an integrated cognitive behavioural therapy using coping skills treatment, stress inoculation, and in vivo exposure of substance dependent patients with PTSD, Triffleman (2001) discovered that improvements were seen across the sample in current PTSD severity, and in number of PTSD and associated symptoms.

Triffleman, Carroll, and Kellogg (1999) reported positive outcomes (reduced PTSD symptoms) when using an integrated cognitive-behavioural approach in the treatment of post-traumatic stress disorder. The approach used involved a 5-month, twice-weekly, two-phase individual cognitive-behavioural treatment using relapse prevention and coping skills training for substance abuse, psycho-education, stress inoculation training, and *in vivo* exposure for PTSD.

Taylor, Fedoroff, and Koch (1999) also reported positive outcomes for some individuals with the use of cognitive behavioural therapy for treatment of PTSD due to motor vehicle accidents. Of the thirty-four adults seeking treatment for PTSD, those who completed the treatment (*n* = 28), 15 improved, while 13 deteriorated – yet there were few differences in pre-treatment variables between those who improved and those who deteriorated.

Volker (1999) examined the efficacy of utilising cognitive and clinical art therapies within a solution-centred approach to victimisation. In Volker’s study,
seventeen adolescent and young female subjects with a history of sexual assault, participated in ten 90-minute sessions of weekly group psychotherapy. Data analysis indicated fewer symptoms of PTSD symptoms in the treatment group than in the control group, and also lower scores on the Beck Depression Inventory.

The combination of exposure therapy (for PTSD symptoms) and stress inoculation therapy has been shown to be successful in assisting sufferers to manage the extreme stress and anxiety while learning to confront the feared memories of their trauma. Foa et al. (1994) compared the combined therapies with exposure alone, stress inoculation therapy alone, and a waiting list control. Preliminary analysis indicated that all three treatments were equally effective in reducing PTSD symptoms, but exposure tended to be more effective in reducing psychopathology. In a study with female sexual assault survivors, involving cognitive processing therapy over 12 weekly sessions in a group format, and exposure therapy (writing a detailed account of the assault and reading it aloud in the treatment group), improvements were reported (Resick & Schnicke, 1992). Treated clients were compared with the waiting list control group, and improved significantly from pre-to post-treatment on PTSD and depression ratings, maintaining their improvement throughout the six-months follow-up period. At post-treatment, none of the treated clients met PTSD criteria, although 12.5% did at follow-up. The waiting list group evidenced no change during a comparable 12-week period.

**Summing Up: Cognitive-Behavioural Methods and PTSD/CP**

In conclusion, the results of the studies outlined previously are consistent with those of case reports that indicate that different forms of exposure therapy and anxiety management can be effective in reducing PTSD symptoms, as well as some related symptoms such as depression and anxiety. Further, there is preliminary
evidence to suggest that the treatment of choice for chronic PTSD may be a combination of exposure and anxiety management training. However, it appears that the effects of this treatment on PTSD symptoms are greater in the studies of female assault victims than in the studies of Vietnam veterans, who are generally resistant to psychosocial as well as pharmacological treatments.

There is also a place for many of the cognitive-behavioural forms of therapy in the treatment of Complex PTSD. Exposure therapies may be important in assisting with a range of symptoms. Some anxiety management methods (such as stress inoculation training, relaxation and biofeedback) have important applications, while other forms (such as cognitive therapy) have broader applications in dealing with associated symptoms.

**EMDR (Eye Movement Desensitization and Reprocessing)**

Eye movement desensitization and reprocessing (EMDR, Shapiro, 1989) is a form of exposure (desensitisation) with a strong cognitive component, accompanied by saccadic eye movements. EMDR involves having patients engage in saccadic (back and forth) eye movements while conjuring up images of the event or stimulus that makes them uncomfortable, unhappy, or anxious. As a treatment for trauma survivors, EMDR involves the following: exposure to trauma-related visual imagery; exposure to aversive trauma-related (negative) conditions; rehearsal of adaptive (positive) conditions; rapid eye movements; active visual attention on an object (moving finger); thought and image stopping; and a deep breath at the end of each set.

The trauma survivor identifies a traumatic event on which he or she wants to work, provides a Subjective Unit of Distress (SUD) rating (0 -10, or 0 -100, from least to most, of subjective units of discomfort or distress) to indicate how much
discomfort he or she feels while recalling the event, articulates positive or negative self-statements related to the event, provides a ‘validity of cognition’ rating for how strongly he or she believes each of the two self-statements, and describes a ‘safe place’ where he or she can return to mentally at the end of the session. With his head held still, the survivor conjures up thoughts and images related to the traumatic event(s) and is instructed to visually track the therapist’s finger for 15 - 20 waves. A number of trials or sets of this treatment are provided and, when the therapist is assured that the traumatic event has become significantly less upsetting (assessed through periodic SUD ratings). The therapist helps the survivor to mentally journey to the “safe place”, the therapist again solicits SUD and validity of cognition ratings related to the traumatic event and the positive and negative self-statements.

Views on EMDR in the research literature have been polarised, with more recent studies questioning this approach. However, there is still a vast array of literature that supports the effectiveness of EMDR for use with adult and children trauma sufferers.

Improvements for PTSD sufferers following EMDR, and reported at post-treatment, have been shown to be maintained on measures of PTSD, depression, anxiety, and general symptoms at three and six-month follow-up (Marcus, Marquis, & Sakai, 2004). Marcus et al. concluded that a relatively small number of EMDR treatment sessions result in substantial benefits that are maintained over time.

A specific EMDR protocol, ‘Resource Development and Installation’, has been shown to be an effective intervention in the initial stabilization phase of treatment (replacing positive cognitions with negative cognitions) with Complex PTSD/DES-NOS (Korn and Leeds, 2002). Case studies including descriptive and behavioural outcome measures) were presented of two female adult survivors of
childhood neglect and abuse. These appeared to support the use of Resource Development and Installation. Although the results of this study are not generalisable to the broader population, they suggest that, for some clients, EMDR may produce benefits in the initial stabilization phase.

In a comparison of stress inoculation training/prolonged exposure therapy and EMDR, used with 24 PTSD patients, there was no difference (post-treatment) between the therapies on global measures (Lee, Gavriel, Drummond, Richards & Greenwald, 2002). However, on the sub-scale measures of the degree of intrusion symptoms, EMDR did significantly better than stress inoculation training/prolonged exposure. At follow-up, EMDR was found to lead to greater gains on all measures.

Shapiro (2001) claimed that, through EMDR, it is possible to enhance self-belief, and create a shift towards change and personal growth that allows traumatic memories to be “metabolized” with less abreaction and in less time. Shapiro claims that EMDR and the use of ego-strengthening techniques enhance other clinical work.

Shepherd, Stein and Milne (2000) carried out a critical appraisal of sixteen studies in which EMDR was compared with (a) alternative psychotherapy treatments, (b) variants of EMDR, and (c) delayed treatment groups. The mean age of participants in the studies they reviewed was 35. The studies were of variable methodological quality, with blinding of outcome assessors to treatment allocation being reported in only five studies. In some cases, there was a high loss to follow-up. From their review, Shepherd and Stein found that, in most cases, EMDR was shown to be effective in reducing symptoms up to three months after treatment. In one case, benefit was maintained up to nine months after treatment, and in another (uncontrolled) follow-up treatment effect was present at fifteen months. In three studies, it was suggested that EMDR was as effective as exposure therapies. In three
studies, greater effectiveness was reported from EMDR when compared with relaxation training, while in another three studies, EMDR was reported to be superior in comparison to delayed treatment groups. Of the studies examining specific treatment components, treatment with eyes moving was more effective than with eyes fixed in two studies, while the two procedures were found to be of equal effectiveness three studies. On the basis of information obtained from this review, the benefits of EMDR appear to be equal to or superior to those of other therapies in the treatment of PTSD. Further success for EMDR is indicated in a study by Rittenhouse (2000), who described the successful recovery of a bi-racial client from complex post-traumatic stress disorder through the use of EMDR.

Earlier studies have indicated the success of EMDR in treating PTSD: in veterans with combat-related PTSD (Carlson, Chemtob, Rusnak, Hedlund, & Muraoka, 1998); for a 44-year old man with PTSD symptoms associated with depressive symptoms (Ilic, Lecic-Tosevska, Bokonjic, Drakulic, & Jovic, 1999); with eight “chronic” PTSD patients (Lazrove, Triffleman, Kite, McGlashan, & Rounsaville, 1998); for one PTSD patient (of six) treated with EMDR (Levin, Lazrove, & Van der Kolk, 1999); following homicide (Pollock, 2000); in 12 war veterans following a single-session of EMDR treatment (Rogers, Silver, Goss, Obenchain, Willis & Whitney, 1999); with sixty 16-25 year-old traumatised females (Scheck, Schaeffer, & Gillette, 1998); in a meta-analysis of treatments for post-traumatic stress disorder, which concluded that EMDR and behavioural therapies were most effective (Van Etten & Taylor, 1998).

Strong support for this mode of trauma therapy has been shown in studies using EMDR with children also indicate. For example, Greenwald (1998) presented the case of a ten-year old girl who developed PTSD following an incident of sexual
and physical abuse, and concluded that EMDR appeared to be a promising resource for assisting children and adolescents recover from trauma and loss. Severe (1998) presented the case of an eleven-year old boy who had witnessed an experienced numerous interpersonal stressor related traumatic events (multiple trauma). The child’s EMDR treatment involved twenty-five sessions. Qualitative changes to the standard adult EMDR protocol were made by the treating therapist, to ensure appropriateness for a latency-aged child. The results of both studies, while not generalisable to the broader population, suggested that EMDR may be a useful adjunct to an overall treatment plan aimed at ameliorating the traumatic symptoms and developmental difficulties associated with PTSD in children.

As the above studies indicate, the value of EMDR has been mostly measured in terms of amelioration of symptoms. Schleyer (2000), however, investigated the value of EMDR by examining the client’s experience of EMDR and life changes after EMDR. Schleyer collected data via unstructured interviews with seven individuals who had experienced some form of trauma, and who had experienced EMDR as a therapeutic intervention for trauma. All individuals had experienced emotional, cognitive, and physical release in response to the EMDR experience, which allowed them to move forward with their lives.

Some researchers (Foa and Keane, 2000; Spector, 1999) have referred to both positive and negative aspects of EMDR in treating PTSD.

**Problems with EMDR**

Several studies have also indicated some reservations with regard to EMDR and its effectiveness when used with trauma patients. Most of these studies have assessed EMDR according to whether or not there has been an amelioration of symptoms as a result of EMDR.
Davidson and Parker (2001), in a meta-analysis of thirty-four studies examining a variety of populations and measures, concluded that EMDR appeared to be no more effective than other exposure techniques, and that the eye movements (which are described as integral to the treatment) were unnecessary. The conclusions expressed in the review by Davidson and Parker are at variance with the research reported earlier, which indicated more positive outcomes for EMDR than other exposure techniques.

Cahill, Carrigan, and Frueh (1999), in another review of research of EMDR, drew attention to studies that indicated positive outcomes for EMDR, but also referred to studies outlining drawbacks for this method when used with PTSD patients. From their review, Cahill et al. claimed that EMDR appeared to be effective in reducing at least some indices of distress relative to no-treatment of a number of anxiety conditions, including PTSD, panic disorder, and public-speaking anxiety. They also claimed that EMDR appeared to be at least as effective as or more effective than several non-validated treatments (for example, relaxation, active listening) for post-traumatic reactions. Cahill et al. also reported that no previously published study had directly compared EMDR with an independently-validated PTSD treatment (for example, therapist-directed flooding), and that in the treatment of simple phobia, participant modelling had been found to be more effective than EMDR. Their review of dismantling studies had also lead them to claim that there was no evidence that eye movements significantly contributed to treatment outcome.

Another review of studies on the effectiveness of EMDR was undertaken by Lohr, Tolin, and Lilienfeld (1998), who examined 17 studies. Lohr et al. reported that the research reviewed indicated that the effects of EMDR were largely limited to verbal report indices, that eye movements appeared to be unnecessary for
improvement, and that reported effects were consistent with non-specific procedural artifacts. They also claimed that the research indicated that the conceptual analysis of EMDR was inconsistent with scientific findings regarding the role of eye movements.

More specific evidence for EMDR’s inadequacy for treating PTSD comes from research by Devilly (2001), who referred to two patients (a 46-year old and a 25-year old female with PTSD) who had been unsuccessfully treated with EMDR, but who responded positively to an operantly cognitive-behavioural treatment protocol. Both participants improved following this treatment protocol, to the extent that one of the participants was asymptomatic at post-treatment and three-month follow-up. Devilly also concluded that these cases demonstrated the ability of cognitive-behavioural intervention to successfully treat childhood sexual abuse victims later in life.

Further evidence to support the view that EMDR has little effect with trauma patients is supplied in a study by Devilly, Spence, and Rapee (1998). In their study, fifty-one war veterans with PTSD symptomatology were randomly assigned to one of three conditions: two sessions of EMDR, an equivalent procedure without EMDR, or a standard psychiatric support control condition. For all groups, there was a significant main effect of time from pre-to post-treatment, with a reduction in symptomatology. However, no significant difference was found between the groups. Participants in the two treatment conditions were more likely to display reliable improvement in trauma symptomatology than participants in the control group. By 6-month follow-up, reductions in symptomatology had dissipated and there were no statistical or reliable differences between the two treatment groups. Overall, with this war veteran population, the improvement rates were less than had been reported in
the past. Also, where improvements were reported, eye movements were not likely to be the mechanism of change. Devilly et al. (1998) concluded that other non-specific therapeutic processes might have accounted for any beneficial effects of EMDR.

Claims have been made that EMDR is effective for civilian but not combat PTSD and that that current data is not adequate to determine whether the eye movement or some other form of stimulation was essential to EMDR’s effects (Feske, 1998). Such claims have emanated from a review of experimental and quasi-experimental outcome studies of EMDR treatment for persons with PTSD. Feske’s conclusions have been supported by research by Macklin, Metzger, Lasko, Berry, Orr and Pitman (2000) who reported few changes (as a result of EMDR) at a five-year follow-up evaluation of Vietnam combat veterans with chronic PTSD. Their research provided results in direct contrast to the research by Rogers, Silver, Goss, Obenchain, Willis, & Whitney (1999) and Carlson, Chemtob, Rusnak, Hedlund, & Muraoka (1998).

In assessing the value of EMDR for treating PTSD, other researchers (Vandeusen, 1999; Coleman, 1999) have focused on the necessity of the eye movement component of EMDR in accounting for positive effects of this treatment. While Vandeusen indicated that eye movements were not essential in achieving a positive outcome, Coleman demonstrated support for the superiority of an eye-movement condition over that of no-eye movement condition and a competing motor activity of single hand tapping.

Other criticism of EMDR has been related more to the assumptions on which EMDR literature is based, than on whether there has been an amelioration of symptoms, or whether eye movements are necessary or not. Muris and Merckelbach
(1999) claimed that EMDR literature is based on three recurring assumptions, for which, they claim, there is little support: the notion that traumatic memories are fixed and stable and that flashbacks are accurate reproductions of the traumatic incident; the idea that eye movements (or other lateralised rhythmic behaviours) have an inhibitory effect on emotional memories; and the assumptions that EMDR can be used with other psychopathological conditions.

Rosen (1999) also condemned EMDR and the continued use of it in face of negative empirical findings. However, Rosen’s criticisms have been countered by Pool, de Jungh and Spector (1999), who claim that Rosen’s paper did not adequately review the existing available data and drew unwarranted conclusions.

**Summing up: EMDR and PTSD/CP Symptoms**

Thus, there appear to still be some reservations and debate concerning the efficacy and usefulness of EMDR in treating PTSD – in particular, the usefulness of the eye-movement component. It appears that that EMDR’s relative efficacy in comparison to behavioural exposure therapies had yet to be established; that the role of eye movements and laterality in attentional focus remained controversial; and that a direct link between the theoretical basis of the therapy and observable psychological and neurobiological changes had yet to be established.

Until conclusive, reliable evidence is presented, clinicians will need to make their own decision, from conflicting evidence, as to whether they will use EMDR in the treatment of PTSD. From those studies that support the use of EMDR, there are suggestions that EMDR may be useful in treating some of the core symptoms of PTSD (in particular, symptoms of re-experiencing, hypervigilance, and irritability associated with memories of the traumatic memories).
Two researchers (Korn and Leeds, 2002; Rittenhouse, 2000) have directly addressed the usefulness of EMDR with Complex PTSD sufferers, Korn et al. (2002) reporting on the usefulness of EMDR in the initial stabilization phase of CP treatment (replacing negative cognitions with positive cognitions). Other researchers (Levin, Lazrove, & Van der Kolk, 1999) have suggested that EMDR may also be useful in treating some of the broader symptoms associated with CP, such as difficulties in affect regulation (anxiety and anger). Yet other researchers have suggested a place for EMDR in enhancing self-esteem (Scheck, Schaeffer, & Gillette, 1998; Shapiro, 2001). Thus, EMDR may be useful in assisting patients to deal with CP symptoms of “Alterations in Affect Regulation” (Criterion 2); and “Alterations in Self Perception” (Criterion 4). As symptom reduction takes place, it is also probable that changes will occur in those cognitions associated with the traumatic memories (unrealistic attributions, idealisation, and pre-occupations with thoughts of the perpetrator (Criterion 5, “Alterations in Perception of Perpetrator”). Improvements in terms of interpersonal relationships (Criterion 6) and systems of meaning (feelings of hopelessness and despair) may, in turn, be noted.

**Hypnosis**

Sutton (1998) defined hypnosis as a situation in which the individual is asked to set aside critical judgement, without abandoning it completely, and is asked to indulge in make-believe and fantasy – they are required to focus their attention and to make use of the mechanism of dissociation: the separation of one part of themselves from another”. (p. 14)

Hypnotic responsiveness varies throughout the life cycle, and individuals are more highly hypnotisable during their late childhood years.
Hypnosis is a procedure used to facilitate therapy and should only be used by properly trained professionals. Hypnosis is important in treating PTSD patients for two main reasons: it can be integrated into various approaches, and it can help patients to recall traumatic events. Hypnosis has been used successfully over several years to strengthen ego and self-esteem, and also with negative cognitions in regard to self and others (Hammond, 1990). Hypnosis can also be used to assist trauma victims with some of the core symptoms of PTSD, in particular, with those associated with arousal, (e.g., insomnia and anxiety/stress). Thus, hypnosis particularly useful for the psychological treatment of shell shock, battle fatigue, traumatic neuroses, and dissociative symptomatology. In addition, hypnosis can be used to help patients face and bear a traumatic experience by embedding it in a new context. However, clinicians must have respect for the notion that traumatic memories are dissociated and ‘forgotten’ because of the overwhelming emotions associated with them; evoking traumatic memories under hypnosis may precipitate the unmodified re-living of traumatic experiences. Such ‘abreactions’ are unlikely to produce any significant therapeutic benefit, and indeed, may traumatise patients.

An individual can also carry out self-hypnosis, which is a powerful technique that can be learned quickly and easily to counteract stress and stress-related illness (Davis, Eshelman, & McKay, 1998). With some assistance, individuals can write their own self induction scripts, which will involve instructions for finding a comfortable place, breathing deeply, relaxing muscles and imagining a special and safe place. Individuals can give themselves post-hypnotic suggestions to help reduce tension.

The successful treatment of a 61-year-old British war veteran who had chronic post-traumatic stress disorder of 40 years’ duration, combined with dissociative
fugues, has been reported (Degun-Mather, 2001). The treatment involved three stages, each stage including hypnosis. Stage 1 involved psycho-education and a cognitive-behavioural approach with hypnosis; Stage 2 involved re-processing of traumatic material by use of safe-remembering hypnotic method, with cognitive re-evaluation of traumatic events to remove negative feelings. Hypnotic dreams also facilitated re-processing. Stage 3 involved further memory integration and rehabilitation. This was aided by dream elaboration, with and without hypnosis. At the end of the therapy, the veteran was virtually symptom free. The successful use of two indirect hypnotic ego-strengthening techniques in the treatment of PTSD among refugees from civil war in El Salvador and Guatemala has also been reported (Gafner, 2001).

Cardena (2000), however, pointed out that although hypnosis had recently been used with survivors of sexual assault, accidents and other traumas, and with various groups (including children and minorities), there had been no systematic study on the efficacy of hypnosis for post-traumatic stress disorders. Despite these reservations, Cardena drew attention to a number of reasons why hypnosis may be efficacious for post-traumatic conditions: it can be easily integrated into therapies that are commonly used with traumatised clients; a number of post-traumatic stress disorder clients have shown high hypnotisability in several studies; hypnosis can be used for symptoms associated with PTSD; and hypnosis can help modulate and integrate memories of trauma. Cardena, however, suggested that no conclusive statement can be made in regard to the use of hypnosis with PTSD until further systematic group or single-case studies are conducted.

Some studies regarding the use of hypnosis to treat symptoms of PTSD have, however, been undertaken. Hypnosis has been used successfully in the
psychodynamic treatment of combat neuroses (PTSD) during World War II (Watkins, 2000). In his study, Watkins described a full-time program of hypnotherapy for battle trauma cases used in a large army hospital during World War II. Symptoms reported by inmates included severe anxiety, phobias, conversions, hysterias, and dissociations. Many hypno-analytic techniques were used, including abreactions – and good therapeutic results were frequent. According to Watkins, there was no evidence that abreactive procedure tended to re-traumatise patients or initiate psychotic reactions.

The efficacy of hypnosis in dealing with PTSD was reported in the case of a male (aged 27 years) who had been a victim of an armed robbery and subsequently developed post-traumatic stress disorder as a reaction to the event (Ffrench, 2000). A combination of cognitive-behavioural therapy and hypnosis was employed over eight sessions for three months. Under hypnosis, the idiosyncratic nature of the subject’s reaction became apparent and he was able to re-integrate the experience of the trauma into his life and alleviate the fragmentation of self that prevented him from functioning adaptively.

Hypnosis has also been successful when used (in combination with cognitive-behavioural therapy) in the treatment of post-traumatic stress disorder (PTSD) with a 48-year-old woman who presented for counselling after a life-threatening home invasion (Lumsden, 2000). Hypnosis was introduced after several sessions of cognitive-behavioural therapy (CBT) and involved direct suggestions to reduce arousal levels and change avoidance patterns, imaginal exposure, imaginative involvement, and use of metaphors. A reduction in arousal levels, level of avoidance, and other symptoms was noted following treatment. Hypnosis was also reported to be a facilitator of treatment for a 31-year old female with PTSD (related to childhood
sexual abuse), providing a framework for eliciting, controlling, and working through the aftermath of her sexual abuse (Spiegel, 1996).

Several studies have indicated that hypnosis may also be helpful in the psychogenic amnesia of PTSD (Spiegel & Cardena, 1990; van der Hart, Brown & Turco, 1990). However, it is in the context of the “false memory” controversy, that hypnosis has recently fallen into disrepute as an effective treatment of PTSD and associated symptoms.

Hypnosis has also reported to be useful in the treatment of PTSD when used in combination with EMDR. Beer, Simon and Welch (2001) evaluated the combination of hypnosis and EMDR in the treatment of psychological trauma and concluded that the two processes combined were useful in resolving traumatic issues. Bjick (2001) also discussed possibilities for using effectively hypnosis and EMDR. Hollander and Bender (2001) considered the different ways in which hypnosis and EMDR may affect responses to treatment. They referred to a treatment intervention within hypnosis (Eye Closure, Eye Movements – ECEM) that could be used for patients who did not respond to either hypnosis or EMDR used separately. Hollander and Bender claimed that ECEM used the eye movement variable of EMDR within a hypnosis protocol to enhance the benefits of hypnosis and reduce certain risks of EMDR.

Other studies have indicated that self-hypnosis has been used successfully to treat a number of conditions often associated with post-traumatic stress disorder. As early as 1978, Benson had compared the usefulness of self-hypnosis and a meditational relaxation technique in the treatment of anxiety. Using psychiatric assessment, physiological testing and self-assessment tools, Benson found that there was essentially no difference between the techniques in therapeutic efficacy.
However, psychiatric assessment indicated overall improvement in 34% of self-hypnosis subjects, and the self-rating assessment indicated improvement in 63% of the self-hypnosis subjects. Self-hypnosis has also been shown to be successful for relaxation. A later study by Kohen (1986) found that self-hypnosis was highly effective in helping children in paediatric emergencies to relax.

As the above indicates, there is insufficient research available to make conclusive statements about the efficacy of hypnosis in the treatment of PTSD. However, the limited research available does provide some support for the use of hypnosis in treating some symptoms associated with PTSD, for example high arousal and anxiety. Although there is little research to support any claims in regard to the efficacy of hypnosis with CP patients, clinical experience indicates that hypnosis has been used successfully over many years in the treatment of a range of conditions. It has been particularly successful in the ego-strengthening, and in the treatment of anxiety-related conditions (with patients with and without a diagnosis of PTSD), and has potential use in addressing CP Criterion 4, “Alterations in Self-Perception” (sense of helplessness, shame, guilt, self-blame, sense of difference from others). This has also been demonstrated in one study (Gafner, 2001). Hypnosis may also be useful in altering cognitions related to the perpetrator of abuse (CP Criterion 5) and other negative cognitions (hopelessness and despair) related to the meanings attached to life (CP Criterion 7, “Alterations in Systems of Meaning”). There are also indications of its usefulness in assisting with relaxation/stress reduction and anxiety reduction (“Alterations in Affect Regulation”, Criterion 2).

**Psychodynamic/psychoanalytic methods**

In trauma-based psychodynamic therapy, the therapist’s over-arching objective is exploring the personal meaning of the traumatic event (Marshall,
Yehuda, and Bone, 2000). Specific attention is devoted to examining the impact of the self-concept and views of others, as well as using defensive manoeuvres to ward off painful emotions and nihilistic, frightening and hopeless meanings attached to the trauma and its aftermath.

There is no single psychodynamic approach to understanding the development and treatment of PTSD. Rather there are a number of complementary approaches that can be subsumed within a broadly conceived psychodynamic tradition (Fairbank & Nicholson, 1987). Horowitz (1973, 1974 – cited in Fairbank & Nicholson, 1987) has classified treatment techniques according to whether they are appropriate for addressing states of intrusive repetition of the trauma or states of denial or numbness. During a state of severe intrusive repetition, supportive or “covering” interventions may be used to alleviate painful affects, to manage regressive symptoms, and to aid repression. On the other hand, during a phase of extreme denial, “uncovering” techniques are used to reduce controls (for example, through interpretation of defenses, hypnosis, suggestion) and to encourage abreaction and catharsis (e.g. through psychodrama, use of imagery etc.). Techniques used in psychodynamic psychotherapies include formal psychoanalysis, self-psychology, brief psychotherapy, supportive psychotherapy, and interpersonal psychotherapy, expressive therapies – music/play/art (Kudler, Blank, & Krupnick, 2000). Management and supportive techniques (Brende & McCann, 1984, cited in Fairbank & Nicholson, 1987) may predominate in the early stages of psychotherapy, whereas later stages may involve induction of regression to facilitate integration of the traumatic experience and emotions associated with it.
Psychoanalysis

Psychoanalysis may also be used effectively with trauma victims – especially those who have suffered trauma as children. Clients interested in psychoanalysis must be willing to commit themselves to an intensive and long-term therapy process. Typically, they come to therapy sessions with the analysis several times weekly for three to five years. In therapy sessions, clients report their feelings, experiences, associations, memories and fantasies to the analyst (Cormier & Cormier, 1998, p.97). The goals of psychoanalytic therapy are to make the unconscious conscious and to strengthen the ego so that behaviour is based more on reality and less on instinctual cravings. Successful analysis should result in significant modification of the individual’s personality and character structure (Cormier & Cormier, 1998). The focus is on using therapeutic methods to bring out unconscious material that can be worked through. Childhood experiences are reconstructed, discussed, interpreted and analysed. The process is not limited to solving problems and learning new behaviours. Rather, there is a deeper probing into the past in order to develop the level of understanding that is assumed to be necessary for any changes to occur. Analytic therapy is oriented toward achieving insight, but not just an intellectual understanding; it is essential that the feelings and memories associated with this self-understanding be experienced.

Self Psychology

Attention to the damaged self prior to other psychological systems is central to self psychology. Garfield and Leveroni (2000) referred to the advantages of self-psychological concepts in the treatment of combat veterans with post-traumatic stress disorder. Garfield and Leveroni outlined core concepts from self-psychology (damage and repair of the self, and the importance of the self object transference in
that process). They presented three vignettes of veterans treated in outpatients, and in doing so, they highlighted how self psychology’s focus on the strengthening the damaged self has aided patients’ improvement.

**Expressive Therapies: Art.**

Art therapy is based on a psychoanalytical approach. This form of therapy has been used extensively with traumatised children, adolescents and some adults. The process of art therapy is based on the recognition that a person’s most fundamental thoughts and feelings, derived from the unconscious, reach expression in images rather than words. When used therapeutically in this way, art can be a means of non-verbal communication, a way of stating mixed, or poorly understood feelings in an attempt to bring them into clarity and order (Dalley, Case, Shaverien, Weir, Halliday, Hall, & Waller, 1987). This psychoanalytic approach to art therapy rests on the premise that spontaneous is similar to the processes of free association. It demands that “one imagine and depict what is uppermost in one’s mind and this demands both the suspension of habitual defence and a high degree of moral courage and discipline” (Kramer, 1980, p. 9). For sufferers of PTSD, art therapy can provide a medium for expression of feelings and thoughts regarding memories that are perhaps too painful for the patient. Its use lies in being part of a broader treatment approach.

**Expressive Therapies: Play Therapy**

Play therapy (based on psychodynamic and developmental principles) has been used with traumatised children since the 1920s. Play therapy is intended to help relieve the emotional distress of young children through a variety of imaginative and expressive play materials such as puppets, dolls, clay, board games, art materials and miniature objects (Webb, 1991). Practitioners who use play therapy do so on the
assumption that “children will express and work through emotional conflicts – within the metaphor of play ” (Reid, 1986, p. 261). Enzer (1988) maintained that the play therapist not only helps bring about relief of clinical symptoms, but also works toward removal of impediments to the child’s continuing development so that the child’s prospects for future development are enhanced. Through the interpersonal interactions with the therapist, the child experiences catharsis, reduction of troublesome effects, redirection of impulses, and a corrective emotional experience (Enzer, 1988). In the safety of the permissive environment of the playroom the child can express his or her feelings in fantasy, thus permitting eventual working through and mastery, which then may carry through into the child’s everyday life.

Strand (1991) reported that with children who have been the victims of sexual abuse, the trauma must be experienced through the re-telling of events in the context of a therapeutic relationship. However, prior to this, the child’s ego-strengths need to be enhanced (thorough, for example, an individualized cognitively-based therapy), and the child must be prepared in a developmentally appropriate fashion for the uncomfortable feelings that may accompany the re-telling of abusive incidents. Once this has taken place, the work of surfacing the trauma can begin. Play, the use of anatomically correct dolls or drawings, the use of specialised workbooks and board games, and art therapy are all useful in bringing out traumatic detail. Once the trauma surfaces, it is then important to help the child work through the impact of the abuse (Strand, 1991).

Terr (1989) reported that “traumatised youngsters appear to indulge in play at much older ages than do non-traumatised youngsters” (p. 29). Thus, the opportunity to play must be available to facilitate the symbolic expression of experiences that are too horrible to verbalise. However, the severely traumatised child needs to verbalise
as well as to play and Terr (1983) recommended a form of child psychotherapy using pre-arranged play in which the therapist deliberately encourages a child to re-enact the trauma by providing the child with play materials suggestive of the traumatic experience. The psychotherapeutic reconstruction includes a verbal review of the traumatic experience in which the therapist helps the child obtain relief from guilt and fear associated with the trauma.

**Expressive Therapies: Music**

Music therapy can also be used with trauma victims to assist in the reduction of stress, anxiety and depression. The Australian Music Therapy Association defined music therapy as “the planned and creative use of music to attain and maintain health and well-being” (1997, p. 1). People of any age or ability may benefit from a music therapy program, regardless of musical skill or background, as music therapy may address physical, psychological, emotional, cognitive and social needs of individuals within a therapeutic relationship.

Music therapy may address a variety of objectives such as socialisation, communication (verbal/nonverbal), relaxation, stimulation, pain or stress management/coping, enhancing self esteem, motivation, independence, physical and motor skills and cognitive skills (MTA, 1997). Erdonmez (1991) provided clear evidence, in an extensive literature review, that music was a viable means of therapy in diverse applications. It can involve a range of diverse applications: listening to pre-recorded music (Chetta, 1981; Hanser, Larson & O’Connell, 1983; Rohner & Miller, 1980; Stratton & Zalanowski, 1984); involvement in music activities, movement to music and games (Aldridge, 1993; Biller, Olson & Breen, 1974; Holligan, 1995; Marley, 1984); song/lyric writing; composition (Holligan, 1995); creative music making and improvisation (Holligan, 1995); and singing/vocalising
Sessions are facilitated by music therapists who draw from a variety of therapeutic processes that reflect their knowledge and experience in areas including psychology, physiology, social/behavioural sciences and human development.

Erdonmez (1991) claimed that the process of healing in music therapy was an interactive one: between the music, the client, and the therapist. According to Erdonmez, the choice of music (for ourselves and for other people) is of paramount importance to the therapeutic process. Erdonmez (1991) recommended that an individual choose to come to the therapy session, as choice empowers an individual with direction for their therapy, and encourages motivation in him/her to be involved and to gain something from the therapy. However, the degree to which an individual becomes involved is dependent upon the persona of the therapist and the relationship built up between therapist and client. Trust and openness to change are important ingredients in building up this relationship. Thus, the third aspect of the interactive process in healing and music therapy, according to Erdonmez, is the therapist him/herself. Erdonmez claimed that the music therapist must have a commitment to facilitate growth in others and also in oneself (Erdonmez, 1991).

In trauma-based psychodynamic therapy (whether it be formal psychoanalysis, supportive psychotherapy or art, music or play therapy), the therapist’s main objective is exploring the personal meaning of the traumatic event, devoting specific attention to the damaged self. The therapist is also aiming to determine and break down defensive mechanisms being used to ward off painful emotions and nihilistic, frightening and hopeless meanings attached to the trauma and its aftermath. Thus, it would seem that these methods of treatment have particular significance for sufferers of Complex PTSD who have experienced, as a
result of their trauma, alterations in self-perception, perception of others, and in life meanings (CP Criterion 4). The contribution of self-psychology appears to have particular relevance here.

Experience gained in a range of clinical settings has indicated that expressive forms of therapy (for example art therapy and music therapy) have more application in enriching the therapeutic process rather than in symptom reduction. The contribution of such self-expression to anxiety reduction, improved self perception can not be under-rated. Thus, they have potential for use with “Alterations in Self” (CP Criterion 4) and “Alterations in Affect Regulation” (CP Criterion 2).

**Group Psychotherapy**

Group therapy has often been recommended as an adjunctive treatment following the primary treatment for symptoms, this treatment usually being conducted in an individual setting. In the aftermath of traumatic stress, there is a primary need to affiliate and to repair damaged attachments. Groups are central to many programs for survivors of abuse, because they provide opportunities for validation and reframing, which overcome the legacy of isolation left by many forms of abuse. Finally, groups provide a vehicle for the acknowledgement and sharing of the life challenges and stresses that often come to dominate the lives of PTSD sufferers as consequences of their symptoms. The modality of group therapy has usually been applied to interpersonal and social problems associated with traumatic experience, due to their salience in the group setting.

For war survivors, group therapy can provide a major form of support. Ford and Stewart (1999) argued that group treatment for military veteran survivors of war and sexual trauma aims not to cure PTSD, but to help each individual regain connection to a sense of self that integrates experiences before, during and after the
military. Groups also assist survivors regain connection to personal, familial and societal resources as a member of a safe and supportive community. Group therapy for military-related trauma allows members and leaders to fully recognise the lasting and profound impact of trauma, while exploring the potential for sharing gradually the experience of renewal (Ford & Stewart, 1999).

Three commonly used treatment approaches are supportive group therapy, psychodynamic group therapy, and cognitive-behavioural group therapy (Foy et al, 2000). Supportive group therapy provides a context that orients members toward current coping. The goal of psychodynamic group therapy for PTSD is to give each survivor new understanding about what it means to have been exposed to trauma and to have reacted the way he or she did, and to help the survivor confront the continuing issues presented by the experience. The primary objective of cognitive-behavioural group therapy is to reduce PTSD symptoms directly or to enhance member’s control of their chronic symptoms.

There are two other ways of categorising group therapy for people who have been exposed to catastrophic trauma. The first category consists of trauma-focused groups (acute crisis intervention groups for persons affected by the same trauma; homogeneous groups for persons with a same history of trauma; and a large variety of self-help groups). The second category consists of long-term heterogeneous groups, and on this category, the emphasis is less on the trauma itself, and more on the exploration of interpersonal re-enactments and the personality changes that have occurred secondary to the traumatisation. What all three groups have in common is that they provide a ‘safe place’, and a space in which members can give voice to their traumatic memories and create narratives for their trauma and its effects on
them. Such ‘treatment’ mode is particularly useful with survivors of child sexual abuse.

**Efficacy of Group Therapy in PTSD**

A large number of studies have investigated the efficacy of group therapy for PTSD survivors. Most research indicates that this form of therapy is successful in treating a broad range of symptoms. Significant reductions in PTSD symptoms (and also anxiety, anger, and depression) were reported by participants (43 incarcerated male juveniles) in a 12-session structured group therapy for PTSD (Ovaert, Cashel, & Sewell, 2003). Successful outcomes (in terms of affect regulation) were also reported for an affect-management group for adult survivors of childhood sexual abuse (Wolfsdorf & Ziotnick, 2001). A previous study by Ziotnick et al., (1997) had suggested that an affect-management group therapy treatment was beneficial as an adjunct to individual psychotherapy and pharmacotherapy for survivors of childhood sexual abuse.

An examination of the effectiveness of two-group treatment components for incarcerated women with a history of interpersonal violence drew attention to the benefits inherent in such therapy in treating core PTSD symptoms, and also associated symptoms (Bradley, 2001). In her study, Bradley described two components to the group therapy: emotional skills training and a writing-based treatment designed to help the women create coherent and meaningful life narratives incorporating the past traumatic experiences. Criteria for participation in the group included a history of multiple incidences of interpersonal trauma (including at least one incident of child sexual abuse) and self-reported psychological symptoms common among survivors of interpersonal trauma. Results of data analysis (pre-post assessment) suggested that the group might have been effective in reducing
symptoms of depression (as measured by the BDI) and in reducing negative beliefs about self. There was also a trend suggesting decreased distrust and increased willingness to engage in social interactions. Although there was not a significant difference between the two methods with regard to PTSD symptoms, post hoc analyses of treatment group participants suggested that women who engaged in more exposure to emotions related past traumatic experiences showed a greater decrease in PTSD symptoms than the women who engaged in less exposure. While the outcomes produced by this study are promising (especially in regard to the associated features of Complex PTSD), there were several limitations to this study, including low number of participants and a high rate of drop out from the treatment group.

Positive results (reduced PTSD symptoms and alterations in dysfunctional beliefs) were reported for group therapy when used with 52 trauma patients, aged 19-55 years (Boos, Scheifling-Hirschbil, and Rueddel, 1999). In their study, all but one of the patients had been severely sexually abused, and all patients suffered from PTSD with a high co-morbidity of other mental disorders. Group therapy for these patients was based on cognitive processing therapy originally developed by Resick and Schnicke (1992).

Group treatment, when used with sexually abused male adolescents, proved to be a valuable part of their treatment, leading to improvements in specific behaviours and negative emotional states (Simmer-Dvonch, 1999). In Simmer-Dvonch’s study, male adolescents (ages 13-17), who lived in a residential treatment facility, participated in a 10-week, 20-session group treatment. All were evaluated pre-and post-treatment on a range of self-report measures. The hypotheses were that these adolescents would demonstrate impairment in general functioning, self-esteem, anxiety, depression, PTSD, empathy, and sexual knowledge before treatment, and
that they would improve significantly in these areas post-treatment. These hypotheses received only partial support. As hypothesised, group members were more impaired than controls at post-treatment. Further, post-treatment indicated some improvement: for sexual knowledge, a medium effect size was found, with 44% of the group indicating reliable change; for depression, there was a modest improvement; on the Child Behaviour Checklist (CBCL, Achenbach, 1991), there was a large effect size, with reliable change in 57% of the group. Simmer-Dvonch suggested that group treatment should be one component of a comprehensive treatment plan for adolescents in residential facilities.

Positive outcomes were also reported for group psychotherapy when used with displaced women living in the war zones of Bosnia-Herzegovinia during the war (Schei and Dahl, 1999). Two study groups (from two cities, Zenica and Tuzla) were formed to ameliorate PTSD and improve psychosocial functioning. The evaluation consisted of a questionnaire to all women, and analysis of responses indicated that highly distressed women derived greater benefit from group psychotherapy (Tuzla, n = 157) than did the group who participated in basic counselling (Zunica, n = 209).

Reduced PTSD symptoms, reduced symptoms of depression, and increased self-esteem were reported at post-treatment following a 10-week group therapy program for female survivors of sexual assault, utilising cognitive and art therapy (Volker, 1999). Positive outcomes were also reported in an examination of the efficacy of psycho-educational group therapy in reducing symptoms of PTSD among multiply traumatised women (Lubin, Loris, Burt, & Johnson, 1998). In their study, Lubin et al. examined the effectiveness of a 16-week trauma-focused, cognitive behavioural group therapy, called Interactive Psycho-educational Group Therapy, in
reducing primary symptoms of PTSD in five groups (n = 29) of multiply traumatised women (aged 18-65 years), diagnosed with chronic PTSD. Post-treatment, subjects showed significant reductions in all three clusters of PTSD symptoms (re-experiencing, avoidance and hyperarousal) and in depressive symptoms. They also showed near-significant reductions in general psychiatric and dissociative symptoms at termination. These improvements were sustained at six-month follow-up. Lubin et al. concluded that the role of group therapy should not be restricted to addressing self-esteem and interpersonal dimensions only, and that the use of structured cognitive-behavioural elements within the group format may allow for more targeted treatment of core symptoms of the disorder.

Roth and Newman (1991) also suggested long-term group therapy for survivors of sexual trauma. They claimed that, in coping with sexual trauma, survivors must come to understand the emotional impact of trauma so that they are no longer pre-occupied or driven by negative feelings, and must “grapple with the meaning of the trauma until an adaptive resolution is achieved” (p. 279). They claimed that the emotional impact may be overwhelming, and the implications for life of the meanings associated with the trauma, disruptive and disturbing to face. Working through the trauma may require a major re-examination of beliefs. However, they also suggested that individuals faced with traumatic experiences are often unable to undergo this ideal coping process and that psychotherapeutic intervention is often required for successful completion of the process. Roth and Newman recommended group therapy, with weekly meetings, over a long period of time (54 weeks).

Other positive outcomes for group therapy for PTSD sufferers have been found for male survivors of childhood incest (Singer, 1989). Group therapy,
therefore, is arguably the most common form of psychotherapy for trauma survivors, having widespread application. In addition to the cost-effectiveness of this avenue, group therapy also provides an opportunity for participants to learn about how other people with similar trauma experiences respond to the trauma and the treatment.

Group therapy could be particularly useful when used with individuals with Complex PTSD, who have experienced alterations in self-perception (low self-esteem). In the safety of a group, individuals can explore and address many of the issues related to such alterations: for example, issues related to their self-perception (feelings of guilt and shame, a sense of stigma, and their feelings of difference from others and low self-esteem) and in their systems of meaning. Group therapy could also be useful in assisting those who have experienced alterations in their perception of the perpetrator, as in the safety of a group, individuals can explore and address many of the issues related to their perception of the perpetrator. It is also useful for those who have developed difficulties in interpersonal relationships as a result of their trauma. Involvement in a safe group may assist alterations associated with interpersonal relationships (feelings of isolation and withdrawal, disruption to intimate relationships, persistent distrust, and feelings of loss of control).

Use of Standard Interventions in Treating Complex Post-Traumatic Stress Disorder (CP)

In conclusion, by examining the standard interventions used with PTSD, and relevant treatment outcome studies, it has been possible to evaluate the PTSD symptoms for which they have been most useful, and also the associated (or CP) symptoms that have been affected. In treating symptoms of “Alterations in Affect Regulation” (CP Criterion 2), all of the following therapies have potential values:
exposure therapy (including imaginal exposure, virtual reality exposure, &
systematic desensitization); cognitive therapy, EMDR, hypnosis and group therapy.
In treating symptoms of “Alterations in Consciousness” (CP Criterion 3) – in
particular dissociation and avoidance – hypnosis, exposure therapy and systematic
desensitization could be beneficial for some individuals. With symptoms related to
“Alterations in Self Perception” (CP Criterion 4), all of the treatment modalities
described in this chapter have some relevance. In assisting with “Alterations in
Perception of the Perpetrator” of Abuse (Criterion 5), hypnosis, EMDR, exposure
therapy and cognitive therapy could all be used with positive effect. In assisting with
“Alterations in Relations with Others” (CP Criterion 6), group therapy and cognitive
therapy could both be used to examine interpersonal relationships, and dynamics
within them. With “Alterations in Systems of Meaning” (Criterion 7), cognitive
therapy and also psychodynamic methods (in particular expressive therapies) may be
useful.

Although all of the same treatment modalities used with core PTSD
Symptoms are also useful with CP, it is important that they are used in such a
manner that they specifically target these symptoms. CP symptoms may appear to
have been indirectly affected by the standard interventions, most PTSD treatment
outcome studies and treatment programs do not specifically target them – and, in
many cases, improvements have occurred in association with improvements in PTSD
symptoms, such as re-experiencing, avoidance, and arousal symptoms. With CP
sufferers, however, the various CP symptoms (alterations in self perception, affect
regulation, consciousness, relations with others, systems of meaning) need to be the
focus of the therapy – and to take place prior to any abreactive work. In this way, the
chances of symptom improvement will be greater.
Clinical judgement is important in deciding the therapeutic approach that is most suitable for specific symptoms. In more severe cases, where a victim of trauma is suffering from extreme depression and has suicidal intent, hospitalisation may be necessary. Further, with those sufferers who also suffer from substance abuse, other interventions are often necessary prior to PTSD treatment.
CHAPTER 4

STUDY ONE: CLIENTS’ PERCEPTION OF PTSD TREATMENTS

As the previous chapter indicates, PTSD research has provided many excellent treatment outcome studies from a wide range of theoretical orientations. However, most research has focused on CBT approaches, with little on psychodynamic forms of therapy or hypnosis. Further, few treatment outcome studies have investigated treatments that address those additional symptoms associated with CP. Thus, in the light of strong support for the concept of CP, and an absence of studies that investigate treatments used with sufferers of CP, there is a need for research investigating the effectiveness of interventions used with sufferers of CP, and for the subsequent development of guidelines for such treatment programs.

This study reports on preliminary work on individuals’ perceptions of the usefulness of past treatment of trauma-related symptoms (in particular, in treating those symptoms reported as CP symptoms). In this study, participants in the study reported (retrospectively) on their symptoms prior to treatment and following treatment. It is important to acknowledge the limitations of retrospective reporting, given the malleability of memory over time. On the other hand, while acknowledging the bias that may result from such methods, participants’ own perceptions may still make a valuable contribution to an understanding of their condition and the role their current treatment methods play (Dube et al., 2004).

Two main research questions were asked. The first question related to the nature of the individual’s trauma experience(s). For the purposes of this research, it was important to determine whether the trauma experiences fulfilled any of the following descriptions: long-term childhood abuse; long-term child abuse followed
by further extreme trauma in later adult life; long-term/chronic and extreme trauma in adult life; multiple trauma experiences. The second question related to those aspects of the participants’ previous treatment that had been most helpful to participants. Responses to this question were to provide an insight into those treatments that individuals perceived were most effective in dealing with CP symptoms, and a basis for the development of an effective treatment program.

**Method**

**Participants**

Participants for this study were volunteers who had reported experiencing extreme or prolonged trauma in childhood or adulthood and who had received treatment (or were approaching completion of treatment) for PTSD. Thirty-three individuals were involved, all but one of these being individuals who had read an advertisement for the study in one of the newspapers. The other person had responded to a poster seen in a Health Centre. None was referred by a treating psychologist. All 33 respondents were sent a questionnaire (see Appendix A) for completion. However, of these, only 15 completed and returned the questionnaire. Those who did not return the questionnaire were contacted by letter (Appendix B) and then by follow-up phone call or e-mail. Ten of these provided explanations for not completing and returning the questionnaire. Eight did not respond to the letter, or to messages left on answering machines. Of the ten individuals who provided explanations, one phoned to say that she did not believe the questionnaire was relevant to the trauma she and her family (two of whom had also received questionnaires) had experienced. On further questioning, this woman disclosed her reasons for this comment: the initial section was devoted to child maltreatment, and
since this was not relevant to her experience, she did not read further and decided not
to complete the questionnaire. Although an explanation was provided for the
rationale for including the questions about childhood trauma, neither the respondent,
nor the other two family members, returned the questionnaires. Four other potential
participants found the questionnaire too difficult. Comments ranged from, “I
couldn’t face it – completing it would cost me too much”, “I couldn’t cope with the
questions”, “It was too gruelling” to “I have really struggled with it – but can’t
complete it”. Another respondent was intending to complete the questionnaire.
However, his wife wrote back to say that her husband had been hospitalised for some
time, and would not be completing the questionnaire. Another respondent’s wife
wrote to say that her husband had recently discovered he had bowel cancer and was
undergoing chemotherapy and radiotherapy – and hence, would not be completing
the questionnaire. One respondent phoned to say that he was in the process of taking
several psychologists in the area to court for mis-diagnosis, and that psychometric
tests were useless as a way of assessing trauma. He commented that he would not
trust the results of my questionnaire and would not want to contribute to the
research.

Of the 15 individuals who completed the questionnaire, 12 were females, and
three were males. The ages of participants ranged from 21 - 73 years, with a mean
age of 46.8 years. Twelve of the participants described their ethnicity as ‘Australian’,
‘Anglo-Saxon’, or ‘English’. Two others described themselves as ‘Irish/Australian’.
Yet another described herself as a ‘naturalised Australian’, but ‘born Dutch’. Six
participants were currently married, and one was in a de facto relationship. Four
participants were divorced, one was separated, and three participants were single
(one of these being a religious sister). Nine of the participants had children, and six
participants had no children. Four of the latter group were single, one was divorced, and one was in a de facto relationship.

Seven of the participants were not employed: one (21 years old) was a student; three (aged 73, 53, 62) were retired; one (aged 43) was a pensioner; one (aged 46) was receiving work care pension; and one (aged 38) was unemployed/undertaking casual labour. Two participants had been teachers: one of these (aged 46) was now at home; the other had become a chaplain (aged 51). Of the six others who were currently employed, occupations included shop manager, support worker in a women's and children's shelter, public servant, research officer, childcare, and religious sister. Twelve of the 15 who responded reported experiencing extreme trauma or multiple traumatic experiences over a long period. Three others described experiences that did not meet the criteria for inclusion in this program.

**Procedure**

In order to obtain the individuals for this study, several sources were used. Firstly, advertisements were placed in premier papers in capital cities from two Australian states/territories, seeking volunteers to take part in the study (see Appendix C). In addition, posters (see Appendix D) were placed in Health Centres located in various parts of one metropolitan centre. Finally, registered psychologists practising in the same metropolitan centre were contacted by letter (see Appendix E). These were selected from those who advertise in the telephone directory as providers of assessment and treatment for PTSD. The psychologists were approached and invited to assist the study by providing written information about the study, a Plain Language statement compiled by the researcher (Appendix F) to any clients who had been treated for PTSD. Those patients deemed as suitable for this study by their
treating psychologist (i.e. satisfying the criteria for PTSD) were invited to contact the researcher by phone if interested in being involved in the study.

Respondents were provided with details regarding the research study. Interested individuals were advised (see Appendix F) that the researcher would make every effort to ensure confidentiality of information gathered, and to secure the anonymity of each participant’s data. They were informed that, throughout the six-month treatment period, participants’ files would be stored in a locked cabinet in the researcher’s home. Participants were also advised that, in the writing up of the study, no names or identifying information (rather, pseudonyms) would be used. In re-assuring participants, re-assurance was provided to them that, due to the sensitive nature of issues surrounding personal and childhood experiences, should they become distressed at any stage of the study, or have any concerns regarding the nature of the research, they would be able to withdraw their participation at any stage of the research.

**Measures**

In measuring the nature and extent of traumatic experience(s), participants were asked to describe briefly in their own words the trauma(s) they had experienced. They were also asked to complete three inventories: Modified Comprehensive Child Maltreatment Scales for Adults (Higgins & McCabe, 2001); Self-Report Inventory for Disorders of Extreme Stress, SIDES - SR, (van der Kolk, 1996); The Post Traumatic Stress Diagnostic Scale, (PDS, Foa, 1995).

*Modified Comprehensive Child Maltreatment Scales, CCMS (Higgins & McCabe, 2001). The CCMS, referred to in Chapter 2, was used to measure the nature and extent of childhood maltreatment. It was selected because it has several advantages over other scales: it assesses a number of childhood maltreatment*
experiences; it can be completed by non-clinical populations; it is easy to administer and it allows the administrator to obtain continuous scores on the five maltreatment scales. The CCMS also has the advantage over some others in assessing a range of childhood maltreatment experiences: sexual abuse, physical abuse, psychological maltreatment, neglect, and witnessing family violence.

*PDS (Foa, 1995).* The PDS, also reported in Chapter 2, was used to measure core PTSD symptoms. It was selected because it is short and easy for participants to use, and clinicians to administer and score and because of its excellent psychometric properties. Participants were asked to complete this inventory (retrospectively) for two periods: that prior to treatment and current.

*Structured Interview for Disorders of Extreme Stress – Self-Report (SIDES-SR, van der Kolk, 1996).* The SIDES-SR was used to measure DSM-IV Associated Features of PTSD. Nine of the Associated features derive from the CP symptoms. Participants were asked to complete this inventory (retrospectively) for two periods: that prior to the treatment they had received, and then again to assess their current functioning. Information regarding treatment approach was gained, in the first instance, from participants. Participants were asked open-ended questions regarding the treatment approach (from their perspective), the most useful aspect of the treatment, the least useful aspect, and other strategies/treatment approaches that may have been useful, but which were not used. It was also hoped that therapists would be able to provide information regarding the treatment approach adopted with their client. The researcher’s intention was to contact therapists, first by phone, and then by mail. In the latter instance, therapists were to be sent a data information sheet that asked them to provide details of the treatment approach used with their client. A
Results

A case-study approach was adopted in the analysis of responses. The results for each research question, based on participants’ responses, are reported below.

Research Question 1: Nature of Trauma Experiences / Categorization of Trauma

Twelve participants described trauma experiences that could be assessed as either extreme/particularly severe in nature, long-term, or multiple – or in most cases, a combination of these characteristics. Four main categories of trauma presented: child abuse over a long period; child abuse followed by other trauma(s) as an adult; multiple and varied trauma over many years as an adult; extreme and prolonged trauma in adult years. All of these categories met the criteria for CP.

Category 1: child abuse over long period (n = 6). Six respondents reported long-term child abuse. Of these, three reported emotional, physical and sexual abuse over many years during childhood and adolescence. One reported sexual abuse by an uncle from the age of 4-24 years, compounded by a dysfunctional family. One other reported emotional and some physical abuse within the family in early years/adolescence, followed by rape at 18 years. All of these cases represented multiple and severe traumatic experiences over a long term. One other case reported emotional/verbal abuse throughout childhood and adolescence – and also witnessing this behaviour toward others. This case also represented long-term/chronic trauma.

Category 2: child abuse followed by further trauma as an adult (n = 4). All of the respondents in this category described trauma that was long-term, severe and multiple in nature. One of the four respondents in this category described multiple
trauma from childhood to adulthood: sexual “interference” (participant’s description) and rape by sibling at 14 years, as well as sexual abuse and mental abuse at boarding school by other girls and staff. There were three others who described child abuse followed by further abuse as an adult. One described verbal abuse by her mother during her childhood years (prior to the age of 13 years), sexual abuse by her father prior to 13 years, and rape by a male colleague when 20 years old. Another individual described multiple trauma: at 13 years, gang rape by three adult male acquaintances; at 17 years, witnessing violence toward grandmother; and at 33 years, rape by a family friend. Yet another individual in this category reported extreme conflict with her father (an alcoholic) in childhood, a series of broken relationships, work stress and conflict, a repeated cycle of emotional conflict, and chronic fatigue in her 30’s.

Category 3: multiple trauma experiences over many years (n = 1). One respondent described multiple armed assaults as a security officer, severe and prolonged back injury, the death of his father (and participation in the decision to remove his father’s life support), the witnessing of deaths as a firefighter, and the loss of his marriage and children. As well as experiencing a range of trauma experiences, this respondent also experienced this trauma over a long period. Most of this trauma was severe in nature.

Category 4: Long term extreme stress. One respondent described date rape (sodomy) at 17 years with subsequent memory loss over 17 years. During the 17 years, she had married and lived with the person who had raped her. At the time of the study, she reported that she was still living with him. Although this respondent did not report multiple trauma, she was unable to separate from the perpetrator of the original trauma incident. The memory of the trauma was thus kept alive every day
for seventeen years, and it is possible that this respondent felt re-traumatised every
time she engaged in sexual activity with the perpetrator. The memory loss over
seventeen years is an indication that the trauma response continued for this period.

*Other trauma experiences.* There were two respondents who described
trauma experiences that represented neither long-term childhood trauma, prolonged
and extreme trauma in adult years, nor multiple traumatic experiences. These
experiences did not meet the criteria for CP. One respondent reported the unexpected
loss of relationship/divorce at 58 years, as well as a more recent assault. Although
these experiences were no doubt extremely stressful at the time for the individuals
concerned, neither involved long-term childhood maltreatment, prolonged and
extreme adult trauma, or multiple trauma. Neither experiences meet the essential
criteria for PTSD. The other respondent reported adult trauma stemming from guilt
over a work colleague’s suicide (due to his uncovering fraud). Once again, although
this experience may have felt “highly stressful” at the time for the individual
involved, it does not represent long-term and extreme trauma, either in childhood or
adulthood, or multiple trauma experiences.

*Research Question 2: Treatment Efficacy*

For each participant in the study, a comparison was made of retrospective and
current responses to the PDS (Foa, 1995) and the SIDES-SR (Van der Kolk, 1996) to
determine whether (from the participant perspective) there had been a reduction in
number and severity of symptoms.

Table 6 on the following page compares pre-treatment and post treatment
symptoms, as determined on the PDS (Foa, 1995). The first three columns indicate
number and severity of symptoms and also level of impairment prior to treatment.
The middle column indicates the length of treatment, while the final three columns indicate the symptoms the patient believed he/she was currently experiencing.

As the table following indicates, nine respondents indicated a reduction in the number of core PTSD symptoms over time. Three of these, however, indicated a reduction of only one or two symptoms. It must also be remembered that the length of treatment differed for each respondent, ranging from no formal intervention to twenty years of therapy with numerous therapists. In terms of reduction in severity of core PTSD symptoms, all but one respondent reported a reduction in the severity of symptoms, several showing a marked decrease. From information obtained from the SIDES-SR (Van der Kolk, 1996), ten of the twelve respondents indicated fewer CP symptoms (See Table 7).

The qualitative responses of those who did indicate a reduction were also examined. Of particular interest was information regarding most /least useful aspects of treatment – and whether (from an individual perspective) CP symptoms had been addressed.
### Table 6

**A Comparison of the Pre- and Post-Treatment Responses to the PSS**

<table>
<thead>
<tr>
<th>Participant</th>
<th>No of symptoms (n=17)</th>
<th>Severity of symptoms (n=51)</th>
<th>Level of Impairment</th>
<th>Length of Treatment</th>
<th>No of Symptoms</th>
<th>Severity of Symptoms</th>
<th>Level of Impairment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clarissa</td>
<td>15</td>
<td>35 (Moderate-Severe)</td>
<td>Severe</td>
<td>2 years</td>
<td>13</td>
<td>36</td>
<td>Severe</td>
</tr>
<tr>
<td>Linda</td>
<td>16</td>
<td>48 (Severe)</td>
<td>Severe (in all areas)</td>
<td>3 months</td>
<td>16</td>
<td>35 (Moderate-Severe)</td>
<td>Mild</td>
</tr>
<tr>
<td>Jenna</td>
<td>17</td>
<td>45</td>
<td>Severe (in all areas).</td>
<td>4 years</td>
<td>9</td>
<td>11</td>
<td>No impairment.</td>
</tr>
<tr>
<td>Felicity</td>
<td>17</td>
<td>47</td>
<td>Severe (most areas).</td>
<td>16 years</td>
<td>9</td>
<td>22</td>
<td>Moderate</td>
</tr>
<tr>
<td>Julie</td>
<td>16</td>
<td>36</td>
<td>Severe (in all areas).</td>
<td>6 years</td>
<td>12</td>
<td>27 (Moderate)</td>
<td>Severe (in all areas).</td>
</tr>
<tr>
<td>Pat</td>
<td>15</td>
<td>38</td>
<td>Severe (most areas)</td>
<td>16 years</td>
<td>14</td>
<td>21</td>
<td>Moderate (affecting 5 areas).</td>
</tr>
<tr>
<td>Rick</td>
<td>16</td>
<td>21</td>
<td>Severe (in all areas).</td>
<td>–</td>
<td>14</td>
<td>31 (Moderate-Severe)</td>
<td>Severe (all areas).</td>
</tr>
<tr>
<td>Beth</td>
<td>16</td>
<td>35</td>
<td>Severe (all areas).</td>
<td>20 years</td>
<td>16</td>
<td>13</td>
<td>Moderate</td>
</tr>
<tr>
<td>Christine</td>
<td>15</td>
<td>33</td>
<td>Severe (all areas).</td>
<td>None</td>
<td>11</td>
<td>24</td>
<td>Mild-Moderate</td>
</tr>
<tr>
<td>Georgia</td>
<td>17</td>
<td>51</td>
<td>Severe (most areas).</td>
<td>3 years</td>
<td>13</td>
<td>17</td>
<td>Moderate</td>
</tr>
<tr>
<td>Elise</td>
<td>17</td>
<td>51</td>
<td>Severe</td>
<td>11 years</td>
<td>17</td>
<td>45</td>
<td>Severe</td>
</tr>
<tr>
<td>Mary</td>
<td>16</td>
<td>21</td>
<td>Severe</td>
<td>7 years</td>
<td>9</td>
<td>9</td>
<td>Severe</td>
</tr>
<tr>
<td>Participant</td>
<td>Pre-Treatment</td>
<td>Length of Treatment</td>
<td>Post-Treatment</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>-------------</td>
<td>---------------</td>
<td>---------------------</td>
<td>----------------</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clarissa</td>
<td>CS scores in 2 main scales and 2 sub-scales.</td>
<td>2 years</td>
<td>No CS scores on main scales – and 2 other sub-scales.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Linda</td>
<td>CS scores on one main scale and 4 sub-scales.</td>
<td>3 months (at 35 years)</td>
<td>Little change – two sub-scale scores no longer present.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Jenna</td>
<td>CS scores on one main scale and 4 sub-scales.</td>
<td>5 years (last 6 months most helpful)</td>
<td>No CS scores.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Felicity</td>
<td>CS score in one main scale and 3 sub-scales.</td>
<td>16 years</td>
<td>No CS on main scale; CS scores on 3 sub-scales (but some reductions - guilt, hopelessness).</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Julie</td>
<td>CS in one main scale and 4 sub-scales.</td>
<td>4 years</td>
<td>CS scores in two main scales, and 3 sub-scales.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pat</td>
<td>CS scores on three main scales, 2 sub-scales.</td>
<td>16 years (Last 9 years spiritual)</td>
<td>No CS scores.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rick</td>
<td>CS scores on 4 main scales and 2 sub-scales.</td>
<td></td>
<td>No CS scores.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Beth</td>
<td>CS score in one main scale and 3 sub-scales.</td>
<td>20 years</td>
<td>No CS on main scale, or some sub-scales. CS in one of previous sub-scales and 2 new sub-scales.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

CS = clinically significant
Treatment Efficacy: Qualitative Analysis

The following information is based on descriptions provided by seven participants, as five of the respondents provided little or no informative details regarding their treatment. The respondents indicated methods of treatment that were important in promoting healing and recovery.

Treatment that Assisted with Altering Self Perception.

Six of the seven respondents indicated that work undertaken in this area was of high importance in their healing and recovery. For example, one respondent (Jenna) claimed that the most helpful aspect of her treatment was that which occurred during the last four years of her 24-year treatment (and in particular, the past six months). During this time (between the ages of 33 and 35 years), Jenna had participated in self-esteem courses. Then, at the age of 36 years, she had undertaken “independent, honest counselors”, in which she had worked on “self-perception, getting to know who I was, and that I was important and to be valued.” Jenna reported on what was most helpful in her treatment: “Having someone listen, really listen, to me and understand the impact of events (and after events) and not be judged”; “Having ongoing support while I tried to go forward (rape counselor, husband, select friends)”; “Finding out that there are people who care and who made my inside feelings count and should be trusted (finding out I actually had my own thoughts and feelings)”; “Finding out that I am strong and capable and worthwhile and that I matter”; “Learning to listen and be aware of my own feelings and emotions and then acting on them”; “Leaving shame and guilt behind”; “Accepting my past and myself as all making me who I am today”.

It is worth noting here that all of the above comments relate to work undertaken in the area of “Alterations in Self Perception”. This work thus appeared
to be important to Jenna in her healing. Other valuable work focused on an area in which this respondent had originally reported problems (“Alterations in Relations with Others”) – no longer pretending to please (parents and others) and being able to say “No”.

Although the above does not provide in-depth information regarding the treatment provided (it was not possible to gain comments from the therapist), it appears that, from the respondent’s perspective, the healing process was dependent on non-judgmental and empathic support, dealing with issues associated with self-perception, shame, guilt, and awareness of feelings and emotions. These areas all represent at least two of the core symptoms of Complex PTSD – and to this respondent, were considered the basis to other problems. Jenna’s final comment indicated that dealing with the issues of self had given a new meaning to her life: “I feel so much better and stronger these days. I do not ever remember having this level of confidence in myself. I feel now that whatever I want to do is achievable.” This participant, as a result of her most recent treatment, appeared to be in a more stable state, with confidence and strength to undertake abreactive work, if she so desired.

Another respondent (Felicity) also reported that the most effective therapy was that received over the most recent two years of her 16 years of treatment: therapy based on a self-psychology model. The respondent claimed that, as a result of the treatment, she could see a change in herself: “I am more assertive that I have ever been”. From discussions with this client, it was apparent that this more recent therapeutic intervention allowed the respondent to feel valued and appreciated. Thus, although this respondent had indicated scores in the clinical range prior to treatment on the domain of “Alterations in Self Perception”, scores were not in the clinical range on this domain post-treatment, suggesting that, at least in her own
retrospective self-perception, there was an improvement in trauma-related symptoms during the period of this therapy.

A further respondent (Pat), who received treatment over 16 years, reported that her condition had only improved in the final eight years of this period (since 1992). The respondent reported that, at this time, she not only received more appropriate medication, but also “appropriate” therapy and spiritual guidance. The therapy in this final stage involved sympathetic, supportive and empathic counsellors who allowed the respondent to gain a stronger sense of self, more certainty in regard to her systems of meaning, and the capacity to regulate her emotions and impulses. The respondent reported a post-treatment reduction in all symptoms associated with Complex PTSD, with scores not in the clinical range on any scale post-treatment. Her retrospective reports of her symptoms prior to this treatment had indicated clinically significant scores on three main scales, and two sub-scales. Thus, it is clear from this respondent’s report that, until her condition had been stabilized, she was unable to participate fully in other work. The reduction in all CP symptoms (“Alterations in Self Perception”, “Alterations in Systems of Meaning”, “Somatisation”, “Difficulties with Relationships”, and “Regulation of Affect and Impulses”) appears to be related to the final stage of treatment. It is unfortunate that this treatment was not available to this respondent at an earlier stage in her treatment.

Finally, Beth, who received treatment over 20 years, explained also that the most useful aspects of treatment were “those parts of psychotherapy that helped me understand that I had always felt wicked, bad (I don’t feel this way now)”. Thus, it appears that therapy that had dealt with her alterations in self-perception had once again been important, providing a basis for further improvement. Beth also reported that another important aspect of her treatment was “understanding that maybe I was
always depressed and I have worked out tricks for getting through those times when it’s worst”. Clearly, therapy that allowed for greater self-knowledge was also extremely important. The efficacy of Beth’s treatment was confirmed by responses to inventories completed by this respondent, prior to and post treatment. Post-treatment, Beth indicated a reduction of some symptoms associated with CP, with scores not in the clinical range on the one main scale and two sub-scales retrospectively reported as being present prior to treatment. However, Beth also reported some new symptoms emerging. Thus, although marked overall improvement was not indicated, Beth believed that the most helpful aspects of treatment were those which assisted with improvements in self-perception, which in turn assisted with other problems, such as those associated with ‘Alterations in Consciousness’.

Yet another respondent, Georgia, reported treatment over six years, the most effective being that which assisted with improved self-perception. For example, Georgia stated [in regard to the 12-step AL-anon program]

It helped to open me up to self expression to deal with denial and strengthen my faith in the self and others. Without this program, I do not believe I would have been prepared to go through with the one on one therapy; nor would it have been as successful.

The success of this respondent’s treatment was confirmed in the results of the SIDES inventory, in which she reported a marked reduction in symptoms associated with CP, with scores not in the clinical range on the three main scales and two sub-scales (retrospectively reported as being present prior to treatment). Thus, therapy that allowed the respondent to gain an enhanced self-concept and greater self-awareness, provided stability and allowed for the next stage of therapy.
Information provided by another respondent, Julie, also indicated that treatment that allows and encourages the strengthening of self-perception is seen as necessary for healing. Julie reported that it would have been beneficial to have “a psychiatrist who cared enough about me and who valued me, to encourage me to continue treatment, instead of letting me drop out of treatment too early”. Julie had felt ignored by her psychiatrist, stating that “I felt useless, a failure, and that he wanted me to leave treatment and never come back.” She also reported that medication was useful in her treatment of core PTSD symptoms. However, very little of this treatment was likely to assist with those symptoms that Julie displayed and which are consistent with a diagnosis of Complex PTSD (somatisation, feelings of guilt, shame, “permanent damage” and difficulties in regulation of affect). What appeared to be missing was empathic, consistent, ongoing support, via which this respondent may have been able to build a strong sense of self, learn affect modulation skills, improve her relationships with others; in other words, achieve some stability in her life. Julie clearly felt that she was not valued by her therapist, and perhaps issues with poor self-perception accentuated her reaction to her therapist’s perceived ignoring of her.

Clearly, assisting patients in strengthening self perception was of critical importance in gaining improved stability. In dealing with self-perception, many reported that they were able to eliminate (or reduce) some or all of the following: feelings of helplessness, paralysis of initiative, self-blame, sense of stigma, or a complete sense of difference to others. Such improvements appear to be essential prior to any further abreactive work, placing the patient in a much stronger position to deal with past memories.
Due to incomplete information, it was difficult to ascertain forms of therapy that were not helpful. However, one participant, who felt that she was “not heard”, claimed that counsellors who did not attempt to gain a full understanding of what she was really experiencing, and drew faulty conclusions, did not help her. This participant did not indicate any improvement in CP symptoms (including self-perception) over 17 years.

**Treatment that Assisted with Affect Regulation**

Julie also reported on the benefits of work associated with improving the capacity to deal with emotions (affect regulation). Julie stated:

Treatment also encouraged me to feel emotions and not fear them. I was emotionally frozen and therefore the treatment needed a person who I could interact with on that level and not feel embarrassed. It was a time of discovery for me and a time to be nurtured and to learn to nurture myself. I found the process did far more for me than I ever imagined it would, and my life has changed for the better as a result.

Again, this aspect of Julie’s treatment allowed the respondent to gain greater self-insight, emotional awareness and enhanced self-concept. It is clear, therefore, that the therapy that Julie received dealt largely with symptoms associated with CP – and that dealing with such symptoms placed her in a much stronger and more stable emotional condition.

**Efficacy of Group Therapy**

The usefulness of group therapy was reported by only one respondent, Mary, who claimed that involvement in a support group of individuals who had suffered sexual abuse was beneficial. No other information explaining this claim was provided.
Discussion

As outlined earlier in this chapter, this initial study reported on individuals’ perceptions of the usefulness of past treatment of trauma-related symptoms, participants describing (retrospectively) their symptoms prior to treatment and following treatment. Although the study had several limitations (small numbers, inadequate information regarding the specific treatment approaches that had been used, and retrospective reporting regarding pre- and post-treatment symptoms), it provided some useful information in regard to components of treatment approaches that individuals have found to be effective.

Qualitative and quantitative data have both contributed to the individuals’ profiles. Quantitative data have indicated a reduction of PTSD symptoms – both number and intensity for most participants. They also indicated a reduction in CP symptoms for most participants. Qualitative data, in the form of participants’ descriptions of aspects of their past treatment that were ‘most helpful’ and ‘least helpful’, have provided a richness and depth of information that could not be obtained through standardized measurement. A consistent message conveyed by many individuals was that the work involving ‘self’ issues was the most important work undertaken. Those respondents who received assistance with their self-perception reported feeling generally much stronger and benefited in terms of overall reduction of CP symptoms. Thus, it appears that a vital element of early stage treatment involves assisting trauma survivors regain a stronger sense of self (Chu, 1998). Such ‘ego strengthening’ may then allow individuals to deal more effectively with emotions, regulate and manage themselves (e.g., dissociation), relate more
effectively to others, and re-establish ‘systems of meaning’ for themselves (those symptoms identified by Herman (1992a) as the criteria for a diagnosis of CP).

This finding supports suggestions made by other researchers in this area (Chu, 1998; van der Kolk, 1996), who have referred to 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 (1998, cited in Chu, 1998) wrote, “this treatment is far from a search for the missing memories; instead, it is a process of life reconstruction and enhancement”. Thus, if clinicians are to really help those people who suffer from long-term abuse (as children or adults), it is important that they routinely assess and treat those symptoms listed under CP. Clinicians thus need to expand their range of treatment targets. In doing so, they should be able to assist individuals with strengthening of ego – essential before any exploration of previous trauma experiences takes place. Chu (1998) stated:

Therapists… must provide education (and limits where necessary) about the need to do solid ego-supportive psychotherapy before proceeding with abreactive work… this kind of therapy may not appear as dramatic as aggressive abreactive work, but it has the best chance of helping patients achieve stability and the capacity for eventual exploration and working through of their early abuse. (p.77)

Thus, the treatment for CP sufferers is time consuming and requires long-term commitment. It requires attending to those symptoms not addressed in the PTSD diagnosis: alterations in self-perception, affect modulation, interpersonal relations, perception of the perpetrator, and systems of meaning.
The feedback gained from those participants who have contributed to the initial stages of this research has provided some support for such claims and for current literature in the area of Complex PTSD. This feedback has been useful in informing decisions in regard to the development of guidelines for the treatment program used in this study.
CHAPTER 5

DEVELOPMENT OF TREATMENT PROGRAM GUIDELINES FOR COMPLEX PTSD

In this chapter, the treatment program guidelines implemented and evaluated in this study are described. These guidelines have been developed as a broad framework, rather than as a prescriptive, step-by-step therapeutic process. However, within the framework, there is scope for catering for individual need.

The guidelines for treating Complex PTSD in the early stages are based on a 6-stage model. The six stages form the acronym, ‘HEALTH’:

H - Having a Supportive Therapist
E - Ensuring Personal Safety;
A - Assisting with Daily Functioning;
L - Learning to Manage Core PTSD Symptoms
T - Treating Complex PTSD Symptoms.
H - Having patience and persistence to enable “ego strengthening”.

Although an appropriate model for treating CP has been developed by Chu (1998), and has also influenced the development of this set of guidelines, Chu’s model has not yet, to the researcher’s knowledge, been used as the basis to a formally-evaluated treatment program.

Influences in the Development of the Guidelines

There have been several factors influencing the development of this program: the models for treatment of CP by such clinicians and therapists as Chu (1998), Herman (1992a), and Lebowitz, Harvey and Herman (1993); the researcher’s clinical
experience in working with sufferers of trauma (1); and information gained by the researcher from the initial study.

A major influence in the development of these guidelines has been the “SAFER” model, developed by Chu (1998) as a basis for treatment programs for adult survivors of long-term or multiple abuse experiences (and who met the criteria for Complex PTSD). In providing a rationale for his model, Chu indicated that “many survivors of childhood abuse require an initial (sometimes lengthy) period of developing fundamental skills in maintaining supportive relationships, developing self-care strategies, coping with symptomatology, improving functioning, and establishing a positive self identity.” Chu (1998) described this process as one of “building a solid foundation of ego functioning”, essential before “embarking on any extensive exploration of childhood trauma or abreactive work.” This is the process required in the treatment of Complex PTSD. Chu (1998) also claimed that, although the eventual abreaction and integration of childhood trauma experiences is useful in assisting with post-traumatic and dissociative symptomatology, there are often problems if clients attempt to uncover and explore past traumatic experiences well before they are capable of doing so. Such individuals appear to be constantly in crisis, often experiencing intense flashbacks, dreams, feelings and intrusive thoughts, which are almost always overwhelming.

(1) Pam Connor (B.A, B. Sc. [Psych], Masters in Counselling) 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.
These clients also experience periods of numbing, and although they often persist in efforts to overcome their difficulties by releasing unbearable thoughts and feelings about the past, their attempts are often premature. Attempts of mastery of past traumatic experiences then result only in re-traumatisation of the client and often regression and increased symptomatology.

Thus, in Chu’s (1998) words, “there is a need for solid ego-supportive psychotherapy before proceeding with abreactive work”. Although this kind of therapy may appear almost bland in comparison with abreactive work, it is more appropriate in early stages and is more likely to help clients achieve stability so that they can eventually explore and work through past trauma. Chu identified certain areas of focus, which he claimed were critical in the early stages of treatment. He discussed these, using the acronym, “SAFER”: Self-care and symptom control, Acknowledgement, Functioning, Expression, and Relationships. Herman’s seven criteria for Complex PTSD have also been important in developing these guidelines, as the CP criteria are being directly targeted in Stage 5, the central component of the program (referred to on page 136).

The current treatment program is also consistent with the concept of Phase-Oriented Trauma Treatment (POTT), which is considered the ‘standard of care’ in the treatment of survivors with severe co-morbidity and a history of chronic childhood maltreatment (Brown, Schefflin, & Hammond, 1998). Although no empirical outcome studies exist, to the author’s knowledge, there appears to be consensus among specialists in this field that there are three recurrent treatment phases: (1) stabilization and symptom reduction; (2) treatment of traumatic memories; and (3) personality (re)integration and rehabilitation. There is also consensus that whatever therapeutic techniques are used in the treatment of complex
cases, they should be used within the context of POTT. The HEALTH program outlined in this study (representing the first phase of POTT: symptom reduction and stabilization) complies with standard of care in the treatment of survivors with severe co-morbidity and a history of chronic childhood maltreatment.

**The HEALTH Program**

**Stage 1: Having a Supportive and Experienced Therapist**

According to the Code of Ethics of the Australian Psychological Society (APS, 1997), “psychologists must refrain from offering advice or undertaking work beyond their professional competence” (II b, p.1)) and “are expected to be cognisant of the reasonably foreseeable consequences of their actions and to endeavour to ensure that their services are used appropriately” (Ib, p.1)). In keeping with both of these codes, it is therefore important that the treating therapist is someone who is not only qualified to treat psychological disorders generally, but someone who has had extensive experience in working with sufferers of long-term and multiple forms of trauma. Psychologists who have had little or no experience working with individuals with a history of long-term or multiple trauma experiences may engage the client in less appropriate treatment approaches, being unaware of “the reasonably foreseeable consequences of their actions”. However, the therapist working with individuals who have experienced long-term/multiple trauma experiences will need to assess carefully for symptoms of Complex PTSD as well as PTSD (as indicated in chapter 2) and to understand the importance of dealing with the associated symptoms of Complex PTSD, prior to engaging in abreactive work (as indicated in chapters 3 and 4). The therapist will also need to be available regularly and over a long period of time to allow sufficient time for “ego strengthening” to take place.
Stage 2: Ensuring Personal Safety

The inclusion of an initial stage, which ensures that the patient develop effective safety strategies is vital to the success of all ongoing work. It is probable that survivors of childhood abuse will become involved in a range of self-destructive and dysfunctional behaviours (Himber, 1994; van der Kolk, Perry, & Herman, 1991). Chronic re-experiencing of the affects related to early abuse (including dysphoria, helplessness, panic, hopelessness and disconnectedness) often lead to suicidal impulses and behaviour. Self-mutilation (non-lethal) is common (Himber, 1994), as is substance abuse (Loftus, Polonsky, & Fullilove, 1994), eating disorders (Welch & Fairburn, 1994), and addiction to risk taking behaviours (Van der Kolk, 1987). Re-victimisation is also very common (Chu & Dill, 1990; Follette, Polusny, Bechtle, & Naugle, 1996). Inadequate self care through both self-destructive behaviour and vulnerability to re-victimisation needs to be controlled prior to the beginning of exploratory therapy. If this does not occur, the likelihood of serious self-harm when traumatic material is re-visited, is high. Thus, it is important that abuse survivors create an environment of personal safety prior to any work relating to past abuse.

Although many clients will find self-care difficult, and will often have lapses in achieving adequate self-care, they must at least commit to the principles of self care and make agreements with the therapist in regard to preventing their own destructive impulses and understanding why they are vulnerable to re-victimisation. It is important to assist the patient in the development of a comprehensive safety plan so that he/she can feel free from harm or the immediate threat of harm in five areas: physical, emotional, psychological, sexual and spiritual. The therapist needs to ensure that safety becomes a primary goal for each client. This will involve
contracting to either “doing his/her best to keep safe” or (when this is not possible), “seeking help in order to achieve safety”.

The importance of devoting time to self-care issues at the outset has also been stressed by Chu (1998), who also recommended self-care as the first stage of his SAFER program for “early stage” treatment of Complex PTSD. It is also worth noting that several respondents in the initial study (Chapter 4) stated that, during their treatment, they engaged in self-destructive behaviour, which impeded any therapeutic interventions at the time. Many of these individuals were never helped with self-care strategies, and they believed that this seriously undermined work undertaken with them. The researcher's clinical experience in working with suicidal clients (and their difficulties engaging in other treatment) also influenced the decision to recommend that attention to safety and self-care aspects precede other work.

**Stage 3: Assisting with Daily Functioning**

Once clients have made a commitment to the principles of self-care, and have developed a safety plan, it is then important to assist them with aspects of daily functioning. Clients who have suffered long-term or multiple trauma often become overwhelmed by the re-experiencing of their trauma and become so consumed by the reality of the trauma that they are not able to function adequately. However, maintaining an appropriate level of functioning is essential to the success of therapy. Therapists must therefore encourage clients to continue involvement in paid employment, a volunteer job, regular activities at home, and other extra-curricular activities. Such functional activity provides much-needed daily structure and also assists social networking. Clients may also begin to feel better about themselves if they maintain a reasonable level of functioning. Although encouraging clients to
maintain an adequate level of functioning will need to take place at the outset of the program, this ‘step’ may need to be an ongoing process, as clients may require constant reminders and encouragement to continue with activities and remain engaged and connected to their environment.

Other assistance may also be given to clients in terms of relaxation and sleep-enhancing strategies, as achieving a restful state will aid adequate functioning. Learning strategies to assist in gaining a restful night of sleep, and also being able to relax effectively, will assist patients in the maintenance of an adequate level of functioning.

Chu also stresses the importance of encouraging clients to “continue functioning”. However, Chu (1998) included this as the fourth stage of his SAFER program – after self-care, symptom (PTSD) control, and acknowledgement (of the part played by trauma). Although it may be argued that inability to manage core PTSD symptoms may impact on levels of daily functioning, the current researcher believes that clients need to be assisted with maintaining an adequate level of functioning as early as possible in the treatment. By maintaining an adequate level of functioning (including gaining an adequate night of sleep, and learning relaxation strategies), clients will be more capable of dealing with some of the core PTSD symptoms. It is also important to note that many of those who participated in the pilot study reported that a key factor in their recovery was being assisted in maintaining an adequate level of functioning.

**Stage 4: Learning to Manage Core PTSD Symptoms**

Once a safety plan has been discussed, and an adequate level of functioning achieved, it is then of vital importance to assist the client with modulation and control of core PTSD symptoms. Such symptoms include re-experiencing the trauma
(in the form of flashbacks, intrusive thoughts, nightmares), amnesia, dissociation, depersonalisation/derealisation, abrupt state changes, hyper-vigilance and hyper-arousal. If such symptoms occur frequently, an individual is likely to remain in a state of crisis. However, the control of such symptoms can be gradually achieved through a range of behavioural interventions, as outlined in Chapter 3. It is useful to think of the treatment of core PTSD symptoms as a form of self-regulation.

Self-regulation is a term that is used to describe the process of becoming more aware of emotions and other internal experiences and managing the intensity of feelings so that they do not dominate your life. Self-regulation is really self-management, as the skills learned can help individuals tolerate (sit with) and control the emotions that may have previously lead to avoidance. This will, in turn, help reduce the frequency and intensity of traumatic stress symptoms and experiences.

This aspect of the treatment program (treatment of core PTSD symptoms) was also included by Chu, but as part of the first stage, ‘Self-Care’. However, the separate components of ‘Self-Care’ require separate focus so that none of these components is overlooked or over-shadowed by another. Without focussed attention on safety aspects, there is a possibility that this aspect of treatment may be overlooked, especially by individuals who, at the time of commencing therapy, do not believe that they need to deal with this aspect. Should feelings of uncertainty regarding safety emerge in the course of treatment, this may undermine efforts to work on Core PTSD symptoms. Likewise, without the achievement of an adequate level of functioning, it may be difficult for the individual to work on Core Symptoms of PTSD, as often this requires energy, commitment and focus. Thus, ‘Self Regulation’ is included as a separate and fourth stage of treatment to ensure that
when clients reach this stage of treatment, they are able to achieve their goals more easily, due to increased feelings of safety, and improved daily functioning.

**Stage 5: Treating Complex PTSD Symptoms**

This is the major focus of this model of treatment. Once the process of assisting the client with self-regulation skills has taken place (Stage 4), it is then appropriate to move towards working on some of the more complex symptomatology experienced. As indicated earlier, the focus of the work, and the order in which an individual proceeds will depend on the needs of the individual. Areas for further work may include all (or some of) the following: affect regulation, self-perception, perception of the perpetrator, interpersonal relations, somatic concerns, and systems of meaning. There may also be a need to undertake further work on core PTSD symptoms (including ‘consciousness’).

Prior to commencing work on Complex PTSD symptoms, it is important to negotiate with clients a treatment plan that caters for individual needs, as clients will vary in terms of CP symptoms – and in terms of which symptoms deserve prior attention. Negotiating a suitable treatment plan may involve discussing in greater depth the information previously provided regarding CP symptoms, and then prioritising treatment areas. Clients can discuss each symptom, its prevalence, and then prioritise the order in which these will need to be treated. Clients may also be provided with a summary of the treatment guidelines so that they are aware of the process they in which they will be involved.

Although negotiation of a treatment plan has not been suggested by Chu in his SAFER model, the current researcher believes that this is an important aspect and will ensure that any treatment following will be relevant and appropriate. The researcher has noted that many of those participants in the initial study reported that
they were often administered inappropriate treatment, and were never asked what was important to them in their treatment process. Many claimed that if they had been consulted, their treatment may have catered more appropriately for their needs. The researcher has also received positive feedback from clients when included in discussions regarding their future treatment plan.

The current researcher has allowed for a wide range of symptoms to be treated in this stage. The model is therefore, somewhat different to the SAFER model of Chu, in which only two of the CP symptoms appear to be addressed; expression (affect regulation) and relationships. Certainly, these two areas will need to be addressed by most CP sufferers. However, the symptoms of alterations in self-perception, and in systems of meaning, as well as alterations in perception of the perpetrator are also important and worthy of inclusion when negotiating a treatment plan. Again, the researcher has taken lead from suggestions of participants in the pilot study, for whom alterations in self-perception, and in systems of meaning appeared to be the areas most in need of assistance. It also appears that work in these areas contributed most strongly to ‘ego strengthening’ – a major goal of a treatment program with CP sufferers.

**Stage 6: Having Patience and Persistence in Enabling “Ego Strengthening”**

It is important for therapists to re-assure clients that changes will not occur within a few therapy sessions, and that sometimes, there will be setbacks. For many, when faced by such setbacks, it may appear that no progress has been made, and that there is no hope of ever maintaining any changes. When clients become discouraged, it is important to assist them to focus on the many changes that have occurred, and to remind them, that becoming stronger and healthier will take time.
Group Therapy

It is also important that, in addition to individual therapy sessions, clients take part in group therapy. Numerous authors (South & Wallis, 2003; Wallis, 2002; & Williams & Nuss, 2002) have referred to the benefits of group therapy for survivors of trauma. As there appears to be almost overwhelming support for group therapy, as a means of providing additional benefits to adult survivors of trauma, and as several individual in the initial study indicated that group therapy was helpful, group therapy is recommended as another avenue via which individuals may receive support, and address some of the difficulties they are experiencing. It is suggested that group therapy be commenced several weeks into the individual treatment program, to allow participants to become accustomed to therapy and the therapist.

Conclusion

The HEALTH model suggests a logical sequence of treatment interventions – one that is allied closely to Complex PTSD symptomatology. This model has formed the basis for the development of treatment guidelines. It is important, when examining the guidelines, to note that, although the order in which to proceed has been prescribed, and possible suggestions have been given for treatment approaches, the guidelines are by no means prescriptive, and allow the therapist to use his/her own clinical knowledge and experience in treating sufferers of Complex PTSD.
CHAPTER 6
EVALUATION OF GUIDELINE-BASED PROGRAM FOR THE RESPONSIBLE TREATMENT OF COMPLEX PTSD

The study investigates whether a six-month individualised treatment program, adhering to empirically-based treatment guidelines, adequately assisted patients with symptoms associated with Complex Post-Traumatic Stress Disorder and enhanced “ego strengthening”. The study received ethics approval from the Deakin University Human Research Ethics and Grants Committee (Appendix G).

Method

Participants

Participants for the study were volunteers who satisfied the following three criteria: individuals who reported having experienced long-term/multiple trauma in childhood or adulthood; individuals who exhibited significant symptomatology associated with Complex PTSD and co-morbid PTSD; and individuals who had only recently been able to accept the need for treatment.

In order to obtain individuals for this study, advertisements were placed in local newspapers in a metropolitan centre, seeking volunteers (sufferers of long-term/multiple trauma) to take part in a study trialling an individualised treatment program for Complex PTSD. Screening of volunteers ensured that participants in the study met all three inclusion criteria listed above. In assessing volunteers for the presence of Complex PTSD, the following sources of information were used: a structured clinical interview, designed to assess Complex PTSD (Structured Interview-Disorders of Extreme Stress: SIDES, van der Kolk, 1996); and an inventory for assessing Complex PTSD (SIDES - Self-Report form). As there are no rigid criteria for diagnosing CP, clinical judgement (of number and severity of the
CP symptoms) was used to determine who was accepted to participate in this trial treatment program.

Individuals who satisfied the three criteria for program inclusion were invited to participate in the study; individuals who were not selected to participate in the study were provided with appropriate referrals. They were advised that feedback on the results of the assessment would be provided to the individual and/or the therapist to whom he/she was referred.

In order to ensure that all selected participants were fully informed prior to signing the informed consent, the following were sent to each individual: a copy of the Plain Language Statement outlining the objectives of the study (Appendix H); an Informed Consent Form to indicate willingness to participate in the study (Appendix I); and a summary of the Treatment Guidelines (Appendix J).

**Measures**

Participants who had met the inclusion criteria and who remained interested in participating in the treatment program after reading the information provided, were required to complete the following prior to commencement of the treatment program: CCMS (Comprehensive Child Maltreatment Scales – Adults, Higgins & McCabe, 2001); and PDS (Posttraumatic Stress Diagnostic Scale – Foa, 1995). Many had already completed the SIDES-SR (van der Kolk, 1996) as a preliminary screening tool. The scales listed above, and their strengths compared with other scales, have been reported in Chapter 2.

At the completion of the treatment program, participants were again required to complete the PDS (Foa, 1995), and also the SIDES-SR (van der Kolk, 1996) to determine whether there had been any reduction in symptomatology in the course of the treatment program.
Procedure

Initial Interview. Participants were interviewed prior to commencement of treatment by the researcher, using a semi-structured interview protocol (Appendix K). The aim of the interview was to explore further themes identified on inventories, and also to discover how individuals felt and thought about themselves, others, their behaviour and their experiences prior to treatment. Each interview was recorded (audio) for later transcription and analysis. The researcher conducted the initial interviews, thereby ensuring that “probing” of relevant themes took place. This, in turn, ensured that participants were given adequate opportunity to express thoughts and feelings about their life and to provide sufficient descriptive detail for later analysis.

The program. Selected participants (ten) took part in an intensive program, involving approximately 24 individual sessions over a six-months period; and group counselling sessions held once every two weeks, and commencing approximately six-eight weeks into the program.

Individual therapy. The individual therapy was based on individualised programs developed from a set of guidelines designed for the treatment of symptoms of Complex PTSD. The guidelines provided a model for therapeutic intervention and also a range of suggestions for dealing with the following CP symptoms: alterations in affect regulation; alterations in consciousness; alterations in self-perception; alterations in perception of perpetrator; alterations in relations with others; and alterations in systems of meaning. Individualised treatment programs were negotiated prior to the commencement of the treatment with each participant, and focused on those CP symptoms identified in the initial interview and inventory of symptoms. The order in which the symptoms were treated was discussed with each
participant, and was in accordance with those symptoms that appeared to be causing most distress to the client.

*Group therapy.* The focus of group sessions was on growth, development, enhancement, prevention, self-awareness, and releasing blocks to growth. A person-centred approach (Rogerian) was adopted in the group sessions (Rogers, 1986). This approach is based on the assumption that human beings tend to move towards wholeness and self-actualisation, and that individual members, as well as the group as a whole, can find their own direction, with a minimal degree of help from the group leader, or facilitator (who will create a fertile and healing climate for participants). Rogers stated,

The person-centred approach is primarily a way of being that finds its expression in attitudes and behaviours that produce a growth-producing climate. It is a basic philosophy rather than simply a technique or a method. When this philosophy is lived, it helps the person expand the development of his or her own capacities. When it is lived, it also stimulates constructive change in others. It empowers the individual, and when this personal power is sensed, experience shows that it tends to be used for personal and social transformation (1986).

Although the participants took some part in deciding for themselves the specific goals of the group experience, some of the general goals for group therapy were as follows: to achieve self-knowledge and develop a sense of one’s own unique identity; to learn to trust oneself and others; to recognize the commonality of the participants’ needs and problems and develop a sense of universality; to increase self-acceptance, self-confidence, and self-respect in order to achieve a new view of oneself; to increase self-direction, autonomy, and responsibility toward oneself and
others; to learn more effective social skills; to become more sensitive to the needs and feelings of others; to learn how to confront others’ with care, honesty, concern and directness; and to clarify one’s own values and decide whether and how to modify them.

**Final interview.** Participants were also interviewed at the completion of their program. The final interview, however, was conducted by an independent and suitably qualified interviewer. Use of an independent interviewer was seen as important for two reasons. Firstly, it allowed participants to feel more confident about speaking openly and honestly about change/absence of change related to the program. It was postulated that the information obtained may, therefore, be more accurate than that obtained by the researcher/therapist. Secondly, use of an independent interviewer reduced the likelihood of researcher bias in questioning. The final interview also used semi-structured interview protocol, with suggestions for questioning were provided to the interviewer (Appendix L), opportunities being provided for additional exploration of issues, where this need became apparent. The independent interviewer was asked to encourage participants to provide honest responses, referring to both positive and negative aspects of treatment, in order to assist the research process. Each interview was recorded (audio) for later transcription and analysis. The aim of the interview was, as with the initial interview, to discover how participants felt and thought about themselves, others, and their experiences. For the final interview, clients were also invited to comment on the therapeutic process.

**Quantitative Analysis of Data**

This analysis involved an examination of the relationship between the treatment approach and participant perception of the number and severity of CP
symptoms following treatment. The independent variable was the treatment approach (i.e. one-session per week over 6 months, and also group therapy). The dependent variable was the “number and severity of Complex PTSD symptoms” experienced by the client (pre- to post- treatment), as measured by clinically significant scores in two psychometric tests: Self-Report Inventory for Disorders of Extreme Stress, SIDES-SR, van der Kolk, 1996 and The Posttraumatic Stress Diagnostic Scale (PDS, Foa, 1995). For each participant in the study, a comparison was made of retrospective and current responses to the PDS (Foa) and the SIDES-SR (van der Kolk) to determine whether there had been a reduction in number and severity of symptomatology.

**Qualitative Analysis: Discourse Analysis.**

Discourse analysis does not represent a single, unified position (McLeod, 2001) and can be used in a number of different ways. McLeod (2001) describes discourse analysis as “a form of social psychology that has taken some basic ideas and methods of conversation analysis but extended them into new areas.” An important influence and continuing inspiration for language analysis has been the lectures given by Henry Sacks, while lecturing at The University of California between 1963 and 1965. Sacks believed that one can only develop a truly scientific approach to studying society (in the sense of making observations which can be checked out, and replicated by other researchers) through studying tape-recordings of conversations. Over the last thirty years, conversation analysis has grown to a large and growing inter-disciplinary field. It has emerged as a credible and scientific way of collecting and analysing data. Associated with it is a large and growing group of international scholars practising and teaching this discipline (Travers, 2001). The relevance of conversation analysis to discourse analysis is the importance and
usefulness of language analysis. However, while conversation analysis focuses largely on the structure of language used in conversation, discourse analysis focuses on the language (vocabulary, metaphors, evaluative terms) itself.

One form of discourse analysis is that of critical discourse analysis (CDA), which has become one of the fastest growing areas of work in human sciences, originally appearing as a sub-field of linguistics (Travers, 2001). Traditionally, critical discourse analysts have chosen texts that communicate an overt or concealed political message, such as the speeches of politicians, or advertisements. The method used to analyse discourse has varied, but has usually involved drawing on ideas and resources from linguistic theory, and then linking this to an analysis of the ideological role of the text. Fairclough (1989) recommends a six-stage method, which involves first describing how language is used, for example by considering evaluative terms, and/or the metaphors used – and then moving on to the stages of “interpretation” and “explanation”. Interpretation involves moving beyond the surface description and examining the “discourse type(s)” used by the participants, such as the grammar, sentence construction, vocabulary, semantics and also the “schemata, frames and scripts” (1989, p.162). For Fairclough, however, the most important aspect of CDA is the sixth stage of “explanation”. The object here is to “explicate the relations of power and domination and the ideologies which are built into these assumptions” by developing a sociological analysis of the wider structural context.

The approach used for this study is based on the initial stages of Fairclough’s model. As it has not been important in this study to analyse the ideological role of the text, some aspects of the model (in particular, the final stage suggested by Fairclough) have not been relevant. Of more relevance has been an examination of
the “discourse type(s)” used by the participants, such as the evaluative terms, vocabulary, metaphors, and in some cases, sentence structure, and grammar. The notion that people largely make sense of their experiences, and communicate their experience to others, through the language they use, has been central to this study. Thus, specific components of language are seen as accurately reflecting the specific feelings and behaviours of an individual at any specific time. In this study, an analysis of participants’ taped descriptions regarding various aspects of their lives and functioning, both before and after their involvement in the treatment program, has been considered a primary source of data. The aim has been to generate a more complete understanding of the process of change over the course of the therapy.

While discourse analysis was the major component of the qualitative analysis, another important component was the evaluation of the extent to which the negotiated individualised programs adhered to (or departed from) the recommended guidelines as outlined in chapter 5. Also undertaken was an evaluation of the actual treatment program from the therapist’s perspective, including problems encountered and positive aspects.

In the next chapter, the results are presented in terms of individual case vignettes, involving the following: a summary of participants’ discourse regarding their traumatic experiences, and their perception of the impact of these experiences on them; an outline of how participants felt and thought about themselves, others, relationships, and their experiences pre-treatment; the psychologist’s assessment of the impact of past traumatic experiences; the negotiated treatment plan for each individual, and an evaluation of the extent to which the planned program adhered to/departed from the recommended guidelines; the treatment program ‘in action’; an evaluation of the treatment program, from the therapist’s perspective, including
problems encountered, positive aspects, and ways the actual program adhered to the planned program; a comparison of pre-test/post-test psychometric assessment; a summary of the participants’ discourse of how they felt and thought about themselves, others, relationships, their experiences and the therapeutic process post-treatment.
CHAPTER 7

CASE STUDIES

The Participants: An Overview

This chapter provides information regarding the ten participants in this treatment program, their trauma experiences, the impact of these on their lives, the treatment program undertaken by them, and their perception of the impact of this treatment program on their lives. Demographic data regarding these ten participants are contained in Table 8. All names used in this chapter are pseudonyms, used to protect the confidentiality of participants, and those with whom they were associated.

Table 8

Demographic Data

<table>
<thead>
<tr>
<th>Participant</th>
<th>Age</th>
<th>Sex</th>
<th>No of Sessions</th>
<th>Relationship</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Cynthia</td>
<td>46</td>
<td>F</td>
<td>24</td>
<td>Divorced</td>
</tr>
<tr>
<td>2. Maria</td>
<td>26</td>
<td>F</td>
<td>24</td>
<td>Partner</td>
</tr>
<tr>
<td>3. Eric</td>
<td>54</td>
<td>M</td>
<td>20</td>
<td>Divorced</td>
</tr>
<tr>
<td>4. Lucy</td>
<td>29</td>
<td>F</td>
<td>24</td>
<td>Divorced</td>
</tr>
<tr>
<td>5. Diana</td>
<td>57</td>
<td>F</td>
<td>20</td>
<td>Divorced</td>
</tr>
<tr>
<td>6. Percy</td>
<td>37</td>
<td>M</td>
<td>16</td>
<td>Single</td>
</tr>
<tr>
<td>7. Geraldine</td>
<td>32</td>
<td>F</td>
<td>24</td>
<td>Married</td>
</tr>
<tr>
<td>8. Matt</td>
<td>32</td>
<td>M</td>
<td>24</td>
<td>Partner</td>
</tr>
<tr>
<td>9. Renee</td>
<td>29</td>
<td>F</td>
<td>24</td>
<td>Single</td>
</tr>
<tr>
<td>10. Beryl</td>
<td>70</td>
<td>F</td>
<td>24</td>
<td>Divorced</td>
</tr>
</tbody>
</table>

The above ten people satisfied the three main criteria for inclusion in the program: they had suffered multiple or long-term trauma (physical, sexual, verbal or emotional) as a child or adult; they exhibited significant symptomatology associated with Complex PTSD and co-morbid PTSD; and they had only recently been able to accept the need for treatment.
Five other people were interviewed and assessed, and four of these were invited to attend the program. Two of the latter group declined the offer, after being provided with details of the program. Both had decided the commitment in time was too great. The other two agreed to participate in the program. One of these attended four sessions. However, her attendance was very irregular, and as she was unable to meet the requirements of the program (regular attendance), I asked her to withdraw from the program. The other client who had committed to the program attended quite regularly, and although he satisfied the criteria in terms of his abuse experiences, and trauma symptoms, he appeared to need to discuss pain management strategies for his most recent “trauma” –his back injury. Attempts to discuss other aspects of his presentation were unsuccessful. After the 16th session, this patient became seriously ill and spent a long period in hospital and re-cuperating. He was unable to complete the program, and due to the fact that little work of significance to this program was completed, his results have not been included in this study. The one client who was not invited to participate in the program was taking legal action against previous medical and other practitioners, and appeared to have intentions to use this assessment and program to support his case.

On the following pages, case vignettes are provided for each of the participants in the program. An outline of each participant’s negotiated treatment program is contained in Appendix M.
CYNTHIA

Summary of Traumatic Experiences Identified

Childhood Abuse Experiences

Cynthia is a mother of three children, 46 years old and divorced. Cynthia was sexually abused, as a child, on a regular basis, from the age of 5 to 13 by an intellectually-impaired uncle. The abuse sometimes involved her siblings, but also occurred for Cynthia alone. Cynthia reported that she attempted to inform adults (especially her mother), but was not “heard”. Throughout her life, Cynthia’s mother continued to dismiss what had happened and told Cynthia that she was mentally unstable.

Cynthia also had a difficult and combative relationship with her mother. Cynthia believed that her mother never liked her, never wanted her, and disliked her from the time she was born. She reported that her mother was always angry toward her, yelled at her frequently, did not protect her, and also beat her cruelly (sometimes, until she bled). Throughout her life, Cynthia’s mother told Cynthia that she was mentally unstable. She has continued to do this and informs the rest of the family that Cynthia is unstable. Cynthia’s relationship with her mother remains a difficult one.

Later Life Experiences of Extreme Stress

At the age of 17 or 18 (Cynthia was uncertain about her exact age at the time), Cynthia was involved in a car accident that lead to a neck injury that did not manifest until later in life. Cynthia reported that she has experienced some very painful episodes as a consequence of this neck injury. Cynthia also reported a 17-year marriage, in which she felt unloved and unappreciated. She “fell” into this relationship at a very young age, but soon realised that she had made a “terrible
mistake”. Cynthia reported that her husband was controlling, never asking her opinion, never spending time with her (but spending hours on the computer). He stayed out regularly until the early hours of the morning and had been having a sexual relationship with a female friend of Cynthia’s over a period of eight years. Cynthia described her marriage as an “empty relationship”, reporting that the period of her marriage was extremely stressful. Cynthia eventually became involved with a married man, who she described as “the love of my life”. However, the “love of her life” decided to remain with his wife, and this was devastating for Cynthia.

Following this extra-marital relationship, Cynthia’s husband accused her of being a “slut”. Another stressful period for Cynthia was related to the death of her brother, who was killed tragically in a car accident. Cynthia reported that her brother was the only sibling with whom she had any closeness. Cynthia’s father also died from cancer five years prior to her attendance at my practice, and Cynthia was at his bedside when he died. Another period of stress has been associated with difficulties in parenting her son, as immediately prior to entering this program, Cynthia’s relationship with him had broken down completely. Cynthia reported that her son treated her in the same way as his father had.

*Abuse Reported on CCMS*

The results on this scale were consistent with reports provided during the initial interview, with Cynthia reporting five forms of childhood abuse occurring during her childhood: psychological, physical, sexual, emotional, and neglect. Cynthia reported being yelled at by mother (very frequently); being ridiculed, embarrassed, and the recipient of sarcasm by her mother (very frequently); being provoked (very frequently); being made to feel fearful or treated cruelly by her mother (frequently); and witnessing physical and verbal abuse of others (sometimes).
Cynthia also reported frequently being physically punished for wrongdoing by her mother and frequently receiving other forms of violence (punching, kicking, hitting) from her mother. She also sometimes witnessed the physical punishment of others. Cynthia also reported being requested to do something sexual by her uncles. Cynthia reported occasionally being neglected (e.g., not being given regular meals or baths) by her mother, but frequently having her requests for attention ignored, or not being spoken to for extended periods of time by mother.

**Assessment for Inclusion in Program: Criterion 1**

*Cynthia satisfies the first criterion for inclusion in this program, as she suffered long-term, multiple forms of abuse as a child, the symptoms resulting from this being exacerbated by ongoing experiences of extreme stress in adult life.*

**Trauma Symptoms**

**Symptoms Identified from Psychometric Screening**

On the PDS (Foa), Cynthia identified 15 of the 17 symptoms commonly associated with PTSD (five in category A ['Re-experiencing'], six in category B ['Avoidance'], and four in category C ['Arousal']. Intensity of her symptoms was rated in the Severe Range (38/54), while level of impairment was Severe. On the SIDES-SR (van der Kolk), elevated scores were indicated on the following main scales: “Alterations in Affect Regulation” (with elevated scores on sub-scales, ‘Suicidal Pre-occupation’ and ‘Difficulty Modulating Sexual Involvement’); “Alterations in Consciousness” (with elevated scores on the sub-scale, ‘Transient Dissociative Episodes’); “Alterations in Self Perception” (with elevated scores on the sub-scales, ‘Ineffectiveness’; ‘Guilt/responsibility’; ‘Shame’; ‘Nobody can
Understand’); “Alterations in Relationships with Others” (with elevated scores on the sub-scales, ‘Inability to trust’; ‘Revictimisation’); “Alterations in Systems of Meaning” (with elevated scores on the sub-scales, ‘Loss of Beliefs’, ‘Despair and Hopelessness’).

Mildly elevated scores were evident on the following sub-scales: ‘Modulation of Anger’, ‘Self Destructive Behaviour’, and ‘Permanent Damage’.

**Symptoms Identified During Pre-treatment Interview**

**Alterations in Self Perception**

Cynthia persistently described feelings of worthlessness, stating that she felt “invisible”. Cynthia reported that her self-esteem had improved over the years during which she has raised her children, although her son’s recent departure to live with his father and had led to some disappointment in herself as a mother. In the course of the interview, Cynthia also indicated self-blame, a sense of stigma, a sense of complete difference to others, feelings of helplessness, and also shame/guilt.

**Alterations in Interpersonal Relationships**

Cynthia reported difficulties in her relationships with most members of her extended family, in particular with her mother. Cynthia reported that she felt anger toward her mother for failing to protect her as a child. Cynthia also reported difficult relationships with her siblings: her older brother, who she admitted to “verbally abusing” at the time of her father’s illness; and her older sister (Cynthia was unable to provide an explanation for this). She also reported that she only spoke with her youngest sister once each year. Cynthia appeared to be perplexed about the underlying causes of her difficulties in her family relationships – even that with her son. Cynthia also reported that she did not have any close friendships, and appeared to place the responsibility for this with others. Cynthia expressed little trust for
males, stating that she believed she had been always searching for a “rescuer”, but that she did not think she would have another relationship with a man. Difficulties with others in the work place also typified Cynthia’s employment experiences. She reported that, quite often, she had left places of employment due to “clashes” with employers or other employees.

*Alterations in Affect Regulation*

Cynthia reported that she had suffered from depression most of her life. She described extreme mood fluctuations at times, stating that these mood swings could take her from extremely low to extremely high. Cynthia referred to the “downward spiralling” in mood often associated with an incident or a comment. When asked to rate her mood at the interview, Cynthia stated, “I’d say a ‘4’ today… Some days I’d even be 100, but most days in the last twelve months have been minus.” Cynthia reported that she found it very difficult to control her moods and emotions, in particular, her anger. She explained that while there was often an outward appearance of control, internally the emotions were still felt intensely. Cynthia also reported that sometimes she felt suicidal, especially when she felt that her mood was spiralling downwards.

*Alterations in Consciousness*

Cynthia reported feelings of detachment from reality, stating that she experienced this a lot as a child: “I remember as a child it happening a lot. It was a form of escape.” These days, she reported that she experiences feelings of detachment when she feels threatened.

**Assessment for Inclusion in Program: Criterion 2**

*Cynthia satisfied the second criterion for inclusion in this program, as in both psychometric assessment, and interview, she indicated marked PTSD and co-morbid CP symptoms.*
The Treatment Program

The Negotiated Treatment Program: Consistency with Guidelines?

The program negotiated with Cynthia was consistent with the treatment guidelines developed for this study, commencing with the development of a safety plan, and assistance with aspects “daily functioning”, and then focusing on the control of core PTSD symptoms – prior to treating those CP symptoms identified during assessment: alterations in affect regulation, self perception, consciousness and interpersonal relationships. Cynthia did not believe it necessary to include work on “Alterations in Systems of Meaning”. Another aspect of Cynthia’s treatment program that differed from the suggested guidelines was that Cynthia declined attendance at the group therapy, stating that she believed that hearing about others’ negative experiences would not be helpful.

How Cynthia’s Program Adhered to/Departed from the Negotiated Program

Cynthia completed all individual sessions, as planned, gaining assistance at the outset with the development of a safety plan, also as planned. The safety plan was referred to regularly throughout the program, as required. Cynthia’s work also focused on aspects of her daily functioning (although work on issues associated with daily functioning was a component of every session, rather than undertaken as a discrete entity, prior to other treatment work). Most importantly, the focus of Cynthia’s treatment was related primarily to the CP symptoms identified at the outset: alterations in affect regulation, interpersonal relationships, and self-perception. Thus, Cynthia’s individual treatment program adhered in many ways to negotiated treatment plan, which, in turn, was consistent with the recommended guidelines.
However, there were some departures from the negotiated plan. After commencing the treatment program, Cynthia reported that PTSD symptoms were not causing any major difficulties currently. She appeared more interested in gaining assistance with the CP symptoms identified pre-treatment. Further, the treatment program was not undertaken in “neat units” as planned, with sessions being more responsive to weekly crises. There were both positive and negative aspects of this mode of treatment. On one hand, this tended to be disruptive with work that may have been commenced during one of the ‘up’ weeks, for example, self-concept inventory, journaling, recording negative thoughts. On the other hand, each symptom was dealt with contextually, rather than in isolation, relating to ‘real events’ at various stages over the course of the 24-week program. This was also true for provision of assistance with aspects of daily functioning. Cynthia did not gain assistance initially with this as a discrete entity, although regularly needed to gain such assistance in the course of the program. Another departure concerned the treatment/control of PTSD symptoms, as although PTSD symptoms had been identified on trauma inventories, and included in the negotiated treatment plan, little work was undertaken in this area.

**Therapist’s Perception of Positive and Negative Aspects of Program**

Cynthia adopted a very positive attitude towards her treatment program, attending every session. She reported looking forward to every session as she had no-one else to talk with about her problems. However, mood instability was a major problem in this therapeutic relationship. Cynthia oscillated between being deeply depressed and with suicidal ideation (initial presentation) and very happy and contented – and with strong motivation to achieve her personal goals. The instability
of mood was present over all twenty-four sessions and lead to some difficulties in terms of undertaking a coherent program of treatment.

Almost every second session, Cynthia presented in an extremely upset state, highly anxious, and ‘in crisis’ – and asked if we could work through the issue she was facing that day. This was appropriate, as the client’s level of distress would have precluded work on any other issues. Another related problem was that Cynthia rarely completed homework. Further, in undertaking cognitive work, Cynthia found it difficult to consider more rational alternatives, and continually defended her previous way of thinking. Cynthia often asked for suggestions regarding certain difficulties she was encountering – but rarely acted upon any suggestions made.

There appeared some resistance to change. There were some additional difficulties toward the end of the 24 sessions, when Cynthia required after-hours assistance, and I referred her to the Crisis Assessment Team. Cynthia felt betrayed by me for not assisting her personally, although after a few weeks of non-attendance, she did return and complete the program. However, this incident had the effect of distancing Cynthia, and she was much more guarded and ‘closed’ in the final sessions. Another issue worthy of note is that, in one of these final sessions, Cynthia also mentioned that she had been diagnosed with bi-polar disorder previously. This information had never been disclosed, even though Cynthia had been asked whether she had any prior diagnoses. When asked why she had withheld this information, Cynthia said that she thought this may have prevented her from taking part in the program.
Post-Treatment Evaluation

Psychometric Assessment: Comparison with Pre-Treatment Assessment

On the PDS (Foa), Cynthia identified 16 of the 17 core PTSD symptoms (compared with 15 pre-treatment). Specifically, there were four symptoms in category A ['Re-experiencing'] compared with five pre-treatment; seven in category B ['Avoidance'] compared with six pre-treatment; and five in category C ['Arousal'] compared with four pre-treatment. Although the number of symptoms had not been reduced, the intensity of symptoms was less, with symptoms rated in the moderate range (25/54). Previously the rating had been in the ‘Severe’ range (38/54) and level of impairment was ‘Very Mild’ (compared with ‘Severe’, pre-test). On the SIDES-SR, no elevated score was evident for the CP symptoms identified at pre-test.

The results of Cynthia’s psychometric assessment thus indicated marked improvements in the following areas: a reduction in intensity (although not number) of PTSD symptoms from ‘Severe’ to ‘Moderate’, and a decrease in the level of functional impairment. The results obtained from the SIDES-SR also indicated an absence of any CP symptoms identified pre-treatment.

Qualitative Data: Symptoms Identified During Post-Treatment Interview

Interpersonal Relationships

Although Cynthia still appeared to be having difficulties in terms of interpersonal relationships, there was a sense of resignation in regard to others – in particular, her mother and her son, and the way she perceived that they treated her. There was also a sense that Cynthia had developed a determination to remove herself from situations in which she was treated more fairly by others. Cynthia spoke about her new confidence in dealing with a past boyfriend, and others who had not treated her well, although there was also still an indication of Cynthia’s difficulties trusting
other people. Despite this, there was some ‘letting down of her guard’, as Cynthia had made contact, and formed a relationship, with a man via the Internet. Over a period of time, she had come to trust this man sufficiently to travel interstate to see him. Thus, some ‘shift’ was apparent in her interpersonal relationships.

*Alterations in Self Perception*

Cynthia reported that her “new attitude” in regard to others (not caring what they thought) was related to feeling stronger and more self-confident within herself, and Cynthia reported no longer having feelings of worthlessness. Cynthia described herself as someone who was no longer prepared to take on the guilt about past events, and as being more confident and assertive. This was evident when, in making contact with a new man via the Internet, she had warned him about “playing games”. Cynthia also reported feeling empowered as a result of the skills gained in counselling sessions.

*Alterations in Affect Modulation*

Cynthia appeared to be much happier than previously. She stated that she and her daughters were having some very happy times together. Cynthia also reported that she was sleeping well, that her appetite was good, and that she was more focused at the moment. She reported having much more capacity to carry out daily tasks. Cynthia also reported living much more in the present, and while living in the present, Cynthia has become more optimistic, with a more positive outlook. Cynthia reported that there were still some difficulties with anger but an improved capacity to manage these feelings. Cynthia also reported that she engaged in less self-destructive behaviour.
Summary of Impact of Treatment Program

On the whole, Cynthia described improvements in two CP symptoms treated: “Alterations in Self Perception” and “Alterations in Affect Modulation”. She also indicated some minor improvements in interpersonal relationships, and improved aspects of her daily functioning. There was also some reduction in intensity of core PTSD symptoms, although these were not specifically treated. Cynthia’s final comment at her interview summed up the way she felt the treatment program had helped her: “It’s been a long road – and I can’t say it’s been easy. I’d sometimes wonder if I’d still be here if I hadn’t seen Pam. I don’t know if I would have come to these conclusions. All the doubting and all those sorts of things I put myself in - my prison - letting go of those has freed me.”

MARIA

Summary of Traumatic Experiences Identified

Childhood Abuse Experiences

Maria is a 26-year old woman, who lives with her partner of four years and works as an administrative assistant. Maria was sexually abused between the ages of five and eight years by her mother’s partner, 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 also sexually abused by another of her mother’s partners. This partner (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 her mother’s partner (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.

Maria also reported that her first stepfather was an alcoholic and that she witnessed his behaviour when he had been drinking, and also many arguments between her mother and him, witnessing him punch her mother in the face. She reported feeling extreme anxiety during these times. As a result of the domestic violence experienced with Ian, Maria’s mother decided to leave him, and Maria was involved in the precarious escape, during which her mother was driving with a migraine, and Maria (only twelve) 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.

Maria was also the recipient of verbal abuse from her mother throughout her childhood and adolescence. Maria acknowledged that her mother was very stressed 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 Ian became her mother’s partner, as Ian would blame Maria for everything. When around 12 years of age, 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 from the age of 8 until the age of 12, for看似 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 young years, Maria was also neglected emotionally and physically, her mother being a heavy drug user, and also pre-occupied with the men in her life and her other children. Maria lived a life isolated from other children, and also took on a parenting role early in life. 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 years, leading to further feelings of rejection for Maria.

**Abuse Reported on CCMS**

The results on this scale were consistent with reports provided during the initial interview, with Maria reporting psychological, physical, and sexual abuse: being yelled at by her mother (very frequently) and by her step father (frequently); being ridiculed, embarrassed, and the recipient of sarcasm by her mother (very frequently) and by her step father (frequently); being provoked (very frequently); being made to feel fearful or treated cruelly by her step father and by her mother (frequently); and witnessing the above behaviours directed towards others in the family (sometimes). Maria also reported being physically punished for wrongdoing by her mother and frequently receiving other forms of violence (punching, kicking,
hitting) from her mother (frequently). She also sometimes witnessed the physical punishment of others.

Maria also reported being requested to do something sexual by her mother and her stepfather. She also reported being shown an erect penis by her mother’s boyfriend, and frequently being made to touch his penis. Maria also reported sometimes having her vagina/breasts touched by stepfather, and sometimes being made to touch his penis. Maria reported occasionally being neglected (e.g., not being given regular meals or baths) by her mother, but frequently having her requests for attention ignored, or not being spoken to for extended periods of time by mother.

Assessment for Inclusion in Program: Criterion 1

Maria satisfied the first criterion for inclusion in this program as suffered long-term multiple forms of abuse as a child.

Trauma Symptoms

Symptoms Identified from Psychometric Screening

On the PDS (Foa), 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']). Intensity of symptoms was rated in the ‘Mild-Moderate’ range (15/54), while level of impairment was ‘Moderate’. On the SIDES, 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 & 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); & ‘Loss of Previously Sustaining Beliefs’.

As the above indicates, although Maria satisfied the criteria for a diagnosis of PTSD, her symptoms were at a mild-moderate level. This was also the case for CP symptoms. However, as the treatment program progressed, Maria’s symptoms of PTSD were still very marked, and she experienced major problems with loss of consciousness, a manifestation of her dissociative episodes. The symptoms described by Maria during her initial interview suggested that CP symptoms were more prominent than was indicated on the SIDES-SR.

**Symptoms Described During Pre-treatment Interview**

* Alterations in Self Perception

Maria reported self-confidence issues, stating that her mother’s use of derogatory words (“fat” and “slut”) remained with her and contributed to the development of an eating disorder. Maria also reported that she had always experienced problems believing she was intelligent, as she was never given any positive feedback. She reported that it was only recently that she had started to believe that she may have intelligence, due to the fact that her partner had re-assured her of her capabilities. She thus described a great deal of self-doubt in her life, and although Maria was also able to recognize her positive attributes, she did not report a strong sense of self. Maria also reported feelings of self-blame and guilt in regard to relationships with her mother and her siblings, and sometimes felt that she could have been more pro-active in maintaining the relationships, and also protecting her siblings.
**Alterations in Affect Regulation**

Maria explained that she had difficulties modulating her anger, and that she could be quite “moody”. Maria also explained that, when she first met her current partner, she “tested” him regularly with her anger, to see how much he would take without leaving. Maria explained that, although she has undertaken some work with counsellors around her anger management, there was still some work to do. 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 cause life was just not worth it”. However, she reported, “I don’t get that anymore. I’m really 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. 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, and also led to confusion in her thinking about sex. She also reported current difficulties in her own sexual relationship, dissociating during the experience, 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 generally she forms relationship with others easily. However, she reported some problems with her closest relationship – that with her partner. There was also a feeling, however, that she may see him as a “rescuer”. Maria worried most about her lost relationship with her mother and siblings.
Alterations in Belief Systems

Maria reported changes in her belief systems over the years. At 16, when searching for answers and needing support, Maria turned to Christianity. She explained that she had 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 moving moved away from formal structured kind religion to a more humanitarian approach to life – wanting to do things for people in society.

Assessment for Inclusion in Program: Criterion 2

Although formal psychometric assessment indicated mild-moderate symptoms of PTSD and CP, Maria indicated at interview that she did have quite marked PTSD symptomatology (dissociative symptoms) and also some specific CP symptoms. Maria thus satisfied the second criteria for inclusion in this program.

Treatment Program

The Negotiated Treatment Program: Consistency with Guidelines?

The program negotiated with Maria departed slightly from the guidelines in that a safety plan was not included as part of the initial work. Maria had suggested that, as there was no likelihood of self-harm and no suicidal ideation, this would not be necessary. Further, no work was included on aspects of daily functioning. However, Maria’s program was otherwise consistent with the treatment guidelines, focusing 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”.

**How Maria’s Program Adhered to/Departed from the Negotiated Program**

Maria’s program was in most ways consistent with the negotiated program, as her treatment involved work on both PTSD symptoms and CP symptoms, as planned. Maria also completed all 24 sessions of the program, and attended most group therapy sessions. As stated earlier, Maria did not indicate a need to undertake work in the area of safety or daily functioning, and no need was indicated throughout the program.

**Therapist’s Perception of 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 “sensitive” material was approached, 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, these 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 (Foà), Maria identified 7 of the 17 core PTSD symptoms, as compared with 9 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 (the same) 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 as follows: ‘Suicidal pre-occupation’ and ‘Difficulty Modulating Sexual Involvement’ (sub-scales 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”).

On the basis of this psychometric assessment, it is clear that there was a reduction in a number of core PTSD symptoms (especially ‘Re-experiencing’) – and also intensity of PTSD symptoms overall. The increase in score on the Avoidance scale of the PDS is 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 results, as there was no clinically
significant score on the pre-treatment assessment. Perhaps the most meaningful information can thus be obtained from the client’s comments at her final interview with an independent psychologist.

**Qualitative Data: Symptoms Identified During Post-Treatment Interview**

**Alterations in Self Perception**

Maria reported increased self-confidence and self-knowledge. She also reported a greater sense of comfort with herself.

**Alterations in Affect Regulation**

Maria reported that she had developed effective strategies to assist her manage her anger more effectively. 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 amount of dissociating – and also in the intensity of her attacks. She explained that the knowledge she had gained about panic attacks, and also the strategies she had learned, had reduced her fear about her collapsing greatly. 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.

**Alterations in Interpersonal Relationships**

Maria reported improvements in her relationship with her partner, and stated that she did not have as much anxiety over her relationship with her mother. 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. She reported that her mother no longer had the same “hold” on her, and reported positive emotions towards both her mother.

Summary of Impact of Treatment Program

On the whole, 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 a number of one core PTSD symptom (‘Re-experiencing’), and dissociative aspects of ‘Avoidance’ - and also 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 [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.

ERIC

Summary of Traumatic Experiences Identified

Childhood Abuse Experiences

Eric is a 54-year old father of five (three of whom were still residing at home). Eric’s ex-wife had died several years prior to his entry into the program. Eric was currently unemployed but had commenced studies in law. Eric was beaten
regularly between the ages of 5 and 15 years by his mother’s partner, who Eric described as having a “very violent temper” and who would “take this out on me”. Eric reported having bruises and other injuries (bleeding from his ear) related to the beatings. He stated, “He’d punch me – cuff me under the jaw – I’d bleed from the ear sometimes. He’d hit me so hard, I could go from one side to the other without touching the floor.” Eric described one incident when 13-14 years old: “One night, he beat me off and on for four hours – it was like I was stupefied.” Eric was also verbally abused by his mother and her partner, and reported that he witnessed the physical abuse of one of his siblings.

Eric reported that his mother did not protect him from the physical abuse and often stood by watching. He stated, “there was never any occasion when she said, ‘You’ve really got to stop’ – there was never any occasion when I saw any effort, emotion, thought or action… no… zero… she didn’t complain to anyone or do anything to stop it.” Eric stated that he believed she was too frightened: “I think she was paralysed by fear – cause I remember, he’d have me against the wall, and she’d say, ‘I’ve got to go now’.”

Eric also reported that his mother neglected him, withholding affection, and ignoring his presence. He stated, “What I found with her was a silence – no talking – not ever acknowledging the fact that I was even there.” Eric’s education was also neglected and he reported that, due to his beatings and consequent emotional state, he was unable to do homework, or function properly at school the following day.

**CCMS Results**

The above information was confirmed by the results of the CCMS, on which Eric identified the following forms of abuse as a child: psychological, physical, sexual and emotional abuse. Eric reported being yelled at by his mother and another
adult (occasionally) and by his stepfather (frequently); being ridiculed and embarrassed, using sarcasm, by his mother (frequently), by his stepfather (very frequently) and by another adult (sometimes); being provoked by his stepfather (very frequently), and being the recipient of cruelty from his stepfather (frequently); and witnessing some of the above behaviours directed to others in the family (frequently). Eric also reported being punished physically for wrongdoing by his stepfather (very frequently); receiving other forms of violence (punching, hitting, kicking) from his stepfather (very frequently); being severely hurt by his stepfather (sometimes); and witnessing some of the above forms of physical punishment to others in the family, (frequently). Eric also reported having his penis touched once by his stepfather. He also reported neglect by his stepfather (for example, not being given regular baths or meals); being shut in a room alone for an extended period of time by his stepfather (very frequently) and by his mother (sometimes); and having his requests for attention ignored (or not being spoken to for an extended period of time) by mother and stepfather (very frequently).

**Adult Experiences of Extreme Stress**

Eric also reported that, over a period of twenty years, he suffered emotional abuse by his wife. She reported, ignored and rejected him in the same was as his mother had.

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**Assessment for Inclusion in Program: Criterion 1**

*Eric satisfied the first criterion for inclusion in this program, having suffered long-term childhood abuse (multiple forms). He reported that his later marriage replicated his relationship with his mother and was also extremely stressful” for him, re-inforcing beliefs about himself, instilled in him by his long-term child abuse.*
Trauma Symptoms

Symptoms Identified from Psychometric Screening

With pre-treatment inventories, Eric had indicated that he found the inventories difficult to interpret, and when asked to complete a second set (to check for consistency), Eric responded differently to many questions in the repeated versions. It was thus necessary to examine the inventories with him, item by item, to gain a more accurate picture of Eric’s symptoms, although Eric still appeared to have difficulties interpreting the statements. Even with assistance, there was much debate about the precise meaning of the items.

On the PDS (Foa), Eric identified 14 of the 17 symptoms commonly associated with PTSD (three in category A ['Re-experiencing'], six in category B ['Avoidance'], and five in category C ['Arousal']. Intensity of symptoms was rated in the ‘Moderate’ Range (28/54), while level of impairment was ‘Severe’.

On the SIDES-SR (van der Kolk), clinically significant scores were evident in one main scale: “Alterations in Systems of Meaning” (including ‘Despair/Hopelessness’; ‘Loss of Previously Sustaining Beliefs’) and four sub-scales: ‘Transient Dissociative Episodes’; ‘Permanent Damage’, ‘Nobody can Understand’ (“Alterations in Self Perception”); ‘Inability to Trust’; and ‘Revictimisation’ (“Alterations in Relations with Others”). Borderline scores were indicated on the following sub-scales: ‘Affect Regulation’; ‘Modulation of Anger’; and ‘Difficulty Modulating Sexual Involvement’.

Symptoms Identified During Pre-Treatment Interview

Alterations in Self Perception

Eric reported a “destruction of self-confidence”, stating that his feelings of low self-worth have led him to believe that he cannot achieve well in any area.
**Alterations in Affect Modulation**

Eric reported that he experiences anxiety in social or group situations, and often feels that people are watching him. He explained that his fears when in public often incapacitate him physically. Eric reported that he also finds it difficult to communicate his thoughts in a way that is acceptable to other people. He explained that he has been criticised over many years for things he has said, and consequently, has developed a fear of speaking in a group situations. Eric also reported that he is an extremely tense person, having a desire to control situations to prevent perceived “mishaps” occurring. He reported that other people perceive him as domineering, but that his apparent dominance was more an indication of his own insecurity, and a desire to “control something” and “gain a semblance of feeling secure.” Eric also described a lot of anger, “some low-grade depression”, and feelings of hopelessness.

**Alterations in Interpersonal Relationships**

Eric indicated that he had little trust, or like, for other people, male or female, and that he was highly critical (sometimes scathing) of other individuals and their views/opinions. Eric also reported that he had difficulties in relating to women and has lost hope of forming a relationship with a woman.

**Assessment for Inclusion in Treatment Program: Criterion 2**

Information obtained through psychometric assessment and interview indicated that Eric displayed co-morbid symptoms of PTSD and CP. Although inventories indicated that PTSD symptoms seemed more pronounced than CP symptoms, symptoms later described at the interview and during subsequent sessions indicated that CP symptoms were more prominent. Thus, Eric satisfied the second criterion for involvement in this treatment program.
The Treatment Program

The Negotiated Treatment Program: Consistency with Guidelines?

The program negotiated with Eric departed from the guidelines in several ways: firstly, a safety plan was not developed at the outset as Eric did not perceive any need for this. Further, there was no work planned on assisting with aspects of daily functioning or controlling core PTSD symptoms (on Eric’s request). However, Eric’s planned program was otherwise according to the treatment guidelines, focusing on treating those CP symptoms identified during assessment and listed above. Eric did not describe any symptoms that indicated a necessity to work on symptoms associated with “Alterations in Consciousness”.

How Eric’s Program Adhered to/Departed from the Negotiated Program

Apart from the two major departures from the treatment guidelines mentioned previously (absence of safety plan, and absence of work on core PTSD symptoms), further departures occurred as difficulties conducting the program as planned (and according to the guidelines) arose throughout the program. These were mainly related to Eric’s need to talk constantly throughout the sessions. However, as weeks continued, it became apparent that the events needing to be discussed by Eric related to one or another of the symptoms, and thus the symptoms were being addressed contextually. Another departure from the negotiated program was that Eric decided to conclude the treatment after 22 sessions, as he felt he had made significant gains. Eric suggested he would prefer to have the remaining sessions “some time down the track”. Eric also only attended half of the group therapy program, although had agreed to attend all sessions.
Therapist’s Perception of Positive and Negative Aspects of Program

Eric was very reliable and conscientious in terms of attendance, and rarely missed sessions, giving abundant notice if he would not be attending due to some other commitment. Eric also regularly commented on how beneficial the sessions were for him, and how important it was for him to talk through ideas with someone. Having an avenue for talking about issues seemed an extremely important aspect of this program for Eric.

However, Eric appeared to have an enormous need to “download” and tended to control most sessions, talking without interruption, and allowing little intervention. While this was clearly beneficial for Eric, from a therapeutic perspective, formal interventions were often difficult due to this aspect. Adherence to the “treatment program” was also difficult, as the sessions were often directed by Eric, and related to issues currently affecting him, rather than addressing specific symptoms in a systematic way. However, as with Cynthia, symptoms were often addressed indirectly through the issues raised. Eric was also resistant to many suggestions made to him, often blocking these with his own “answers” to problems. I sometimes felt as if I was merely a “sounding board”. Another limiting factor was that Eric rarely completed any of the “homework” given to him. On occasions, he would commence the homework, but did not continue with an exercise or see it through to a useful conclusion. This happened with the work related to improving self-concept, writing, narrative therapy, and relationship strategies. Eric often explained that he was too busy, as he was studying, had a family to run, and had many other duties. Difficulties were also encountered in attendance at group therapy, and although Eric attended initial group therapy sessions, his attendance lessened toward the end of the program. Further, others in the group reported that
they found him overbearing, and when the group was re-formed (after several left), several individuals suggested that they would not attend if he came. However, Eric decided not to attend the re-formed group due to study and family commitments at the time agreed upon by the majority of participants.

**Post-Treatment Evaluation**

*Psychometric Assessment: Comparison with Pre-Treatment Assessment*

Although Eric had difficulties, and was assisted with completing pre-treatment inventories, no assistance was given with post-treatment inventories. However, as the post-test results were not consistent with outcomes reported at the final interview with an independent psychologist, indicating some possible misinterpretation again, Eric’s results were not included in the evaluation.

*Qualitative Data: Symptoms Identified During Post-Treatment Interview*

**Alterations in Self Perception**

Eric reported increased self-knowledge in the course of the program. Despite the results on post-treatment SIDES-SR (indicating no change in self perception), there also appeared to be some increase in confidence.

**Alterations in Interpersonal Relationships**

Eric indicated that he still found social situations quite difficult. He stated that his attitude toward other people had changed “marginally”, but that he did not fit in easily (nor enjoy) with social groups. Eric still described himself as a “loner”, stating that he could do without people. However, there had been a slight improvement in the way he saw other people, in that there was less fear and fewer reports of feeling threatened. Nevertheless, Eric did not see that major change would be possible for him. Eric’s relationships with his children also did not seem to have
improved. His daughter had decided, at the age of 17 years, to move in with another family due to the ongoing difficulties in her relationship with her father. Eric was scathing about this move. However, apart from this, there was much more positive reflection on his children. Eric also stated that the work he had done in the treatment program had given him more confidence in terms of his relationships with women. The ‘opening up’ during sessions appeared to have moved him further towards being able to approach women confidently.

**Alterations in Affect Modulation**

Eric reported greater control over affect, more stability, improved ability to cope with pressure more effectively, and less agitation. Eric also reported an ability to function more effectively, and this, in turn, was assisting in and preventing the re-occurrence of depressed feelings. He reported being more “pro-active” in important areas of his life, as well as in preventive measures. Eric also demonstrated his current focus on the present, and indicated some contentment in undertaking simple pleasures, such as reading, sitting in the garden, and watching nature. Despite this, there was still an indication of little optimism about the future.

**Perception of Perpetrator**

Although Eric indicated during sessions that he had “moved on” from the past and had been able to forgive his ex-wife (and also his parents), there were still indicators of blame and negative thoughts when Eric described his ex-wife in the final session, despite his stated determination to prevent the past with her to influence his present and future.

**Summary of Impact of Treatment Program**

In commenting on the overall program, Eric stated:
the significant part of it [the program] has been being able to talk, and to
clarify some of the stuff in my own mind. I haven’t said it out loud – but just
being able to talk about it – clarify situations and issues – that had happened –
it sort of clarified things a lot. Pam took the time and physical effort to listen
actively and constructively.

He also stated, “I’m getting more pro-active – that’s the rational effect. Just talking
with Pam through the issues – about the time with my ex-wife and when I was a
child.” In describing the overall gains made from the program, Eric stated:

- There comes a time when you just have to get over it irrespective. It did
  happen. It was painful. It was hurtful. It has left a lot of emotional nasty scars
  for me. But hey – that was history – that was yesterday. It’s gone. I fall over
  often enough when I’m walking forwards. I’m not going to walk backwards
  for the rest of my life. I’ve got to look to what I’m doing now. It’s like a
  hurdle in a race. The hurdler has got to concentrate positively on this hurdle.
  That’s coming at him 40km per hour – and take care of it – and then the other
  one. And that’s what I’ve got to do – deal with each one well, and forget
  about the things that happened… and things that might happen. So I’ve gone
  from my focus being 360 degrees to being more like that… and my focus is
  gradually coming down to being here.

- Clarity of understanding appears to be the greatest gain for Eric. He claimed,
  “Understanding for me is the most important thing I can have – knowledge and
  gaining understanding about myself is important. As Sir Francis Bacon said, ‘Know
  thyself’”.

- Post-treatment, Eric some displayed improvements in some CP symptoms:
  “Alterations in Self Perception”, “Alterations in Affect Modulation”, and
“Alterations in Perception of the Perpetrator”, “Somatic Concerns”, and minor changes in “Alterations in Relationships with Others”. Eric reported feeling greater confidence, improved capacity for relating to others, improved capacity to regulate affect modulation, and fewer health problems. No improvement in core PTSD symptoms was reported. However, these symptoms were not a focus of therapy.

LUCY

Summary of Traumatic Experiences Identified

Childhood Abuse Experiences

Lucy is a 29-year old single woman, who is employed as a statistician in the public service. Lucy experienced sexual abuse by her father from “as early as I can remember – probably eight or nine years of age”, until the age of 15/16 years. Lucy explained that her father touched and fondled her inappropriately during this period of her life. Lucy recalled, when 14-15 years old, going on numerous trips to the coast with her father, sharing a sleeping bag with her father, and “inappropriate things” happening. Lucy stated that, on one of these occasions, her father told her not to inform her mother of the sleeping arrangements, and this acknowledgement that they were doing something wrong led to enormous feelings of guilt and shame for Lucy. Lucy’s two sisters were also sexually abused by their father.

Lucy also reported that, although she believes her mother was aware of what was happening, she did not protect her, or ever discuss the matter.

CCMS Results

On this scale, Lucy confirmed the above reports of abuse, identifying the following forms of childhood abuse: sexual abuse (being shown her father’s erect penis sometimes; being touched by her father on the vagina and breasts very
frequently, and being made to touch her father’s penis frequently); emotional abuse (being yelled at by her parents occasionally; and being ridiculed and embarrassed very frequently, being the recipient of sarcasm by mother and father); and some physical abuse (occasionally being punished physically for wrongdoing).

Other Life Experiences of Extreme Stress

Other events added to the stresses caused by the sexual abuse. Lucy suffered from severe childhood asthma and, at school, felt separated from the other children, as she was required to regularly use a ventolin machine and mask. From secondary school onwards, there was also constant pressure to succeed in order to please her father. The drive to please her father became an end in itself, with acquisition of knowledge being of secondary importance. In later years (19-25), Lucy became obsessed with health concerns, and over a period of time, developed the belief that she had contracted a range of serious and/or terminal illnesses: heart condition, AIDS, and various forms of cancer (many AIDS-related). There was great anxiety during this period.

Lucy has had difficulties in sexual relationships with any men, and although she married at the age of 20, this marriage ended due to her inability to enjoy a sexual relationship with her husband. This event and loss caused considerable distress for Lucy.

Assessment for Inclusion in the Program: Criterion 1

Lucy satisfied the first criterion for inclusion in this program, having suffered long-term childhood abuse (mostly sexual - but also verbal and emotional).
Trauma Symptoms

Symptoms Identified from Psychometric Screening

Lucy displayed co-morbid symptoms of both PTSD and CP. On the PDS (Foa), Lucy identified 11 of the 17 symptoms commonly associated with PTSD: three in category A ['Re-experiencing'], five in category B ['Avoidance'], and three in category C ['Arousal']. Intensity of symptoms was rated in the ‘Mild-Moderate’ Range (15/54), while level of impairment was ‘Severe.’

On the SIDES-SR (van der Kolk), elevated scores were indicated on following main scales: “Alterations in Self Perception” (with elevated scores on the sub-scales of ‘Ineffectiveness’, ‘Permanent Damage’, ‘Guilt and Responsibility’, ‘Shame’, ‘Nobody can Understand’) and “Alterations in Relationships with Others” (with elevated scores on the sub-scales of ‘Inability to Trust’ and ‘Victimising Others’).

There were also elevations on the following sub-scales: ‘Despair and Hopelessness’; ‘Loss of Previously Sustaining Beliefs’; ‘Difficulty Modulating Sexual Involvement’, and ‘Self-Destruction’. Borderline scores were indicated on the following sub-scales: ‘Excessive Risk Taking’ and ‘Suicidal Pre-occupation’ (low level); ‘Amnesia for Events’ (low); and ‘Sexual Symptoms’ (low).

Symptoms Identified During Pre-Treatment Interview

Alterations in Self Perception

Lucy reported that she did not really believe she was clever, and that her past good marks in studies were really due to study techniques – not to any ability. She also reported feeling “not pretty enough” and being unable to objectively look at
anything to do with her appearance. Sexually, Lucy saw herself as a complete failure. This poor self-concept appeared to have been present from an early age.

**Alterations in Interpersonal Relationships**

Lucy reported that she had always experienced difficulties in “a party atmosphere”, reporting extreme shyness, and explaining that she did not believe she had good interpersonal skills. Lucy also described difficulties in friendships, specifically a lack of interest in maintaining them. Lucy’s withdrawal from people has led to some isolation over the years. Lucy also referred to a lack of trust, which occurred mostly in relationships with men, and she explained that she believed that, for most men, there was an “ulterior motive” in engaging in a relationship. Lucy also reported persistent difficulties in all sexual relationships. She explained that the major relationship in her life, her marriage, had failed due to her difficulties in sexual intimacy. Lucy expressed a sense of hopelessness in regard to future relationships.

**Alterations in Affect Modulation**

Lucy reported high levels of anxiety in the past. She explained that her anxiety levels had been “out of control” until a couple of years ago, and that she had developed different “phobic anxieties.” Lucy’s concerns over her health came in waves between the ages of 19 and 24 years, and she reported having great difficulties controlling her fears. Lucy said that, eventually, she stopped having the fears regarding her health, stating, “it was as if I exhausted myself”. She also reported that she has worked hard at learning to control her fears. Lucy also described other ways in which her anxiety manifested itself, stating that her fears not only involved health concerns, but other aspects of life, such as flying in a plane. Lucy also reported recurring obsessive thought patterns and reported that she also became anxious about eating. She stated that she turned down many activities because she did not want to
be in a situation where she was going to have to eat some things – or to have alcoholic drinks. This also kept her isolated. Lucy also became obsessed with exercising and attending the gym. However, she did not believe that this was a problem for her currently. Lucy reported that, when her anxiety disappeared, it appeared to have turned to “flatness”. She reported not being able to connect with her emotions at all. Lucy also reported persistent depression. There was also an indication of some change in regard to belief systems. Lucy reported that she had become more spiritual over the years.

**Somatic Concerns**

Lucy reported that currently she did not have any health problems, but that she was frightened to do anything that might lead to problems. She also reported that she was frightened of losing control. Lucy stated that she was currently suffering amenorrhoea, stating, “I think that I am sexually turned off in every way.”

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**Assessment for Inclusion in Treatment Program: Criterion 2**

*Information provided at interview appeared consistent with that obtained through psychometric testing. Lucy satisfied the second criterion for inclusion in this program, having marked symptoms of PTSD and co-morbid CP.*

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**The Treatment Program**

**The Negotiated Treatment Program: Consistency with Guidelines?**

Lucy’s planned program departed from the guidelines in that a safety plan was not developed at the outset, as Lucy reported no concerns regarding self-harm and no suicidal ideation. There were also no plans to undertake work to assist Lucy with daily functioning, as Lucy indicated that she did not need assistance with this
aspect of the program. Both of these aspects of treatment were recommended in the treatment guidelines, however. Further, there was no work planned on controlling core PTSD symptoms (Lucy did not see these as a priority) although this was later included. However, Lucy’s planned program was otherwise according to the treatment guidelines, focusing on treating those CP symptoms identified during assessment: “Alterations in Affect Regulation”, “Alterations in Self Perception”, “Alterations in Perception of the Perpetrator”, and “Alterations in Relationships with Others”.

**How Lucy’s Program Adhered to/Departed from the Negotiated Program**

As mentioned previously, there were initially some specific departures from the recommended guidelines (exclusion of work around safety, daily functioning, and core PTSD symptoms). In the actual program, however, some work was completed on dissociation (which is included in the CP Symptom “Alterations in Consciousness”, but is also considered a core PTSD symptom). As planned, the main focus of the treatment was on the other CP symptoms identified, although no work was undertaken on “Alterations in Belief Systems” or “Somatic Concerns”, The difficulties maintaining the focus on the identified CP symptoms have already been referred to. Another impeding factor was that, as Lucy had a “break” from therapy for about six-seven weeks, she was unable to complete all 24 sessions, as recommended, completing only 20 sessions in total. Another departure from the recommended guidelines was that Lucy elected not to continue with group therapy after the group re-formed and changed its location.

**Therapist’s Perception of Positive and Negative Aspects of the Program**

Lucy was initially very conscientious and attended regularly, undertaking readings suggested, and completing “homework”, trialling different strategies, as
required. However, one major problem with Lucy was that she had a tendency to commence exercises/work on symptoms enthusiastically, but then lose interest in the work before it had been taken through to its effective conclusion. She would then wish to discuss some other problematic area. Further, approximately two-thirds of the way through the program, Lucy became involved in a relationship and directed each session toward discussing problem issues within the relationship. The implication of this was that she did not adhere to the original plan. An additional problem was that Lucy started cancelling sessions after about 16 sessions, and when asked whether she really wanted to continue, she said that she did not. No reasons were given. I suspected that “the relationship” had become of more interest than the sessions. Several weeks later, Lucy asked to re-join the program, and I agreed to this suggestion.

Another major problem was that initially, Lucy minimised the nature of her past abuse, and this continued for most of the period. She also avoided any reference to the abuse in most sessions. However, after returning to the sessions after the break, she was more open and asked to arrange a session to openly confront her father about the abuse inflicted on her.

**Post-treatment Evaluation**

*Psychometric Assessment: Comparison with Pre-Treatment Assessment*

On the PDS (Foa), Lucy identified only 3 of the 17 core PTSD symptoms – compared with 13 pre-treatment (none in category A [‘Re-experiencing’] compared with three pre-treatment, one in category B [‘Avoidance’] compared with five pre-treatment, and three in category C [‘Arousal’] – the same as pre-treatment. Intensity of symptoms was rated in the ‘Extremely Mild’ range (4/54) compared with ‘Mild-
Moderate’ range (15/54) pre-treatment, while level of impairment was ‘Moderate’ (compared with ‘Severe’, pre-treatment). No clinically significant score was indicated on either main scales, or sub-scales, of the SIDES-SR (van der Kolk).

**Qualitative Data: Symptoms Identified During Post-Treatment Interview**

**Alterations in Self Perception**

Post-treatment, Lucy reported feeling much stronger, more confident and more assertive in her behaviour. This was evident in her being able to overcome the avoidant tactics used over many years, and face her father, the perpetrator of her abuse. Lucy also reported no longer needing to seek her father’s approval, as she had done for many years. When asked about the most valuable aspect of the program, Lucy responded: “self esteem/assertion training – the self-esteem presentation in the group – and using positive adjectives about myself – the cognitive work”.

**Alterations in Affect Modulation**

Post-treatment, Lucy reported being able to connect with her emotions again. When asked whether she could feel much more now, her response was, “Definitely – definitely – very much.” Lucy also described improvements in her overall mood, and expressed optimism. Lucy talked about travelling overseas soon, buying a house, and becoming more independent. Lucy also appeared highly functional and discussed her work with enthusiasm.

**Alteration in Interpersonal Relationships**

Lucy reported more openness to people and to friendships – having many more friends these days. She reported turning to friends when she had difficulties. This was something that she avoided previously. Lucy also reported that she is much more assertive in other relationships these days. She also stated that she is better able to cope when a relationship does not turn out “as hoped” and that she has developed
strategies to cope with this. Lucy reported that she would like to be in an intimate and close relationship in the future, and has some fears about being alone forever.

**Alteration in Perception of Perpetrator**

When Lucy initially commenced the program, she intimated that she did not wish to do anything that would change the love she had for her father. However, by the end of the program, Lucy had developed anger toward him, to the extent that she wished to confront him about the past, and request an apology. This was empowering for her and changed the way she viewed him. She still expressed her love for him, however, stating that it was a “love-hate relationship”. In all of this was a recognition that he was the guilty party, not her.

**Alterations in Consciousness**

Lucy reported that she still experienced a certain amount of dissociation. However, she reported that awareness of what is happening had helped her.

**Summary of Impact of Treatment Program**

Lucy indicated improvements in all CP symptoms treated, namely: “Alterations in Self Perception”, “Alterations in Interpersonal Relationships”, “Alterations in Perception of the Perpetrator”, “Alterations in Affect Modulation”, and “Alterations in Consciousness”. There was also a reduction in number and intensity of all core PTSD symptoms, although the only symptoms directly treated was ‘Avoidance’ (dissociation). When asked about the most positive aspects of the past six months, Lucy reported that the whole family facilitation was very useful. She stated, “Then my parents and I sat down and talked about it and actually apologised. And it really has improved it for me.” She also referred to self-esteem/assertiveness training – in particular, the self-esteem presentation in the group and the cognitive work. Having a greater awareness of the impact of the past
on her adult behaviours also appeared to be important: “She [therapist] put a lot of pieces together. And the material she gave me to read – on long-term effects of childhood experiences – was helpful.” When asked about any problems she was still experiencing, Lucy reported that there were still problems with physical intimacy. Lucy concluded with, “I would like to openly thank Pam for facing the hardest issue of my whole life.”

**DIANA**

**Summary of Traumatic Experiences Identified**

*Childhood Abuse Experiences*

Diana is a 57-year-old divorced woman, who is estranged from her only son and three grandchildren. Diana has resigned from her permanent public service position, but does contract work occasionally. Diana identified several traumatic childhood experiences. At the age of four years, she was taken by a stranger to a place away from her home, the stranger trying to undress her. Although nothing further eventuated, Diana reported that this experience was very frightening to her, and has remained in her memory. At the age of eight years, Diana was sexually abused by her sister and cousin (her sister was four years older than her, and her cousin was about 14 years old). She reported that her memory of the incident is vague, but she remembers that she was held down and “interfered with” by them. This occurred on only one occasion. Diana and her sister were also physically beaten by her father (using a stock whip) when they were young. Diana reported being left with welts on her legs. She also reported physical abuse by her mother (being hit on the face and neck, being slapped in the face, and punched in the back) and remembered having items thrown at her. This physical abuse was usually
accompanied by verbal abuse. Diana described name-calling and put-downs by her father from her teenage years onwards. She also reported some neglect by her parents, reporting that she and her sister were left to care for themselves a lot, and had to care for their own clothes and cook meals for a very early age.

At the age of 12 years, Diana was sexually abused by her uncle, who digitally penetrated her. There has been ongoing harassment from this uncle over the course of her life – and this is still continuing. During family functions, he attempts to kiss her (by putting his tongue into her mouth), fondle her breasts, and touch her bottom). He also makes suggestive comments and phones her in a harassing manner. Although she avoids contact with him, Diana has felt powerless to do anything without causing major disruption within the family.

**CCMS Results**

Diana’s results on this scale confirmed the abuse reported at interview, with the following forms of childhood abuse being identified: psychological abuse, physical abuse, sexual abuse and neglect. She reported being yelled at by her mother (frequently) and by her father (sometimes); being ridiculed and embarrassed, using sarcasm, by her father (frequently) and by her mother (sometimes); being provoked, and treated cruelly by mother and father (frequently); and witnessing the above treatments toward others frequently. Diana also reported receiving physical punishment for wrongdoing by mother (very frequently), and receiving physical punishment from her father (very frequently); receiving other forms of violence (hitting, kicking, punching) from her mother (frequently), and her father (sometimes); witnessing the above physical abuse directed towards others (frequently). Diana also reported being neglected: not being fed, bathed, regularly; being shut in a room alone for an extended period of time by mother and father.
(frequently); having her requests for attention ignored and not being spoken to for an extended period by her mother (frequently); and by her father sometimes. Diana also reported being touched sexually by an adult; having an adult put a finger in her vagina on one occasion.

**Adult Experiences of Extreme Stress**

In her adult life, Diana has experienced ongoing events of extreme stress, which have added to, and compounded, the impact of events of her early life. Diana described her involvement in a 23-year “loveless marriage”, in which she felt ignored, unappreciated and in which there was little intimacy of love. She reported having several affairs in the course of the marriage as was “crying out for love and comfort”. Diana reported that her marriage was stressful for her over a long period. Diana also reported that several affairs in which she became involved were also stressful, as the breakdown and loss of each relationship lead to further grief. In one 18-month relationship with an older married man, the sense of loss was extremely strong. Diana also described the loss of another major relationship in her life: a 16-year relationship with a married man, who was not prepared to leave his wife for her. Although there were many happy times, for most of the relationship there was a great deal of stress due to the nature of the relationship. Ten months prior to attending for therapy, this relationship had ended when the partner had just disappeared without explanation. This relationship, and the disappearance of the man involved, had been extremely stressful for Diana.

Other extremely stressful periods related to close family members. Diana reported that, six years ago, her son decided he wanted no further contact with her, and actively excluded her from his life, and that of his wife and children. Diana did not understand the reason for this exclusion. Diana also reported the breakdown of
relationships with both her older and her younger sisters for different reasons. The loss of these relationships, and the tension and stress in the relationships over the years, has also been a source of extreme stress for Diana. The death of her mother, and subsequent feuding with her sisters in the period following her mother’s death, was also a source of extreme stress. Diana also reported that the development of a golden staph infection, which led to serious health issues over a period of three years around the time of her mother’s death, was also extremely stressful.

Assessment for Inclusion in Program: Criterion 1

Diana satisfied the first criterion for inclusion in this program, having suffered long-term childhood abuse (multiple forms). The early childhood traumas were compounded by ongoing events of an extremely stressful nature.

Trauma Symptoms

Symptoms Identified at Psychometric Screening.

At pre-intervention assessment, Diana displayed co-morbid symptoms of both PTSD and CP. On the PDS (Foa), Diana identified 12 of the 17 core PTSD symptoms (one in category A [‘Re-experiencing’], six in category B [‘Avoidance’], and four in category C [‘Arousal’]. Intensity of symptoms was rated in the ‘Moderate’ range (38/54), while level of impairment was ‘Moderate’.

On the SIDES-SR (van der Kolk), elevated scores were indicated on the following main scales: “Alterations in Relationships with Others” (with elevated scores on the sub-scales of ‘Revictimisation’); also on the sub-scales, ‘Inability to Trust’ and ‘Victimising Others’ (low); “Alterations in Systems of Meaning” (with
elevated scores on the sub-scales of ‘Despair/Hopelessness’; ‘Loss of Previously Sustaining Beliefs’).

Clinically significant scores were also indicated on the following sub-scales: ‘Minimising’ (“Alterations in Self Perception”) and ‘Somatisation’ (cardio, conversion, chronic pain, digestive). Borderline scores were indicated on the following sub-scales: ‘Modulation of Anger’; ‘Suicidal Pre-occupation’; ‘Self-Destructive’; ‘Guilt/responsibility’; ‘Shame’; ‘Nobody Understands’ (all within the “Alterations in Self Perception” scale).

**Symptoms Identified In Pre-Treatment Interview**

**Alterations in Interpersonal Relationships**

Diana reported that she has changed the way she views men, and now believes they are selfish and self-centred. She reported that she is no longer interested in having another close relationship with a man, as feels she has been hurt too much. Diana reported that she has also become isolated from other people and stated that she prefers to be alone. She reported making excuses about not going to social functions and stated that she prefers to stay at home alone watching the television. Thus, Diana reported a certain loss of trust in relationships now and being very guarded. She explained that this has not only been related to being ‘let down’ in recent relationships, but feeling betrayed in all the close relationships of her life.

**Alterations in Self Perception**

Diana also reported suffering from extremely low self-esteem, which she attributed to the treatment she experienced as a child. Diana admitted that her mood is often reliant on praise from others, and that she is very sensitive to criticism.
Alterations in Affect Modulation

Diana reported that she often feels sad. She reported times in her life when she has had suicidal ideation, but that this has not been recently. Diana also reported that she has been very pessimistic for a long time and there had been a loss of optimism. She believes that for most of her life, she has searched for a rescuer.

Assessment for Inclusion in the Program: Criterion 2

Diana satisfied the second criterion for inclusion in the program, as indicated PTSD symptoms and co-morbid CP symptoms.

The Treatment Program

The Negotiated Treatment Program: Consistency with Guidelines?

The treatment program developed departed slightly from the program recommended in the guidelines. Firstly, there were departures in terms of not developing a safety plan or including work on aspects of daily functioning, as recommended. However, in general, the planned treatment program adhered to the guidelines, in that some work was planned on dealing with core PTSD symptoms, and the remaining sessions were devoted to CP symptoms: “Alterations in Self Perception”, “Alterations in Affect Regulation”, “Alterations in Relations with Others”, and “Alterations in Belief Systems”.

How Diana’s Program Departed from/Adhered to the Negotiated Program

In addition to the departures from the treatment guidelines negotiated, there were some additional changes in the actual program. Firstly, as indicated above, the number of sessions actually received was 17, rather than the 24 planned, and Diana did not participate in group therapy sessions. Further, no work was undertaken on
core PTSD symptoms. Attempts were thus made to deal with the identified CP symptoms. The difficulties in actually undertaking interventions have already been mentioned, with symptoms being treated “in context” rather than in discrete units/themes.

**Therapist’s Perception of Positive and Negative Aspects of Program**

Diana attended regularly until group therapy commenced, and then she suddenly withdrew from the program. She did, however, return to individual therapy some weeks later. The major difficulty in conducting this program was that Diana did not complete all 24 sessions, leaving the program after approximately 12 sessions, as soon as group therapy commenced. She attended the first group session and then phoned to say that she was withdrawing from the program due to illness. Diana was invited to re-join the group at any time, and was asked if she would take part in an evaluation interview. Diana agreed, and arranged to come and talk with me first. At this session, she explained that having to participate in the group process had been a prime reason for her leaving. She explained that she could not be totally truthful and honest in front of the others in the group, and therefore, it was unfair of her to participate. Diana also felt that, since she had made a commitment to undertake the group therapy as part of the program, it was unfair to still have the individual sessions. As a result, she withdrew totally. After some further discussion, Diana agreed to continue with individual therapy. She was happy about this, and came to five more sessions before deciding that she had made sufficient gains to discontinue. Another difficulty was that, although Diana would present with problems, and would ask for suggestions, she rarely applied any suggestions or strategies suggested. In most areas, she found her own solution (often at variance with ones decided upon in the session). Further, Diana tended to talk continuously
throughout the session, and it was very difficult to discuss possible strategies to help deal with the problem. Diana also tended to use the sessions to discuss immediate crises. As with other participants, most crises still related to one or more of the issues outlined in the treatment program – and so these situational discussions were used to assist the client with broader issues.

Post-Treatment Evaluation

Psychometric Assessment: Comparison with Pre-Treatment Assessment

On the PDS (Foa), Diana identified 10 of the 17 symptoms commonly associated with PTSD, compared with 12 pre-treatment (two in category A [‘Re-experiencing’] – compared with one pre-treatment; four in category B [‘Avoidance’] compared with six pre-treatment; and 4 in category C [‘Arousal’] – same as pre-treatment). Intensity of symptoms was rated in the ‘Mild-Moderate’ range (26/54) compared with ‘Moderate’ range pre-treatment (38/54), while level of impairment remained ‘Moderate’.

On the SIDES-SR (van der Kolk), elevated scores were still indicated on the following main scales: “Alterations in Relationships with Others”, with elevated scores on the sub-scales of ‘Re-victimisation’; also ‘ Inability to Trust’ and ‘Victimising others’ (low); “Alterations in Systems of Meaning” (with elevated scores on the sub-scales of ‘Despair/Hopelessness’; ‘Loss of Previously Sustaining Beliefs’).

However, clinically significant scores were no longer indicated on the following sub-scales: ‘Minimising’ (sub-scale of “Alterations in Self Perception”) and ‘Somatisation’ (cardio, conversion, chronic pain, digestive). Borderline scores were still indicated on the following sub-scales: ‘Modulation of Anger’; ‘Suicidal
Pre-occupation’; ‘Self-destructive’; ‘Guilt/Responsibility’; ‘Shame’; ‘Nobody Understands’.

**Qualitative Data: Symptoms Identified During Post-Treatment Interview**

**Alterations in Self Perception**

Diana reported improvements in the way she viewed herself, describing herself as stronger, more confident and more assertive.

**Alterations in Interpersonal Relationships**

Limited improvements were indicated in terms of interpersonal relationships. Diana reported that she had developed more strength in coping with the difficult relationships in her life. However, she reported that she was still finding relationships with others difficult, and still expressed little trust in other people.

**Alterations in Affect Modulation**

Limited improvements were also seen in terms of Diana’s capacity to modulate her affect. Diana reported that she still suffered some depression, although had developed strategies for dealing with her depressed moods. She reported gaining benefit from some of the relaxation strategies shown to her and reported using these regularly.

**Alterations in Belief Systems**

There did not appear to be any significant shift generally in regard to feelings of pessimism and hopelessness. Diana reported feeling better about the future, but attributed this to the return of her son to her life – not to the treatment program: “Not so much (to be honest) from the work with Pam. I think the fact that my son is in my life. Until I saw Pam, I saw my future as bleak.” Diana did, however, indicate that connecting with him again was indirectly associated with the work done as part of the program.
**Group Therapy**

In describing her experience of the group therapy with the independent interviewer, Diana reported:

I absolutely hated it. I said, ‘I can’t come to see you any more’. Not ‘I can’t come’, but ‘I feel too vulnerable.’ It took me so long just to pluck up the courage just to come to Pam [therapist]. I’m happy to listen to everyone else’s problems, but I don’t want to talk about mine. I don’t want to open up about the things that have happened. They are more private – or more personal. In the group session, I cried. I just hated it. It took me a week to get over the first session. It was just too stressful for me.

**Summary of Impact of Treatment Program**

Psychometric assessment indicated that there were still marked PTSD symptoms and also some CP symptoms at post-intervention. However, details provided at interview indicated some reduction of one CP symptom (improved self perception), although only limited improvements were reported in interpersonal relationships and affect modulation. On the whole, however, improvements for Diana appeared limited. Diana reported that one of the most helpful things about the program was being able to talk about the betrayal by her sister – something she had never discussed with anyone before. She said that, on the whole, the program had “helped me to see things in a different light”.

PERCY

Summary of Traumatic Experiences Identified

Witness to Father Committing Suicide / Suicide of Stepfather

Percy is a 37-year-old man who lives alone and works as a financial adviser within the public service. When Percy was five (almost six) years of age, his father committed suicide from an overdose. Percy was present when he died. Later, his stepfather told him that his father had committed suicide because he was a bad child, and Percy believed this. Percy’s stepfather then committed suicide during Percy’s adolescent years.

Physical, Emotional and Verbal Abuse by Stepfather

Percy’s description of the physical abuse meted out to him explains his abuse most accurately:

He was a very cruel person. He was an exceptionally cruel person – and basically, until I was 13, life was fairly miserable. My mother sort of disowned me in the family relationship. And Allan sort of treated me worse than he treated a dog. Quite often, I was made to eat out of the dog bowl with the dog. I was beaten many, many times. I was locked in my room. I was only allowed to go to the toilet once per day – and if I went outside of that time, I was made to drink my own urine, and eat my own faeces. I didn’t have a mattress on the bed. Quite often, I’d be chained to the bed. Allan lost a leg in a motor-cycle accident shortly after my mother married him – and he used his crutches to continually beat me.

Percy also reported that, “He tried to kill me twice by drowning – once in the bath and once in the sink.” According to Percy, verbal abuse accompanied the physical abuse.
Sexual Abuse by Stepfather

From the age of 9 or 10, Percy was sexually abused by his stepfather. He reported that his stepfather “used his crutches” to undertake this abuse.

Neglect

Percy’s educational needs were also neglected, and he reported not attending school until about the age of 12-13 years. As a result, he was unable to read or write until later in life. Percy was also unaccustomed to interacting socially with others his age, as had very little interaction with anyone during his younger years. Percy stated, “I wasn’t allowed any friends – so I had no friends, no nothing. So the only interaction I had was with James and my mother.” There was also emotional neglect, Percy reporting that his mother showed him no affection at all.

Rejection by Mother/Placement in a Home

After his stepfather committed suicide, Percy was then “allowed” to attend school. However, because he had missed so much, he played truant. His mother took him to a psychologist, who recommended he be put in a home - and his mother complied. Percy described this as “a horrendous time’ as the home was for extremely violent children. He only remained in this home for a few months. However, while there, he claimed, “I shut off even more in there.”

CCMS Results

On this scale, Percy confirmed the reports of abuse, indicating psychological abuse, physical abuse, sexual abuse and neglect. He reported verbal abuse by mother (sometimes) and by another adult (very frequently); being ridiculed, embarrassed and provoked by another adult (very frequently); witnessing the above treatment to others (frequently); physical punishment for wrongdoing (very frequently); receipt of other forms of violence – punching, kicking; hitting (very frequently); being severely
hurt by an adult (very frequently); sexual abuse and being shut in a room by stepfather.

**Later Experiences of Extreme Stress**

Percy struggled over many years to “catch up” from lack of early education, and this he did, but studying hard over many years. Percy also described two suicide attempts: one in mid-twenties, and another more recently. Percy wrote, “Then I tried to take my own life when I was at Barclays. I just thought at the time, ‘I’m getting more and more depressed about everything.’ Everyone thought I was an amazing person. Inside it was just turmoil – I didn’t really intimate to my girlfriend that I was suicidal. I took an overdose.” Percy took another overdose in the year prior to commencing this treatment program.

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**Assessment for Inclusion in the Program: Criterion 1**

Percy satisfied the first criterion for inclusion in this program, having suffered long-term multiple forms of abuse as a child.

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**Trauma Symptoms**

**Symptoms Identified by Psychometric Screening**

Percy displayed co-morbid symptoms of both PTSD and CP (both at quite a marked level). On the PDS (Foa), Percy identified 16 of the 17 core PTSD symptoms: four in category A ['Re-experiencing'], seven in category B ['Avoidance'], and five in category C ['Arousal']. Intensity of symptoms was rated in the ‘Moderate’ range (35/54), while level of impairment was ‘Severe’.

On the SIDES-SR (van der Kolk), elevated scores were indicated on the following main scales: “Alterations in Affect Regulation” (with elevated scores on

Symptoms Indicated at Pre-treatment Interview

Alterations in Self Perception

Percy indicated a total lack of self-esteem and a sense of feeling different to (and less worthy than) others. Percy also reported that there has been a stigma attached to the past: “that I didn’t have an education. I didn’t go to school. I didn’t have a ‘normal’ life”. He indicated that there had been an underlying depressed feeling about life, and a feeling that he wasn’t worthwhile.

Alterations in Interpersonal Relationships

Percy described an inability to form close relationships, a total lack of trust, and sense of suspicion, in others. He explained that his lack of trust was associated with a belief that people were inherently “bad”. Despite this, Percy reported that he always seems to need one person in his life. However, having formed a close relationship, Percy would then sabotage that relationship.
**Alterations in Affect Modulation**

Percy explained that he had always been depressed and had never been able to find enjoyment in anything in life. He expressed the belief that he was being punished for being himself. Percy also described a sense of hopelessness and helplessness developing over the years, and reported that even when he did achieve anything in life, he would then sabotage his achievement. Percy also explained that he had become increasingly irritable and intolerant towards other people. He explained that, on two occasions, his depression had been so extreme that he had attempted suicide.

Percy reported that he was a “chronic worrier”, and that this worry often paralysed him. He also reported extreme social anxiety, stating that his aloofness was often mis-interpreted by others as unfriendliness or coldness.

**Alterations in Consciousness (Dissociation)**

Percy reported that he spent a lot of time staring into space – and that this tendency appeared to be increasing.

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**Assessment for Inclusion in Program (Criterion 2)**

Percy satisfied the criterion for inclusion in the treatment program, having marked symptoms of PTSD and co-morbid CP. The information provided during interview was consistent with that provided in psychometric testing. As Percy had reported extreme depression and a recent suicide attempt prior to attending therapy, his inclusion was considered carefully. However, given the nature of the program, it was decided that his condition could, at the worst, be stabilised, and that it was also important that he have regular contact with a therapist.
The Treatment Program

The Negotiated Treatment Program: Consistency with Guidelines?

Percy’s planned program departed from the original recommendations in the treatment guidelines, by not including the development of a safety plan, aspects of daily functioning, nor core PTSD Symptoms (the latter being surprising, given the number and intensity of core PTSD symptoms identified). Most of the planned program was devoted to CP symptoms: “Alterations in Self Perception”, “Alterations in Interpersonal Relationships”, “Alterations in Affect Modulation”, and “Alterations in Belief Systems”.

How Percy’s Program Departed From/Adhered to Negotiated Program

As safety issues and aspects of daily functioning were dealt with throughout the program, Percy’s program reverted to the recommendations of the treatment guidelines in which it was suggested that clients were assisted with safety and aspects of daily functioning first, prior to working on other symptoms. However, as planned, no work was undertaken on core symptoms of PTSD – and this departure from the guidelines remained. Percy’s actual program thus focused mainly on the CP symptoms identified (“Alterations in Self Perception”, “Alterations in Interpersonal Relationships”, “Alterations in Affect Modulation”, and “Alterations in Belief Systems”), although work on these was limited, as described earlier. In addition, Percy completed only 20 of the 24 sessions prior to departing without explanation. On the last occasion that we met, I sensed, from Percy’s body language, tone of voice, and facial expressions, some hostility. I was unable to determine the reasons for this, although this may have been related to the fact that Percy was becoming increasingly frustrated with lack of improvements, thinking this was “just
another failure”, as predicted in the initial sessions. Percy may also have felt some annoyance at being referred to the Crisis Team at the hospital when his partner phoned one night requesting assistance.

Therapist’s Perception of Positive and Negative Aspects of Treatment Program for Percy

Percy appeared to understand well, and have clear insight into, the nature of his problems. However, from the initial session, Percy reported a negative view of psychologists and psychiatrists, stating in the initial session that he had “no faith” and “no trust” in such practitioners. He described previous therapists in very negative terms (e.g., ‘useless’, ‘idiots’). Percy also indicated a lack of trust about therapy generally, and its capacity to assist people such as himself. He indicated that he also did not believe this program would be any better than other therapy he had received and stated that it was possibly a “waste of time” him coming to therapy. He reported that he was there largely because his partner had pressured him to attend. The negativity of Percy towards therapy pervaded all sessions. In every session, he spoke pessimistically about therapeutic approaches outlined, insisting that these would be unlikely to assist him.

Non-attendance at individual sessions was another major problem. Percy regularly missed sessions often phoning on the morning of his appointment and stating that he was ‘too tired’, or was ‘not feeling the best’. On other occasions, he would state that he had work to complete or that he needed to go away for the weekend. This made undertaking a coherent program very difficult. Another result of this was that, with one or two sessions missed, each time we met, we would spend much of the session discussing how things had been since the last session, and discussing problems encountered during this period. Further, when Percy attended, he usually
had not completed homework requested, or had left important items for the session at home. This may have been related to the fact that he had no faith in the capacity of the work to help him.

Another problem was that, on most occasions, when cognitive therapy was attempted, Percy was unable to consider alternative ways of thinking and would not be ‘shifted’ from his original negative thoughts. The move was made to undertake behavioural therapy, and better results were achieved here. However, extreme negativity still pervaded all sessions, and Percy always presented with very flat affect and was difficult to “engage” in the therapy process. There also appeared to be some avoidance of hypnosis, although Percy had stated that he thought it would be beneficial, and following a “practice session” had commented that he felt “safe” undertaking this process.

As the weeks progressed, I assessed Percy as having Avoidant Personality Disorder (DSM-IV 301.82). This explained much of his social avoidance, and also his therapy avoidance. On the whole, I found Percy difficult to engage in the therapeutic process.

**Post-Treatment Evaluation**

*Psychometric Assessment: Comparison with Pre-Treatment Assessment*

As Percy ceased communication with me toward the end of the program, I was unable to obtain completed inventories from him. He did, however, attend the final interview with an independent psychologist. It was also difficult to obtain information from this final interview, as Percy provided little detailed information, and also spoke very softly, so that it was difficult to determine from the recording what he was saying.
Qualitative Data: Symptoms Identified at Post-Treatment Interview

Alterations in Self Perception

Percy expressed statements that indicated that he had not improved his view of himself, stating that he saw very little change in himself. He also spoke about the fact that he did not really believe he had an identity.

Alterations in Affect Modulation

There appears to have been little change overall in terms of capacity to modulate affect. There were times throughout the program, when Percy’s mood appeared more elevated – especially during the times when he undertook behavioural changes as a result of planning his week and including new and different things. However, at the final interview, he indicated that his depression had returned. On the whole, there was little optimism expressed by Percy, who stated that he wished there was not a future, knowing that it would be more of the same. However, one aspect of life seemed to have become more functional (Percy’s work and study). Percy also explained that he still experienced a certain amount of dissociation.

Alterations in Interpersonal Relationships

Percy had ended the relationship with his partner by the time the treatment program had finished, indicating that he was unable to meet the expectations of his partner. As for other relationships, Percy still expressed distrust of others, and had not made moves to broaden his friendship group/circle. He had, however, formed a relationship with his 11-year-old nephew and reported that he enjoyed this relationship as his nephew was not critical of him.
Alterations in Perception of Perpetrator

Percy did not believe his perception of the perpetrator of his abuse had changed at all. Percy reported that he did think a lot about what happened. He also stated that the work done with me had not really affected the extent of his memory, and that there had been no real change in this area.

Summary of Impact of the Program

As the above has indicted, few changes occurred for Percy as a result of the treatment program. Percy commenced the program with little optimism, and his expectations were fulfilled. The program was thus a “self-fulfilling prophecy” in this case. Percy’s responses at the end of the program indicated that he viewed this program in the same way that he had viewed previous therapy attempts – ‘useless’. He thus continued to view himself in a negative way and as a dysfunctional. Percy stated that he found the hardest aspect of the program the group therapy. He stated that he found it frustrating and that he did not believe had had engaged with it.

Although Percy’s condition did not appear to have improved, it is unlikely that the program lead to any further deterioration in Percy’s condition, as the program focussed on “ego-strengthening” and, as such, was unlikely to lead to deterioration in any participant’s condition, as would a program focussing on past trauma experiences.

On the whole, it appeared that the lifelong mood cycle reported by Percy in the initial interview (shifting from depressed mood state to extreme depression/suicidality) had continued unchanged throughout this program.
GERALDINE

Summary of Childhood Abuse Experiences Identified

Witnessing Domestic Violence and Verbal Abuse Between Parents

Geraldine is a 32-year old married woman, who is employed as a manager within the public service. Geraldine’s descriptions of her abuse provide the most accurate representation of her experiences:

There was a lot of fighting between him [her father] and my mum – yelling and screaming – throwing things, hitting. I remember things like, my mother had locked him out of the house and he put his foot through the door, trying to get back in, things like that. It was always a family joke that the rock had a dent in it where my mother had hit him over the head one night when he was being particularly bad. There was a lot of yelling – quite a high level of yelling. Mum and Dad fighting could have gone on for hours… I can remember lying on the bed as a kid, with the covers over my head, trying not to listen to the screaming. It would have happened about two nights out of seven.

Verbal Abuse

Geraldine reported that her mother yelled at her and her brother a lot: “Mum would, yell if we hadn’t done something: cleaned up our room/ not done homework – the sort of things parents yell about. She was always ‘anal retentive’ about a lot of things – really, really ‘anal-retentive’”. Geraldine also reported that her father called her (and other family members) names regularly: “I remember he called Mum the ‘big bitch’ and me the ‘little bitch’ and my brother, ‘little pig’”. Geraldine provided other examples of her father’s “name calling” and put downs:
Nothing ever of us ever did was good enough for him. I’m quite academic, and if I got 9 and a half out of 10, he’d ask where the other half was. He would make sarcastic and rude marks when I was going through puberty – and in front of other people. Once he made a comment about body hair – it was humiliating.

Physical Abuse

Geraldine also described long-term physical abuse by her father:

Once, he gave me a black eye. My brother and I lived in fear of Dad’s belt. It was never a strap across the back of the legs. It was always full-on laying in – you’d be sore for days. It was right through my life until I was 16. It was variable in frequency – no real consistency. The time he gave me the black eye was when I forgot to wipe down the sink after I’d done the dishes. I’d cooked dinner and done the dishes – and forgot to wipe down the kitchen sink, and for that, I got a black eye. It started with an argument - and would escalate.

Lack of Protection by Mother

Geraldine reported that she cannot remember her mother trying to protect her. On two occasions, Geraldine plucked up the courage to tell someone - and on one of these occasions, her mother was called in. However, she denied the abuse.

CCMS Results

Geraldine’s results on this inventory confirmed reported abuse experiences. The following childhood abuse experiences were reported: psychological abuse: verbal abuse by mother and father (very frequently); and witnessing this to others (very frequently); physical abuse (frequently); and witnessing this to a sibling (frequently); receiving other violence from father (frequently) and sometimes being
severely hurt by him; witnessing this to her sibling and mother sometimes; neglect (by her mother).

**Later Life Experiences of Extreme Stress**

Geraldine described a very destructive relationship with a man, experienced after leaving home:

He cheated on me constantly and consistently. I felt a lot of stress during the relationship. I went from two cigarettes a day to two packets. I’d drink a six-pack of beer and went from a size 10 to a size 24. I loved him, but he didn’t love me. I was very depressed right through – and had one suicide attempt.

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**Assessment for Inclusion in Program: Criterion 1**

*Geraldine satisfied the first criterion for inclusion in this program as suffered long-term multiple forms of abuse as a child.*

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**Trauma Symptoms**

**Symptoms Identified from Psychometric Screening**

Geraldine satisfied the criteria for PTSD. However, according to the results of psychometric assessment, Geraldine did not fulfil strongly the criteria for CP. However, as the treatment progressed, it became evident that CP symptoms were stronger than initially indicated. On the PDS (Foa), Geraldine identified 14 of the 17 symptoms commonly associated with PTSD: three in category A ['Re-experiencing], seven in category B ['Avoidance'], and four in category C ['Arousal']. Intensity of symptoms was rated in the ‘Mild-Moderate’ Range (32/54), while level of impairment was ‘Severe’.

On the SIDES-SR (van der Kolk), no clinically significant score was seen on any main scales. However, elevations were indicated on numerous sub-scales:
Elevations on following sub-scales: ‘Affect Regulation’; ‘Modulation of Anger’ (“Alterations in Affect Regulation” scale); ‘Transient Dissociative Episodes’ (“Alterations in Consciousness” scale); ‘Guilt and Responsibility’ (“Alterations in Self Perception” scale); ‘Inability to Trust in Relationships’ (“Alterations in Relationships with Others” scale); and ‘Somatisation (cardiopulmonary).  Borderline scores were indicated on the following sub-scales: ‘Suicidal Preoccupation’; ‘Self Destructive’; ‘Difficulty Modulating Sexual Involvement’ (within “Alterations in Affect Regulation” scale); ‘Ineffectiveness’; ‘Shame’; ‘Minimising’ (within the “Alterations in Self Perception” scale); ‘Digestive’ (within the “Somatic Concerns” scale) and ‘Despair and Hopelessness’ (within the “Alterations to Beliefs Systems” scale).

**Symptoms Identified During Pre-Treatment Interview**

**Alterations in Self Perception**

Geraldine described a poor self-concept that had been strongly influenced by her father. Geraldine also felt that there was not a strong sense of who she was and that she often changed to suit the situation.

**Alterations in Interpersonal Relationships**

Geraldine reported that relationships were difficult for her. She explained that she has never really been certain of the appropriate way to behave in a relationship, given her poor role models. Geraldine also reported difficulties with showing affection, explaining that she had never witnessed any between her parents. She also referred to difficulties with trust, reporting that it has always taken her a long time before she can trust people and open up to them. This was especially so with her husband, and has also been the case with friendships. Geraldine also reported that she had difficulties in apologising when she is wrong, as neither of her parents had
ever apologised, or admitted to being in the wrong. Geraldine also reported
difficulties with honesty within a relationship, in terms of saying what she really
believed.

Alterations in Affect Regulation

Geraldine reported suffering from depression from a very early age.
Geraldine reported that her depression “went up and down” over the years. There
was a brief “happy” period while attending a tertiary vocational training college.
However, when she entered her first serious relationship, she suffered from major
depression again. Geraldine then experienced depression again after she married her
current partner. Geraldine was also depressed again at the time she commenced this
program. Although the episodes have not been as frequent more recently, Geraldine
believes that she always feels vulnerable to depression. Geraldine reported that she
has had difficulties with anger management over the years.

Assessment for Inclusion in Program: Criterion 2

There was no clinically significant result on the SIDES. However, although few CP
symptoms were indicated on the SIDES as being clinically significant, Geraldine
explained at interview that many of those symptoms were still present, although not
as severe as in the past. Geraldine satisfies the second criterion for inclusion in this
program, with symptoms of PTSD and also co-morbid CP

The Treatment Program

The Negotiated Treatment Program: Consistency with Guidelines?

Geraldine’s negotiated program departed from the guidelines in that no work
was included in terms of developing a safety plan or working on aspects of daily
functioning. Geraldine had identified no self-harm or suicidal ideation/intent, and
appeared to be functioning reasonably well in her daily life. Further, no work was included on core PTSD Symptoms, as Geraldine did not see these as a priority. However, in all other respects, the guidelines were adhered to, with some work on self-regulation and the predominant focus on CP symptoms: “Alterations in Self Perception”, “Alterations in Affect Regulation”, “Alterations in Relationships with Others”, and “Alterations in Belief Systems”.

**Therapist’s Evaluation of Positive and Negative Aspects of Program**

Firstly, Geraldine was generally very reliable with appointment attendance, although occasionally missed sessions in the early stages of her pregnancy. She completed 22 sessions but was unable to proceed with the last two, as gave birth to her first child in the week after completing her 22nd session. Geraldine was also very conscientious in terms of experimenting with, and applying, strategies worked on in sessions. Geraldine was also happy to attend group therapy. However, when the nature of the group changed, and the group met in the evenings, Geraldine chose not to continue with group therapy, as she became tired with the approaching birth of her baby.

The major “problem” encountered (from the perspective of evaluating the impact of the program) was that Geraldine became pregnant some time after commencing the program, and in the weeks following this, was absent from several sessions due to nausea and tiredness. Geraldine’s mood improved to the extent that she had a more positive outlook on life generally, and felt better about her self. However, it has been difficult to determine whether the program or the pregnancy was the major factor in her improvements.
Post-Treatment Evaluation

Psychometric Assessment: Comparison with Pre-Treatment Assessment

On the PDS (Foa), Geraldine identified 7 of the 17 symptoms commonly associated with PTSD, compared with 14 pre-treatment. This involved two in category A ['Re-experiencing'] compared with three, pre-treatment; one in category B ['Avoidance'] compared with seven pre-treatment; and four in category C ['Arousal'], as for pre-treatment. Intensity of symptoms was rated in the ‘Mild’ range (7/54), compared with ‘Mild-Moderate’ range (32/54), pre-treatment while level of impairment was ‘Mild’, compared with ‘Severe’ pre-treatment. On the SIDES-SR (van der Kolk), no elevated scores were indicated on any of the main scales, as for the pre-treatment. However, mild elevations were still indicated on numerous sub-scales: ‘Self-Destructive’; ‘Amnesia’ and ‘Transient Dissociative Episodes’ (“Alterations in Consciousness”); ‘Ineffectiveness’, ‘Permanent Damage’, ‘Guilt and Responsibility’, ‘Shame’, ‘Nobody can Understand’ (“Alterations in Self Perception”); ‘Inability to Trust’, ‘Victimising Others’ (“Alterations in Relationships with Others”); and some somatisation symptoms. Note: pre-treatment (and not post-treatment), elevated scores were indicated on the following sub-scales: ‘Affect Regulation’; ‘Modulation of Anger’ (“Affect Regulation” scale).

Qualitative Data: Symptoms Identified at Post-Treatment Interview

Alterations in Self Perception

Geraldine stated that her confidence and sense of control over her life, and being able to change things in it, had increased. Geraldine acknowledged that having a baby had also contributed to her increased confidence: “Part of it has been facilitated by having a baby. That makes a big difference as to how you see yourself – it changes your focus a lot.” However, despite this, she saw positive changes in her
self-confidence. Geraldine described herself as “a capable person”. Geraldine also reported having more confidence in asking for help in regard to caring for her baby.

**Alterations in Affect Regulation**

Geraldine felt that she was better able to control her moods and stated that she now looked at things more objectively. In the past, Geraldine reported that she had not had any opportunities to undertake any preventive work to ensure that she is “prepared” for any depressive bouts. However, she reported now doing some things that were going to prevent depression occurring: planning who she would talk to and establishing support networks (parent groups). Geraldine had also put in place a strategy to ensure that she did not become too sleep deprived and had also planned to walk on a daily basis with some neighbours and attend a hospital “shape up” group. All of the above indicated that Geraldine’s awareness had helped her to put in place some strategies that would help avoid further bouts of depression. Geraldine also reported that having greater understanding of depression, as gained through the program, had helped her.

In regard to anger management, although Geraldine and her partner did quite extensive work in this area, Geraldine did not feel that they had made a great deal of use of this at this stage, mainly due to tiredness. However, Geraldine could see some improvements, reporting that she and her husband listened to one another more.

**Alterations in Interpersonal Relationships**

Geraldine reported that she was now much more honest in relationships. She attributed her greater honesty to her increased self-confidence. Geraldine also felt that her increased self-confidence had led to increased levels of affection in her relationship with her husband.
**Alteration in Perception of Perpetrator of Abuse**

Geraldine reported a changed attitude towards her father more recently, in having the confidence to put her needs before what he wanted. She also reported being more objective in the way she saw her father, and less easily upset by him.

**Alterations in Belief Systems**

Geraldine reported that her focus was currently fairly narrow and that she was only really thinking short-term. The demands of being a new mother had contributed to this. Although she attributed some of the belief system changes to the birth of her baby, she still felt that she had learnt a lot from her participation in the program.

**Summary of Impact of Program**

Geraldine appeared to make several notable improvements in terms of some CP symptoms: “Alterations in Self Perception”, “Alterations in Relationships with Others”, and “Alterations in Affect Modulation”. Geraldine reported that it was very difficult to determine how much change was attributable to the program, and how much to her baby:

> It is very hard to know. As so many things have come to it. And one of things I was depressed about was that we wanted to have a baby and that wasn’t happening at the time – so obviously that cause for the depression was taken away. On top of that were all the hormonal changes that happen to you during the pregnancy and post-pregnancy. But I don’t think I would have felt as confident in myself – about myself without the program. I think I’ve learnt a lot.

She concluded, however, that she believed that the past had little effect on her now.

In regard to group therapy, Geraldine reported,
I think it helped to see how other people go through stuff - see how other people deal with it. It was good to see different perspectives on life. The group stuff was good. It was disappointing when not many people came – and I do wish I could have come to the smaller sessions. I did find that – seeing that some people were further behind than I was. I actually found that good. It made me realize there are worse cases and this is how far I’ve come – and I can go a lot further, as it hasn’t been all that hard.

Improvements were also identified for core PTSD symptoms – both number and intensity, although no direct work was undertaken with these symptoms.

**MATT**

**Summary of Traumatic Experiences Identified**

*Accidental Killing of a Seven-Year Old Boy in Motor Accident*

Matt is a 32-year old man, who lives with his fiancée, and works as a fitness program co-ordinator. At the age of 17, Matt accidentally killed a 7-year old boy as he was driving on a local street. He reported:

I was at a party and was just driving to pick up a friend and went down the road and a little boy just ran out between two cars in front of me – and everything went into slow motion. I didn’t know what to do, or anything. I felt totally helpless – I didn’t know what to do.

Matt did not receive counselling at the time and described his response: “I didn’t go to school for a month I don’t think. I just basically sat at home – just wanted – just not with it – every day, just staring into space.” His life came to a stand still for a while after this:
A lot of thing stopped at that time. I was refereeing basketball. I was cleaning for a contractor in the mornings. And I was just about to be doing a scholarship for representative basketball. I couldn’t do anything. I stopped everything.

Matt reported that he avoided thinking about it (“I blanked it out”) every since that time, until recently, when he has become overwhelmed with memories. More recently, in the months prior to attending for therapy, Matt started having vivid flashbacks and nightmares about the accident.

**CCMS Results**

Matt did not report any childhood abuse experience was reported on this scale.

**Subsequent Life Experiences of Extreme Stress**

*Back injury.* As a result of a work-related incident accident at the age of 23 years, Matt was not able to work for two years, was in a lot of pain, and suffered stress from money shortage, and pressure from his wife to return to work.

*Destructive and unsupportive relationship.* Matt reported that his marriage was “traumatic” for him, as, during his period off work with a back-related injury, his ex-wife was unsympathetic and unsupportive, and blamed him for her not being able to stay at home with their child. She also asked him to choose between her and his parents, as she felt that she competed with them for Matt’s attention. Matt chose his wife and did not speak to his parents for two years. This was very stressful for him, as he had always been close to his family. He stated, “I felt totally isolated – no-one to talk to.”
Feelings of loss associated with limited access to child after separation.

Matt reported that his wife would not allow him to have access to their child after the break up, and he was forced to take this through court. Matt explained that, even though he sees his son every second week-end, he still experiences difficulties with not being a regular part of his life. He stated, “You just feel that part of you is missing.”

Death of grandfather. Matt reported that, while overseas in 2002, his “pop” (“the person dearest to me”) passed away, having a heart attack. His death was completely unexpected, and Matt has felt an enormous sense of loss. He believes that the emotions felt as a result of his grandfather’s death have triggered a range of other emotions from the past. Being overseas, and unable to be with his grandfather and family, again raised feelings of powerlessness and helplessness.

Assessment for Inclusion in Program: Criterion 1

Although Matt did not suffer from any forms of long-term childhood abuse, as did many of the others in this program, he experienced an extremely traumatic incident at the age of 17 years, suffered from PTSD, was never treated for this, and then suffered a series of extremely stressful life experiences that exacerbated and intensified the feelings of helplessness and powerless he had felt after the first traumatic event. There has clearly been an accumulative impact of an untreated single traumatic incident – followed by several events event of extreme stress in adult years, and this has had a similar impact to multiple traumatic experiences. I thus assessed Matt as satisfying the first criterion for inclusion in this program.
Trauma Symptoms

Symptoms Identified by Psychometric Screening

On the PDS (Foa), Matt identified all of the 17 symptoms commonly associated with PTSD: five in category A [‘Re-experiencing’], seven in category B [‘Avoidance’], and five in category C [‘Arousal’]. Intensity of symptoms was rated in the ‘Moderate’ range (29/54), while level of impairment was ‘Severe’.

On the SIDES-SR (van der Kolk), there was no elevation on any main scale. However, elevations were indicated on numerous sub-scales: ‘Affect Regulation’; ‘Amnesia for Events’ (within “Alterations in Consciousness” scale); ‘Permanent Damage’ (within “Alterations in Self Perception” scale); ‘Inability to Trust’ (within “Alterations in Interpersonal Relations” scale); and digestive problems and conversion symptoms (“Somatic Concerns” scale). Borderline symptoms were indicated on the following scales: ‘Self Destruction’, ‘Modulation of Anger’; and ‘Difficulty Modulating Sexual Involvement’ (“Alterations in Affect Modulation” scale); ‘Transient Dissociative Episodes’ (within “Alterations in Consciousness” scale); ‘Guilt and Responsibility’, ‘Nobody can Understand’ (within “Alterations in Relationships” scale) ‘Re-victimisation’ (within “Alterations in Relationships” scale); and ‘Despair and Hopelessness’ (within “Alterations in Systems of Beliefs” scale).

Symptoms Reported At Interview

Core PTSD Symptoms (Re-experiencing and Dissociation)

Although Matt repressed memories of the accident involving the young child for many years, more recently, in the months prior to attending for therapy, he started having vivid flashbacks and nightmares about the accident. Matt reported detachment and feelings of dissociation over many years.
Alterations in Affect Modulation

In the months following the car accident in which the little boy was killed, Matt suffered depression, withdrawing from people, school and other activities. He reported just sitting for hours, staring into space. He lost all energy and motivation to do anything. Then several years later, having received no assistance for the PTSD he suffered as a result of the accident, he experienced a work-related accident, which lead to back injury, and Matt being unable to work for two years. Matt being unable to do much at all, due to the pain, and the restrictions of his back injury. Matt experienced depression again following the death of his grandfather, and prior to entry into this program. Matt also reported a great deal of guilt and self-blame over the accident in which the little boy was killed. His feelings of guilt returned following his work-related injury, when he was off work, as his inability to work led to feelings of guilt and helplessness. His wife blamed him for their financial predicament, and this lead to further feelings of guilt and helplessness. Matt’s guilt feelings over the accident returned more recently. Matt stated that he had also become very self-focused and introspective and that he has not really been able to enjoy life much since the accident in which the child was killed. Matt reported that since then, he has experienced reduced desire to form friendships. Matt also reported anxiety in some situations, such as in crowds, and recently he has experienced many panic attacks. More recently, Matt reported that he has cried a lot when memories (in the form of flashbacks, nightmares, intrusive thoughts) of the accident have returned.
Alterations in Interpersonal Relationships

Matt reported a great deal of anger towards individuals from past relationships (in particular, his ex-wife). He believed that this anger was affecting him being able to commit fully to his current relationship.

Somatic and Health Concerns

Matt reported a range of somatic concerns, these having intensified more recently, with the revived memories of past traumatic incidents. He reported nausea and also gastric complaints starting after the first panic attack, then disappearing, but coming back again when he came back from overseas when his grandfather died. Matt also reported many headaches over the past two years and referred to pain in other parts of his body: his shoulders and neck holding a great deal of tension.

Alterations in Belief Systems

Matt reported that the greatest change related to the traumatic incidents has been a sense of helplessness.

Assessment for Inclusion in Program: Criterion 2

Matt satisfied the criteria for PTSD, and there were indicators of some CP symptoms (‘Alterations in Affect Modulation’, and ‘Alterations in Belief Systems’, although not at a clinically significant level). However, details provided at the interview indicated that some CP symptoms (‘Alterations in Affect Modulation’, ‘Alterations in Belief Systems’, ‘Alterations in Self Perception’, and ‘Alterations in Interpersonal Relationships’) were perhaps more prominent than indicated on the SIDES-SR. As the treatment progressed, these symptoms appeared to be quite prominent.
The Treatment Program

The Negotiated Treatment Program: Consistency with Guidelines?

Matt’s planned program departed slightly from the guidelines in that no work was included on developing a safety plan or assisting with aspects or daily functioning. Matt had indicated no self-harm or suicidal ideation/intent. Further, he was living an active and functional life. However, in all other respects, Matt’s planned program adhered to the guidelines, focusing on relevant core PTSD symptoms and also CP symptoms: “Alterations in Affect Regulation”, “Alterations in Interpersonal Relationship’s”, “Somatic Concerns”, “Alterations in Consciousness”. As the program progressed, work on “Alterations in Self Perception” was included, as Matt identified that a poor sense of self was problematic.

How The Actual Program Departed from /Adhered to Negotiated Program and Treatment Guidelines

The actual program did not depart from the negotiated planned program in any significant way.

Therapists Evaluation of Positive and Negative Aspects of Program

There were several positive aspects regarding Matt’s program. Firstly, Matt attended every session and was diligent in his approach to this treatment program. He worked very conscientiously, trialling different strategies until he found one that worked for him. In addition, Matt attended all group therapy sessions. However, Matt had difficulties attending/listening in sessions, and this made therapeutic intervention somewhat difficult; however, this was not a major problem.
Post-Treatment Evaluation

Psychometric Assessment: Comparison with Pre-Treatment Assessment

On the PDS (Foa), Matt identified 12 of the 17 core PTSD symptoms (compared with all of the symptoms pre-treatment). Of these, there were four in category A [‘Re-experiencing’] compared with five pre-treatment; four in category B [‘Avoidance’] compared with seven pre-treatment; and four in category C [‘Arousal’] compared with five pre-treatment. Intensity of symptoms was rated in the ‘Mild’ range (12/54) compared with ‘Moderate’ pre-treatment (29/54), while no impairment was seen post-treatment (compared with ‘Severe’, pre-treatment).

On the SIDES-SR (van der Kolk), there was no elevation on any main scale or sub-scale. However, pre-treatment, elevations were indicated on numerous sub-scales: ‘Affect Regulation’; ‘Amnesia for Events’ (within “Alterations in Consciousness” scale); ‘Permanent Damage’ (within “Alterations in Self Perception” scale); ‘Inability to Trust’ (within “Alterations in Relations with Others” scale); and digestive problems and conversion symptoms (“Somatic Concerns” scale).

Qualitative Data: Systems Identified in Post-treatment Interview

Alterations in Affect Modulation

Matt reported that he believed the “release work” had been most effective in helping him modulate his emotion. Matt also used writing to help modulated his emotions and explained that, when “things” came up, he needed to do something with them: “If I don’t do something with it, then I don’t sleep that night - it just keeps going round and round and round… when each thing comes up, I’ve gotta do something with it.” Matt also reported that he had not felt depression for quite a while. He stated that, when memories returned, or when he started to think or feel negatively, he used strategies to help himself maintain a positive mood. Matt
reported that he has been able to deal more effectively with memories of the past, revived by his children, by focusing on the present. Matt reported being able to deal with his negativity more effectively and reported increased optimism.

**Alterations in Self Perception**

Matt indicated that he saw himself in a more positive light than prior to treatment. Much of this was related to developing strategies that allowed him to feel greater control of his symptoms, less helplessness, and reduced guilt and self-blame. Matt described that he had had “a whole life change”.

**Alterations in Interpersonal Relationships**

Matt reported that he is currently in a positive relationship and is engaged to be married. His relationships with his children are also being maintained. He has released much of the anger associated with past negative relationships.

**Management of Somatic Complaints**

Improvements were indicated by Matt in terms of somatic complaints, as, with assistance, Matt has learned to reframe these bodily symptoms - and not to fight them. Matt has also gained weight after many years of “stunted growth”. He believes that this weight increase is related to his release of the past.

**Summary of Impact of the Program**

Matt reported some reduction in the number of some core PTSD symptoms identified, and also intensity. Matt also appeared to make marked improvements in all CP symptoms treated: ‘Alterations in Affect Modulation’, ‘Somatic Concerns’, ‘Alterations in Interpersonal Relationships’, and in ‘Belief Systems’. Matt reported, “Basically I see myself as being a lot better than when I first come to Pam [therapist]. Basically back then, all this stuff was coming up and I didn’t know what
it was and how to deal with it”. Matt stated that there had been “heaps of changes” and that, “it’s been a whole life change.” He stated,

Pam has worked with me really well, and I really appreciate what she has done with me because I have been to other psychologists, and no-one has ever shown me how to deal with things, and I think this has been a very positive experience.

RENEE

Summary of Trauma Experiences Identified

Childhood Physical Abuse

Renee is a 29-year old single woman, who is currently unemployed and enrolled in a Music Diploma course. From the age of five, Renee experience physical abuse form her father. During all incidents of abuse, her mother was present and did nothing to prevent the physical abuse. Renee reported the first incident she can recall:

The first negative event that was significant that I can remember was when I was five years old, when my dad belted me really hard. It was very confusing, as I didn’t know why he did it and it was set up by my sisters. I was really so proud that I had learned all the words of a song. I sang it to my sisters, and they suggested that I sang it to me father. When Dad came out, my sisters prompted me again, and I thought he’d be really proud. My Dad was really strict and if we did anything that he decided was wrong, then we’d get a belting for it. He’d never ever explain why. When I sang it, he totally ignored me, and so I started singing it again. I don’t know how far I got into it, but everything went black, and he’d punched me in the face so hard I’d fallen to
the floor and slid down the hall. I kind of woke up. I can remember seeing stars and not knowing where I was. My face was really throbbing. I didn’t know what I’d one, but I thought it must have been really bad for him to do that. I didn’t think it was the song. It must have been me. My sisters then ran off. I was gonna run past Dad to Mum in the kitchen, but I was too scared. I was just screaming, but my Mum didn’t come, so I just turned and ran to my room. I was crying for about a full hour – screaming out my window, which was opposite the kitchen (the house was u shape) – and Mum just didn’t come. She didn’t come at all, and it was so obvious that I was so hurt. I don’t understand whys eh didn’t even come to see if I was OK or what happened. She never came and she never saw if I was OK. All I can remember was being in my room for about an hour. I kept asking, ‘Why? Why? Why?’ Renee can also remember beltings for other “misdemeanours”. She recalled:

I remember he used to give my sisters the strap, and then it’d be my turn, I was old enough to start getting it. I remember having to go to his room, which was really scary, and a couple of times, Marni or Debra [her sisters] had gone in ahead of me to get the strap and I’d just be waiting outside for my turn. I’d just hear them getting strapped and crying their eyes out. I remember my elder sister saying, ‘Make sure you choose the black belt – it hurts less. So I was pretty grateful she said this.

These beltings occurred over a four-year period (from five years to around nine years of age) while the family was living in New Guinea. Renee reported that the beltings occurred regularly:

I don’t think it was necessarily once a week, but fairly regularly. I just remember getting scared, or getting scared when my sisters where in there
and hearing them crying. And Mum would be lying in the bed reading a book like nothing was happening… He’d hit you across the back of the legs (above the knees/below the bum). It was more being scared about how hard he’d do it, and everything… if you talked back, or were trying to defend yourself – or looking away – or rolling your eyes – you’d get another one.

The family later moved back to Australia, and Renee can remember the physical abuse continuing (she was 9-10 years old). She saw it as “sort of normal.” However, she also reported that her mother and older sister became the brunt of her father’s abuse. The abuse of Renee increased when the family moved interstate (when Renee was 11). She stated, “From 12 –16 years, Dad started picking on me more than anyone else. As soon aw I turned 13, I was the focus of punishment and blame. He came down really hard – and was extra strict.”

**Witnessing Violence toward her Siblings**

Renee witnessed physical and verbal violence toward her sisters and brother. When she was 9 or 10, she reported that most of her father’s violence was directed at her older sister, Debra. When she was 17 or 18, Renee witnessed the attempted strangling of her brother by her father:

> When I was 17 or 18, I saw my Dad trying to strangle my brother to death – and nobody was there but me… Dad was punching him really hard – really laying into him hard. I thought he was going to break his bones (he would have been 15). He was punching him in the arm and chest. I blame myself. I can’t remember what happened. Dad held him down on the bottom bunk bed and was strangling him around the neck. And Graeme was going red and blue, and he couldn’t breathe. He was kind of screaming. But Dad was choking him, and I was freaking out.
On this occasion, Renee attempted to intervene, and was tempted to report to the police, but was too afraid.

**Witnessing Father’s Violence Toward Mother**

Renee also witnessed her father being physically abusive toward her mother:

“I remember being in the car and he started yelling at my mother and hitting me with his left hand – and calling me a bitch – and she was trying to get over to the left side of the car so he didn’t hit her and she was covering her head and crying.” On this occasion, all children defended their mother against their father.

**Emotional Unavailability of Mother**

When Renee was about 9-10 years old, her mother became severely depressed and was not emotionally available for her children. Renee stated, “She wasn’t very nice to me – not there for me. I hated her in a way, but I couldn’t do anything as she was already in a bad way.”

**Verbal Abuse/’Put Downs’ by Father**

Renee reported that, during her teenage years, her father used verbal abuse to control her. She stated:

If you ever had anything good going for you, he’d rip it to shreds. If you had anything good going in your life – school or anywhere – he’d pay special attention to putting you down so that you could feel good about anything. He wanted to keep you under his finger tips. At that time, he let off on Mum for a while.

Renee also described his derogatory comments in regard to her appearance. She stated:

He was putting us down all the time. And he was fat and ugly - and balding and had the most ugly personality, but if any of us put on an inch of fat, he’d
look at us with disgust: ‘Look at you. You’re getting fat. What guy is going to
look at you?’ He made us all keep our hair long to attract men. Cause he
thought we’d never get a man – and short hair was so ugly – and we had to be
these little ‘barbie’ dolls for him. And we had to do all the washing and
cleaning and cooking. But if you washed up, he’d come out and inspect it.

**Attempted Running Over By Father.**

Renee reported the following incident when she was 19, the incident following
an argument in the car, when Renee had defended herself to her father:

I got out of the car and slammed the car door as hard as I could as I knew that
was the one way I could get back at Dad. He then reversed the car and tried to
hit me. Then he reversed and I walked slowly over the lawn I wanted him to
hit me. And he came zooming up really fast and he came that close and just
missed me. Then he got out and said, ‘You fuckin’ bitch. You slammed my
door.’ I had to move out after that.

**CCMS Results**

On this inventory, Renee confirmed the abuse reported above, identifying the
following forms of abuse in her childhood: psychological abuse, physical abuse,
sexual abuse, witnessing abuse, and neglect. She reported being yelled at by her
father (very frequently) and by her mother (sometimes); being ridiculed, put down
and embarrassed by her father (very frequently); being provoked, made to feel fear,
treated cruelly by her father and mother (frequently); being provoked, treated cruelly
by her mother (occasionally); and witnessing the above behaviour to others in the
family (frequently). She also reported being physically punished for wrongdoing by
her father (frequently); being physically punished by her mother (sometimes); being
hit, punched, kicked by her father (frequently), and by her mother (occasionally);
witnessing the above forms of physical abuse to others in the family (frequently). Renee also reported being requested to do something sexual (once) by another adult/adolescent; having her breasts touched by another adult/adolescent). Renee also reported being shut in room alone for extended periods by both parents (occasionally); having requests for attention ignored (frequently); and not being spoken to for extended periods – by both mother and father.

*Later Life Experiences of Extreme Stress*

*Abusive landlord.* Firstly, after leaving home, Renee lived for nine months with the uncle of a friend, and he also turned out to be very controlling and abusive. This was extremely stressful for a 19-year old.

*Loss of relationships.* After moving away from her hometown, Renee formed a relationship with Barry, who, after a fairly short relationship, “dumped” her the day before her birthday. Renee reported being very much “in love” with Barry and being devastated by the end of this relationship. Renee then formed another relationship with a male who pursued her. However, he was often flirting with other girls, and on one occasion, he “stood” Renee up, and her response lead to their break up. She blamed herself for the end of her relationships and told herself, “I’m fucked. I’m just fucked.” I get all these amazing relationships with people and I can’t hold them down. I’m insecure. I’m unlovable.” After a major breakdown, and then some healing, Renee formed another relationship with Andrew. However, Renee was not interested in having a child with him at this stage, and this lead to some disagreements, and eventually this relationship also fell apart.

*Rape by boyfriend.* Renee was also raped one night by her boyfriend, Andrew. She described the incident, stating:
He basically had sex with me in a really forceful and painful way, and I felt
so angry and so upset, and I couldn’t cry or do anything. I just rolled over in
the corner and was trying to fall asleep. I didn’t want to think about it. I didn’t
want to deal with it. I just didn’t know what it was.

*Extreme depression and suicide attempt.* Renee then went through a very severe
period of depression, during which she tried to commit suicide by taking an
overdose.

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**Assessment for Inclusion in Program: Criterion 1**

Renee satisfied the first criterion for inclusion in this program, having experienced
long-term physical, emotional and verbal abuse at the hands of her parents, during
her childhood. In her adult life, there have been ongoing stressful events that have
compounded the effects of early abuse experiences.

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**Trauma Symptoms**

*Symptoms Identified by Psychometric Screening*

On the PDS (Foa), Renee identified 15 of the 17 Core PTSD symptoms: four
in category A [‘Re-experiencing’], six in category B [‘Avoidance’], and five in
category C [‘Arousal’]. Intensity of symptoms was rated in the ‘Moderate’ range
(27/54), while level of impairment was ‘Moderate’. On the SIDES, the clinically
significant scores were obtained on the following main scales: “Alterations in
Attention and Consciousness” (including ‘Transient Dissociative Episodes’;
‘Amnesia’); and “Alterations in Relations with Others” (in particular
‘Revictimisation’).
The presence of the following symptoms was also recorded (at a low level): ‘Affect Regulation’; ‘Modulation of Anger’; and ‘Difficulty Modulating Sexual Involvement’; ‘Permanent Damage and Ineffectiveness’; ‘Guilt and Responsibility’; ‘Inability to Trust’; somatisation symptoms; ‘Despair and Hopelessness’; ‘Loss of Previously Sustaining Beliefs’ ‘Nobody Can Understand’.

**Symptoms Identified In Pre-Treatment Interview**

**Alterations in Self Perception**

Renee has reported always feeling that there is something innately wrong with her – that perhaps she is evil. In her twenties, she blamed herself for the demise of close relationships, and this led to feelings of insecurity and worthlessness. She also reported despising herself, experiencing a sense of failure. Renee has also indicated some insecurities in regard to her weight, reporting that she gained weight during her final years at school: “I just ballooned. I went to 100 kg. In three years, I went from being normal/thin to being huge, and I had stretch marks everywhere – and guys looked at me with disgust”. Renee’s weight has fluctuated over the past years, and she has now increased her weight again, believing that allowing her self to gain weight is, in part, a response to the emphasis placed on low weight by her father. Renee has often stated that she is happier being overweight, as then she knows that people who like her are not superficial. However, Renee has also regularly requested assistance with weight loss. Renee also expressed confusion about her sexuality over many years as a result of the negative experiences she had had with men, in particular her father. Renee has been involved in relationships with both men and women, in an attempt to determine her sexual preference. She reported persisting confusion.
**Alterations in Affect Regulation**

Renee has suffered from depression during many periods in her life. When 16-17, she suffered her first major depressive episode. She described experiencing “sadness, grief, pain, and anger.” Renee reported experiencing helplessness from an early age – and this persists to today. Her feelings of helplessness intensified at 16 – 17; they arose from feelings that no-one could help her escape from what she perceived was a miserable life. Renee also reported self-harm in her later teenage years: “I used to get glass and cut my skin. I started cutting my arms and hands at the top – and then the wrist. I didn’t know why I was doing it. I just felt an urge to do it.” As a result of her depression during her formative years, Renee’s academic performance declined, although she reported being was very intelligent. She stated that in her final two years of secondary schooling, “I was really struggling just to be a ‘C’ grade student – all through to the end of College.” Renee then suffered another depression episode when she was in her early twenties, and after the break-up for two relationships. Renee reported that her depression became so bad that she did not want to live, and she attempted suicide. Renee reported that she “kept sinking more and more”, reporting a great deal of grief, and wondering how she was going to improve her life. After another relationship breakdown (with Andrew), Renee became very depressed again. After this period of depression, Renee experienced severe panic attacks. Then later, after some hypnotherapy, to help treat her depression, Renee suffered even more panic attacks. She reported one very frightening one while on a train [between two capital cities] and another one on a bus several days later:

I started having a major, major – biggest panic attack that I had ever had in my whole entire life… so it felt like something was really wrong in my body
– something was very, very wrong – and I felt like my heart was pounding and skipping a beat. I thought I might be having a heart attack. I tried to ignore it. But I couldn’t ignore it.

Renee was taken to hospital, but informed there was nothing wrong with her, physically. However, she continued to have panic attacks, and after several more hospital visits, and calls to her hypnotherapist, Renee returned to live in her hometown.

*Alterations in Interpersonal Relationships.*

Renee has reported difficulties in her interpersonal relationships, and has felt betrayed by those with whom she has developed strong connections (mother, father, sisters, partners). Renee’s history also indicates a patterns of re-victimisation and poor boundary setting and Renee has referred to her own lack of assertion at times, as well as her “neediness” and tendency to “cling” in some close relationships. Renee’s experiences in her relationships have lead to a belief that people are fundamentally evil and intent on hurting others. Renee explained that, in late adolescence, she developed negative views of men, and has not been interested in trying to attract their attention, at times, making deliberate attempts to “look plain and dowdy” by “wearing men’s clothes” and “covering up”.

*Alterations in Perception of Perpetrator of Abuse.*

Renee reported that she had broken all contact with her father, and spoke in hostile and negative terms in regard to him.

*Alterations in Belief Systems*

In an attempt to give meaning to her life, Renee developed a faith in the ‘spirit world’ and a belief that spirits can guide us in our lives.
The Treatment Program

The Negotiated Treatment Program: Consistency with Guidelines?

Renee’s planned program adhered to the guidelines in every way, starting with the development of a safety plan, undertaking work on aspects of daily functioning, addressing core PTSD symptoms, and then focusing on CP symptoms identified: “Alterations in Self Perception”, “Alterations in Affect Modulation”, “Alterations in Interpersonal Relationships”, “Alterations in Perception of Perpetrator”, and “Alterations in Belief Systems”.

How Renee’s Program Departed from/Adhered to the Negotiated Program

There was some adherence to the negotiated program in that Renee developed a safety plan, and devoted many sessions to discussing aspects of daily functioning. Further, at various stages in the program, Renee dealt with some of the core PTSD symptoms and CP symptoms. However, although issues/symptoms appeared to be ‘dealt with’, this was in a very haphazard manner, and intervention was not coherent. At times, it seemed as if Renee was benefiting from talking and clarifying issues for herself. Despite this, some interventions were attempted and some, such as hypnosis and EMDR, were reported to be reasonably successful.

Another departure from the plan was that, although Renee experienced 24 sessions, many of these were taken up with recording her “story”.

Therapist’s Evaluation of Positive and Negative Aspects of Program

One major difficulty for Renee was that, as she had no transport, she was dependent on bus travel, and as she shifted regularly (and to places distant from the therapy location), getting to the appointments was often a major difficulty for this client. Late appointments often meant that she had no transport home. Despite these difficulties, Renee’s attendance was very good.
Although Renee was very reliable in attendance, conscientious, highly motivated, and usually did homework, there were other difficulties. One major difficulty was that Renee had a tendency to talk continuously through the sessions and had difficulties listening for longer than a minute or two. This made therapeutic interventions were difficult. Further, Renee appeared to be unable to maintain focus on one topic, and she would lead from one topic to another to another – with little coherence. She often referred to her talking as “rambling”, but stated that she felt powerless to maintain focus. Another difficulty was that Renee used approximately six-seven sessions to undertake the recording of her “story” of abuse, due to providing abundant detail of each stage of her life. She was aware that, as the program was time limited, this use of time meant that there was less time to work on aspects of the actual treatment program. However, she indicated that there was “so much to tell” and that all details were important in providing an accurate picture. Another difficulty was that sessions were usually crisis driven – and so it was difficult to undertake a coherent plan of treatment. Much of the work was, therefore, associated with discussing aspects of “daily functioning”.

Conducting the program with Renee was therefore challenging. However, it was important to be flexible in approach, and make allowances for her “rambling, and inability to maintain focus.

Post-treatment Evaluation

Psychometric Assessment: Comparison with Pre-Treatment Assessment

On the PDS (Foa), Renee identified 16 of the 17 symptoms commonly associated with PTSD, compared with 15 pre-treatment: four in category A [‘Re-experiencing’] as for pre-treatment; seven in category B [‘Avoidance’] compared
with six pre-treatment; and five in category C ['Arousal'], same as pre-treatment. Intensity of symptoms was rated in the ‘Moderate’ range 34/54 (compared with 27/54 pre-treatment), while level of impairment remained ‘Moderate’. On the SIDES-SR (van der Kolk), the clinically significant scores were still obtained on the following main scales, previously indicated: “Alterations in Attention and Consciousness” (including ‘Transient Dissociative Episodes’; ‘Amnesia’); “Alterations in Relations with Others” (in particular ‘Re-victimisation’); and “Alterations in Self Perception” (‘Nobody Can Understand’; ‘Ineffectiveness’ (new), ‘Permanent Damage’ – new).

In addition, Renee experienced elevated scores on the following sub-scales: ‘Despair and Hopelessness’, and ‘Loss of Previous Sustaining Beliefs’ (“Alterations in Belief Systems”). The presence of somatisation symptoms was still recorded (at a low level).

**Qualitative Data: Symptoms Identified in Final Interview**

Renee had made improvements in the course of the program, although there were often periods of improvements, followed by periods of stagnation, or of depression/indecisiveness, and anxiety. Renee identified a number of improvements.

**Core PTSD Symptoms**

Renee indicated a reduction in ‘re-experiencing’ of past events and reported that, although the process has been painful, she has been able to release much of the past. Renee reported that EMDR had been useful in assisting with this: “And the EMDR did work - it was brilliant.” Renee reported less dissociation and more present-focused awareness than previously.
Alterations in Self Perception

Renee explained that she felt “re-born”, more confident and assertive. Renee commented that the work on self-concept was one of the most valuable aspects of the program: “The work on my self concept helped me at the time – and learning how to do affirmations was great”.

Alterations in Affect Regulation

Renee reported more control over her emotions, in particular over her anger, stating that she had let go of she anger held toward her father. Renee reported that, on the whole, her mood had improved. Renee stated that hypnosis had been useful in helping her embrace a more positive state of mind: “Hypnosis has also been useful – imagining myself in the future has made me feel happy. The visual imagery helped at the time.” However, Renee also indicated a measure of instability, related to stressors currently in her life, and a need to resume medication. Renee also reported that some of the emotional numbness had started to disappear and indicated a renewed interest in life, as demonstrated by her renewed ability to engage in courses and activities, and to plan her short-term future. However, long-term planning still appeared difficult for Renee due to low motivation and to concerns about the impact of the loss of years due to her mental state. Renee reported, however, that she would like to have two children at some stage in the future.

Alterations in Interpersonal Relationships

Renee was still experiencing some difficulties in her relationships with friends and family, including her older sister. However, she also stated that her relationship with her mother had been improving more recently, “through being with her through this experience – through conversations we’ve had – arguments we’ve had – through her learning and my learning - we’ve become closer than we ever
were.” Although some caution was still evident in relationships, some level of trust had returned. Renee was still experiencing some confusion over her sexuality, in the last twelve months, having become involved with a young male for a few months – and then a female. The two experiences had left her still unsure about her sexuality. Renee indicated that she was enjoying living on her own currently, and a desire to focus on her self and her own needs.

**Alterations in Perception of Perpetrator**

Renee reported that she no longer felt any anger toward her father. She explained that he no longer held a place in her mind and that she felt “nothing”. She reported that she had even forgotten his birthday recently.

**Summary of Impact of the Program**

Renee’s progress was marked by periods of improvement, followed by periods of stagnation, or of depression/indecisiveness, anxiety. Although Renee expressed improvements in most CP symptoms, and some core PTSD symptoms, it is uncertain that Renee’s improvements were related to the treatment program, given that there were few opportunities for interventions.

**BERYL**

**Summary of Childhood Abuse Experiences Identified**

*Neglect/Abandonment/uncertainty at an Early Age*

Beryl is a 70-year old mother of three, and grandmother of three. She lives alone. Beryl was unable to remember the years before she was five years. However, she remembers that her father moved away with another woman when she was about five and paid no attention to her ever again. She stated, “At his funeral his ‘new family’ didn’t even know of my existence.” Between the ages of five and seven, this
Beryl was separated from her siblings and all were placed in foster care—residing in many places over a two-year period. Thus, Beryl’s early life was typified by uncertainty and lack of stability in terms of the people in her life.

**Rejection by Mother Throughout her Life**

Beryl reported that her mother rejected her and openly indicated dislike throughout her life, telling her, “You are just like your father”. She reported that there was always a feeling of not being loved.

**Physical Abuse by Mother**

Beryl reported that her mother punished her physically: “Just the odd electric cord from my mother. It was very rare. But it was there to remember forever. I don’t believe I deserved it.”

**CCMS Results**

On this inventory, Beryl reported the following during her childhood: psychological abuse (being yelled at frequently; being ridiculed/embarrassed sometimes; being provoked/ being treated cruelly occasionally); witnessing the above behaviours toward others occasionally; physical abuse (physical punishment from mother sometimes; occasional violence from others; and witnessing physical abuse to others in family sometimes).

**Later Traumatic Experiences During Adult Life**

Beryl was the victim of domestic violence in several marriages/relationships. Beryl’s first husband abused her verbally and physically if she questioned where he had been (and after he had stayed out all night). This first husband, however, died of a heart attack. Beryl suffered domestic violence at the hands of her second husband (the father of her son), who “usen’t to mind giving me a good smack”. This occurred once or twice a week over a fourteen-year period. Bruises often resulted from the
hitting. There was also “pushing and shoving”. Although Beryl left her husband three times, he came to ask her to return each time, and, when she became pregnant with her son, she did not feel able to move away from him for many years. There was also some violence in the third major relationship for Beryl. However, this partner was killed in a car accident after two years, so Beryl experienced a different kind of trauma. Finally, Beryl was involved in a nine-year relationship in which she was the victim of vicious domestic violence (physical, emotional and verbal abuse). She stated, “One month after we were married he belted me up. There was no sign of anything prior to that. I had heard him raise his voice to other people but not to me. There were many outbursts after this.” Beryl told of the next major beating, the one that finally lead to her seeking help:

He had said we could both get rid of everything to do with the past. I did and he didn’t, and when I commented on it, he beat me up. He got stuck into me – then he’d leave. Then he’d come back and start again. There were people boarding downstairs. The girl downstairs called the police. They set a date to go to Goulburn court. Meanwhile, he’d apologized and “brainwashed me”- said that he’d go to gaol unless I covered for him, and so I dropped the charges. And I went back to him.

Beryl described other “smaller incidents: “He would sometimes slap me around. I used to call them tantrums/paddies. He’d break something in the sink – but he didn’t do it when my son was around.” The final beating occurred after a series of alleged phone calls and visits from a man, which allowed Reg (the perpetrator) to accuse Beryl of having an affair. Beryl described this event:

He pushed me in the front door and I had a frozen shoulder for 18 months.

To get away from him, originally I called my son and said, ‘I think he’s going
to go off.’ My son came over with his wife and suggested getting a pizza. He insisted on coming with us – he wouldn’t let me get away. So I told my son to go – I was afraid for him too. The taxi driver then came for the changeover. I told him. Reg. came out and said that he didn’t hurt me, so the taxi driver went off. After that, he beat me up again ‘even worse’. I used to pray someone would hear me.

Although Beryl left her husband after this beating, he pursued her and once again, she returned:

I can’t believe I had him back in my life after that. But I did. This is when I should have stopped. I felt terrible because he didn’t have anywhere to live, but that wasn’t my problem. He came back a few months after – had got himself a unit. He’d come back with all these dreams: ‘We’ll do this. We’ll do that.’ But he still kept throwing stuff up. He came back and promised all would be OK. He never laid a hand on me for many years after that, but the verbal abuse was there. He would yell at me and push me where people would hear. Imagine what that’s like. It’s dreadful.

Prior to the last violent relationship, Beryl found an escaped murderer in her house, and he was holding a loaded gun at the time. Fortunately, Beryl was accompanied by a friend, who managed to obtain the gun from the man, and Beryl was able to fire it outside. This was a very frightening episode for her.
Assessment for Inclusion in the Program: Criterion 1

Beryl satisfied the first criterion for inclusion in this study. Although her abuse as a child may not seem as overt as others, there was severe emotional deprivation throughout her childhood – and this laid the basis for her acceptance of very abusive relationships throughout most of her adult life. Beryl experienced over 50 years of physical, emotional and verbal abuse in her adult life.

Trauma Symptoms

Symptoms Identified by Initial Psychometric Screening

Beryl indicated mild symptoms of PTSD and also mild symptoms of CP. Beryl had a tendency to minimise her symptoms – and the impact of her traumatic experiences on her self-perception and interpersonal relationships. On the PDS (Foa), Beryl identified 12 of the 17 symptoms commonly associated with PTSD: three in category A [‘Re-experiencing’], five in category B [‘Avoidance’], and four in category C [‘Arousal’]. Intensity of symptoms was rated in the ‘Mild-Moderate’ range (17/54), while level of impairment was ‘Moderate’.

On the SIDES-SR (van der Kolk), elevated scores were indicated on only one main scale: “Alterations in Consciousness” (low). Borderline scores were also indicated on the following sub-scales: ‘Self Destructive’; ‘Excessive Risk Taking’; ‘Amnesia’; ‘Ineffectiveness as a Person’; ‘Permanent Damage’; ‘Guilt/responsibility’; ‘Shame’; ‘Nobody can Understand’; ‘Minimising’; ‘Inability to Trust’; ‘Victimisation of Others’; ‘Despair and Hopelessness’; ‘Loss of Previously Sustaining Beliefs’; ‘Revictimisation’ (high).
Symptoms Identified In Pre-Treatment Interview

As Beryl had difficulties maintaining focus in her responses, which were often unrelated to the question asked, it was difficult to gain relevant information on the impact of the past abusive experiences. However, some symptoms were identified.

Alterations in Self Perception

Although Beryl was able to point to many positive attributes, and on the whole, seemed to have a reasonably healthy self concept, her seeming inability to avoid abusive situations within relationships suggested that she was unable to place her own needs as a priority. Early childhood and youth experiences had lead to some vulnerability in Beryl. It is possible that Beryl’s choices in life (involving acceptance of poor behaviour) were related to some unmet emotional needs. Beryl reported that she believed that she was “emotionally needy”: that she has craved someone to love her, and so has accepted bad treatment from people over the years just to get a hug – something she missed in her childhood.

Somatic/Health Concerns

Beryl developed breast cancer toward the last years of her last violent relationship. She believes that the extreme stress of the relationship contributed greatly to her health condition.

Alterations in Affect Modulation

Beryl reported experiencing extreme anxiety while in the relationship she has recently left, but stated that she is not as anxious or vigilant any more – although, if she hears a sound in her house, she is “nervy”. Beryl reported extreme depression
during her last relationship, and in the last stages. However, she currently experiences “down” periods only occasionally

*Alterations in Interpersonal Relationships*

Beryl has become somewhat more withdrawn from people more recently, although does make some efforts to go out and socialise with others. Most of her reluctance is related to not wishing to intrude on others with partners.

*Minimisation*

Beryl had a tendency to minimise all the abusive relationships in which she had been. When asked why she did this, she replied that this helped her “block it all out”.

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**Assessment for Inclusion in program: Criterion 2**

Both formal psychometric assessment and interview indicated few symptoms – either of PTSD or CP – and those that were listed, were reported as being in the mild-moderate range. However, Beryl’s tendency to minimise her abuse experiences also appears to apply to her reporting of symptomatology. Beryl has been included in the program due to the long-term nature of her abuse experience (over 50 years) and on the basis that there appears to have been quite a lot of minimisation of symptoms. Her inability to avoid abusive relationships indicates difficulties in many of the CP symptoms, such as ‘Alterations in Self Perception’, ‘Alterations in Interpersonal relationships’, ‘Alterations in Affect Modulation’, and also in ‘Perception of Perpetrator’.
Treatment Program

The Negotiated Treatment Program: Consistency with Guidelines?

Beryl’s negotiated program departed from the recommended guidelines in that it did not include work on a safety plan or on daily functioning. Beryl did not see any need to develop a safety plan (reporting no self-harm/suicidal ideation or intent), or to gain assistance with daily functioning, reporting functioning reasonably well on a day-to-day basis, being involved in social groups, and in several other activities. Beryl also did not see a need to treat core PTSD symptoms, and so the program focused on CP symptoms identified: “Alterations in Self Perception”, “Alterations in Interpersonal Relationships”, “Alterations in Affect Modulation”, and “Alterations in Perception of Perpetrator of Abuse”.

How Beryl’s Program Departed From/Adhered to the Negotiated Program

It was difficult to adhere to the program, as planned, as Beryl had a compelling need to discuss her most recent relationship, and the abuse received in this. However, it was still possible to develop a safety plan, focus on aspects of daily functioning (neither of these were in the negotiated program), and work on several key CP symptoms (“Alterations in Self Perception”, “Alterations in Interpersonal Relationships”, “Alterations in Perception of the Perpetrator”, and “Alterations in Affect Modulation”) through discussions of this relationship.

Another departure was that Beryl did not complete all 24 sessions, as after 20 sessions, she informed me that she was feeling much stronger and able to remove herself from the control of the perpetrator of her abuse. She decided to complete the program at this stage.
**Therapist’s Evaluation of Positive and Negative Aspects of Program**

There were several positive aspects related to this treatment program. Firstly, Beryl attended regularly, and was very reliable in this regard. Beryl also expressed appreciation for having the opportunity to undertake the program. She also enjoyed the group therapy and attended regularly. Beryl read any literature provided to her and seemed to benefit from this. However, there were also problems. A major problem was that Beryl minimised the nature of her abuse for most of the program. For example, Beryl initially informed me that her most recent partner] “slapped me around a bit”. When questioned further about the nature and frequency of the abuse, she reported, “He beat me up regularly – about every week”. Such minimization was evident in most of Beryl’s reporting and she needed constant reminders that what had happened to her was ‘severe’. Another difficulty was that Beryl did not always complete her homework, other than the reading provided to her. This impacted negatively on Beryl’s progress somewhat. Beryl also continued to keep in contact with the perpetrator of her most recent abuse. She continued to wear his wedding ring, and to call him “the other half”, and although I encouraged her strongly to move away from this relationship, she claimed that she needed to, to “keep an eye on him”, given financial connections. This appeared to be an excuse for maintaining contact. Even in the final interview, and following his divorce of her, Beryl indicated that she was still in contact with the perpetrator. I believe that this was a major impediment in her moving forward. Another point worthy of note is that Beryl did not ever seem to fully understand what the nature of program in which she was involved, despite regular explanations. The connection between her long-term abuse/multiple traumas and the “symptoms” she had indicated, did not really seem to take place.
Post-Treatment Evaluation

Post Test Results: Comparison with Pre-Test Assessment

Beryl’s results on psychometric assessment have not been included, as Beryl identified symptoms that had not been identified at any stage of the treatment program, and also did not identify many that had been identified. When the results were discussed with Beryl, item-by-item, it appeared that in most cases, she had mis-interpreted the statements provided. Thus, the results of the inventories were not able to be used in the evaluation.

Qualitative Data: Symptoms Identified in Post-treatment Interview

Alterations in Self Perception

Beryl reported feeling stronger, more confident and assertive, and able to manage her life alone.

Alterations in Interpersonal Relationships

Although Beryl reported that she was able to “go it alone” and did not need her “ex” any more, at other stages in the interview, information provided indicated that Beryl was still maintaining contact with the perpetrator of her abuse. Beryl reported ongoing supportive relationships with her family and some interest in developing new relationships.

Alterations in Affect Modulation

Beryl reported that she is not always happy, and often experiences loneliness, living on her own. She stated that, although she usually appears happy on the outside, this is not always the case. However, she also indicated an ability to “pick herself up” her mood declines, and explained that she gains happiness from her extended family. Beryl also sounded optimistic at her final interview.
**Alterations in Perception of Perpetrator**

It is difficult to know how far Beryl had truly shifted in her view of the last perpetrator of her abuse. Although she made ‘strong’ statements about him, she still seemed unable to cut her ties completely with him – and provided regular explanations as to why she needed to maintain contact.

**Summary of Impact of Treatment Program**

CHAPTER 8

GROUP THERAPY

In this chapter are outlined the various aspects of the group therapy component of this treatment program. Ten 2-hour sessions were initially planned, with sessions to commence six weeks into the program, and to be held every two weeks. However, as some participants commenced the program later than others, the commencement date for many participants was delayed to allow the “late starters” to have participated in at least six individual sessions, and to have developed a rapport (and a reasonable level of comfort) with the therapist, prior to engaging in group therapy. Further, in practice, not all participants were involved, with nine participants commencing the program, and only five participants being involved in the final five sessions.

Method

Participants

Of the 10 participants in the main study reported in Chapter 6 and 7, only nine committed to participating in the group therapy sessions. Cynthia elected not to attend, although had agreed to attend at the outset, stating that, as she believed she was experiencing some improvements in her condition, hearing others talk about their difficulties would be detrimental to her progress. Another participant, Diana, attended only the initial session, and withdrew from the program after this session, explaining that she found the “group process” too confronting. Both continued to undertake the individual therapy sessions.
Procedure

All participants were asked, in individual sessions, to nominate most preferred times, and the time that appeared to be most suitable to participating clients was Saturday afternoon, 3pm until 5pm. All sessions were designed to allow for a coffee break, half way through the session, and to provide opportunities for more relaxed interaction.

The sessions were held in a large room in a community facility close to the office in which individual sessions were held. The room had been chosen instead of smaller rooms available, in the belief the smaller rooms available would have been somewhat “claustrophobic” for the participants, and would not have provided the “space” from other clients required by this client group. The larger room would also allow for breaking away into smaller groups, as required.

The Initial Sessions (Sessions 1 – 5)

Session 1. Seven of the nine original group participants attended the first session. Beryl was ill at the time of this session; and Maria was overseas (Maria’s decision to travel had been a spontaneous decision made in the week prior to commencement). As this first session was likely to be uncomfortable for several individuals, all participants were asked, on arrival, to create their own nametags (using coloured pens) to reflect their personality. This activity was designed to provide something for participants to focus on while waiting for the group members to arrive and be seated. Participants were asked to write their first names only on the tag (to maintain confidentiality).

Participants were not asked to introduce themselves at the outset, as is often the process in group therapy, as many had informed me that this would be to confronting for them. Introductions were carried out later in the session, once
participants were feeling more comfortable. As the initial session is often a critical one in the group process, it was important to undertake certain tasks. Firstly, an explanation of the framework on which the group was to be conducted (Rogerian principles) was provided (Appendix N). Participants were informed that the group would be conducted using a person-centred approach, and that an accepted premise of this approach was that individuals had the ability to move forward if the appropriate conditions fostering growth were present. Participants were informed of the leader’s trust in their capacity to realise their full potential, and in the group’s ability to realise its own potential by moving in a constructive direction. Participants were also informed that, for the group to move forward, it must develop a trusting and accepting atmosphere in which members could show aspects of themselves they may usually conceal, and move into new behaviours. Discussion was encouraged in regard to the framework on which the group would be based – and participants were provided with some reading material to peruse at home in regard to this approach. Second, group rules were negotiated and agreed on by the group. These included confidentiality, tolerance/respect for difference; encouragement of equal participation by the members; and the right to say “no” and to withdraw from an activity/discussion if feeling uncomfortable. Discussion was also held regarding the extent to which members wished to talk about past traumatic experiences. It was agreed that the focus should be on moving forward, rather than dwelling on the past, and that there should be no compulsion/pressure to discuss – or listen to – individuals’ past traumatic experiences. Discussion was then held about the content of the weekly sessions. Participants were asked to provide feedback regarding issues/themes they would prefer to cover in these sessions. They were provided with forms listing possible areas of interest: self issues (self confidence/self esteem);
managing depression/dysthymia; managing anxiety/panic attacks; managing feelings of anger; improving the capacity to develop effective interpersonal relationships, changing patterns of negative thinking, managing somatic concerns. Participants were asked to identify and prioritise the areas on which they would most like to work in group therapy. They were encouraged to suggest other themes not listed on the form provided. Participants were informed that their responses would be collated, and the content for the following weeks would be based on their responses, and outlined at the outset of the next session. A little more than half way through this session, participants were asked to talk with the person next to them about themselves for a few minutes, each to take a turn at being the “listener”. Participants were advised to disclose only aspects about themselves that they felt comfortable disclosing. At the end of these discussions, participants were then asked to introduce their “partner” to the group. This method of introduction was, for most, less confronting than having to talk about themselves to the entire group. A larger group discussion was then held about “what scares you most” about participating in the group discussions. At this stage, not everyone contributed to this discussion. However, the group members raised some common fears, such as “talking in front of the group” and “being honest” about oneself. After this discussion, a break was held to enable participants to have some more informal discussion. Coffee, tea and biscuits were provided. A range of books had been displayed on a side table, to permit participants to browse if they felt awkward about speaking to others. Different reading material was displayed at each session. Following the break, participants were allotted to one of two smaller groups (one of three, and one of four people) and asked to share their thoughts with others in the group about the following questions: “What do you hope to gain from attending the group sessions?”
“What changes would you like to see in yourself as a result of the program?” The exercise was designed to open up lines of communication, and to allow participants to become more familiar with others and their expectations in regard to the group process. At the conclusion of the session, clients were asked to draw up their own “self contract”, which provided a statement about what their own personal objectives were for this program.

Sessions 2 and 3. Eight participants were present at the second session. Diana had decided, after the first session, that she did not wish to continue with group therapy. However, Beryl and Maria, who were not present at the initial session, were present for this session. As this was their first session, it was important to introduce them briefly to the others, to explain the group rules decided at last week’s session (and ask for any further suggestions regarding these), and to outline the way the group sessions would be conducted. Participants were then informed about the ‘themes’ to be covered in the following weeks, based on their choices made in last week’s session. As most participants had identified work on ‘self” as the first priority, two sessions (Sessions 2 and 3) were allocated to this topic. After ‘self”, the topics identified as priorities were as follows (in order of priority): managing depression (Session 4), improving interpersonal relationships (Session 5), changing negative thinking patterns (Session 6), managing anger (Session 7), and managing anxiety (Session 8). Participants were advised that, in general, one week would be devoted to each of these areas of interest, but if more time was needed on any particular area that could be negotiated, as two of the ten weeks had not been allocated a topic.

Valuing self. In these sessions, the focus was on ‘self”, the theme being ‘valuing self”. In both sessions, participants were involved in both paired, small-
group, and full-group discussions, on questions related to self, for example, “How do we work out ‘the value’ of an individual?” “Why is this difficult to determine?” “What does it mean to be worthy, to have value, to merit esteem?” Participants were asked to identify the attributes they valued in people generally (this lead to very enthusiastic discussion and revealed vast differences within the group). They were also asked to identify the attributes they valued in themselves – and to share these with others. Participants also discussed times in their lives when someone else had made them feel “worthless and without value”. They were asked to discuss with others how that made them feel, whether these feelings had remained with them, and how they had the individual coped with these feelings. Participants were also asked to reflect on what they least liked about themselves – what they considered their “flaws”. In discussion with others, participants assessed whether these were things they could change, whether they wanted to change them, and if so, what was preventing this happening. Participants were also given opportunities to discuss whether it was possible to have self-esteem, without liking every part of themselves, and whether they could “like themselves warts and all”. An important aspect of the group work in this area was gaining the opportunity to learn from others the strategies they used to maintain a health self-concept. Finally, opportunities were given for participants to discover how others in the group viewed them. On the whole, these sessions generated a great deal of discussion, and allowed participants to learn a lot more about themselves and others in the group. Notes used as the basis for these sessions are contained in Appendix O.

Session 4: Managing depression. Only four participants (Matt, Maria, Renee and Beryl) attended this session. Geraldine had previously said that she had a family wedding interstate. Lucy, Eric and Percy phoned on the day, explaining that they
were ill. Although the intention was to undertake group work related to managing depression, the four participants present agreed that it would be better to wait until the other four participants were present. One member suggested that they spend the time in this session talking about their past traumatic experiences. The other members agreed to this. As there were only four (plus therapist) present, it was possible to be seated around a table for this “activity”. The participants present did not have any difficulties disclosing the details of their past lives in this small setting, and volunteered information readily. Although all participants became overwhelmed emotionally at stages (indicated by tearfulness), all commented at the end of the session how comfortable they had felt telling their stories in this small-group setting, and how beneficial the experience had been. One person suggested that it was unfortunate that the others were not able to experience what they had, and suggested that the other four be given a similar opportunity. In light of my decision to focus on ‘moving forward’ and not dwelling on past traumatic experiences (in the belief that individuals may find this confronting in a group), this session provided some interesting insight into the needs of some of the clients, and led to a re-assessment of the value of including opportunities for some to talk about their past experiences in a small-group setting. Several commented that they felt more comfortable sitting around a table – and others commented that the room was too large, and that they felt “vulnerable” in it. My original belief that a larger room would be more comfortable for everyone appeared to be incorrect. As a result of these comments, I arranged to move the sessions to a smaller room, in which a large conference table was situated.

Session 5: Managing depression. This was attended by four individuals again (Beryl, Maria, Geraldine and Lucy). Renee had phoned to say she had transport difficulties, Eric had notified me that he had a lot of other things to attend to that
day, and Percy phoned to say he was too sick to attend. Matt attended for the first 45 minutes, but had work commitments after that, of which he had previously informed me – so left early. Then, about half an hour into the session, Lucy rushed out, without explanation, and did not return. This session was abandoned, as those present again decided that there were insufficient people there to allow the “group process” to operate effectively. Nevertheless, some work was commenced on “Managing Depression” – with discussion around different forms of depression: depressed mood, dysthymia, depressive episodes, major depressive mood. The symptoms were also discussed in the group. However, this was really only introductory work, and once again, it was agreed to delay this topic until the whole group was present.

Sessions 6 – 10. As it appeared that some individuals did not wish to participate in group therapy, I decided that it was important to discuss with each participant his/her feelings/responses to the group situation. Several (Maria, Matt, Renee, Beryl, and Geraldine) reported finding it beneficial. However, Renee and Geraldine reported that Saturday afternoons were difficult, but also reported that any other evening time was also difficult. Percy claimed that, although he found it difficult, he would still like to participate, but had been too sick to attend on those dates missed. As Percy also had regular absences from individual sessions, I did not feel confident that he would be a regular attendee. Lucy and Eric both explained that they found Saturday afternoons difficult, although they had both listed this time as a preferred option initially. They also both felt that it was time consuming and that they did not really have the time to commit to it regularly. Another issue raised by Percy (and agreed on by others) was that the original room was “off-putting”, being too large, and lacking the “safety” of a smaller room. Yet other participants
expressed negativity about one member of the group (Eric), who, when given the opportunity, would talk in detail about his views on specific issues - and proposed his views as “reality”, rather than as his perceptions/beliefs. Several in the group indicated that his presence made attendance at the group less attractive. As a result of the information provided to by clients, I decided to re-form the group for those who were committed to attending regularly (every two weeks) and to conduct the sessions in my own office, which was smaller and in which the participants felt less vulnerable and more comfortable. The time was moved from Saturday to an evening during the week. Five of the participants reported that they wished to continue: Matt, Maria, Renee, Beryl and Percy. Lucy and Eric both explained that they did not wish to commit regularly to another weekly session (apart from their individual session). Eric further explained that his study and family commitments were considerable at the moment. Lucy also reported to be establishing a new relationship, and this appeared to be consuming much of her evening time. Geraldine explained that, although she was interested, she would find the evening times difficult, as she was becoming tired at the end of the day as the birth date of her baby approached. Thus, five more group sessions were planned for the smaller group. In the first of these sessions, discussion took place as to how the members would like to use the time: with a theme central to the discussion (as before); or with greater emphasis each week on issues of concern to individual members at that particular time. All agreed that the latter suggestion appealed more. Thus, the original “thematic” approach was abandoned, giving way to a less structured approach. This still was in keeping with a client-focused approach, allowing participants to feel a sense of ownership in their group. In each of the following sessions, several different themes emerged, related to incidents/issues participants needed to “air”: perception of those in the community
about mental health and their problems, disclosure to others about their problems/past experiences, support/or lack thereof from friends, setting boundaries with other people, being assertive, psychosomatic illness, coping strategies, stress reduction/anxiety management strategies. Each session ended with participants reporting something positive that had happened in their lives over the past two weeks – or a ‘gain’ they had made. Most individuals expressed positive views about the smaller, more intimate, re-formed group. However, in this smaller group, one participant (Renee) became a dominant force, and although she admitted to “taking over”, stated that she was unable to control herself, and needed to “unload”. Again, however, others expressed negative views about her ‘dominance’, and one person withdrew from the group, mainly due to this factor. Attempts to provide a more balanced discussion usually failed, as other members in the group were shy, and even if “drawn in” to discussion, could not hold their position if challenged by Renee.

**Summary: the Usefulness of Group Therapy with CP**

Although research has indicated that group therapy is an important aspect of treatment programs for adult survivors of trauma (PTSD), in this study, many problems were identified: negative attitudes (prior to commencement) regarding possible benefits of the group process by some; fear by some participants regarding aspects of the group process; and difficulties for many in maintaining a regular commitment. There were several in the group (for example, Percy, Diana, Geraldine) who suffered from social anxiety/shyness, and these individuals experienced enormous fear in the group situation. Perhaps, for this reason, absences became common. Yet with the success of the group depending on group cohesiveness, the regular absences in the initial weeks (and of different individuals each time) led to
difficulties in forming the sense of cohesion required to engender feelings of safety. Another problem in this group related to the dominance of certain individuals (Eric in the first five weeks, and then Renee in the final smaller groups). Their dominance was identified by others as a reason for their departure from the group.

Despite the problems experienced by this group, several participants reported to me that they enjoyed the group, and benefited from it. However, it is possible that group therapy may be difficult with many individuals who have suffered from long-term-multiple trauma experiences.
CHAPTER NINE

ANALYSIS and DISCUSSION

In this study, an analysis of participant’s taped descriptions regarding various aspects of their lives and functioning, both before and after involvement in the treatment program, has been considered a primary source of data. Some conclusions have been drawn regarding the extent to which, after six months of treatment, each of the participants perceived notable improvements in symptoms of Complex PTSD, with consequent “ego strengthening”. The aim has been to generate a more complete understanding of the process of change over the course of the therapy.

The analysis method used (critical discourse analysis) has been based on the initial stages of Fairclough’s model (1998), referred to in chapter 6. It has involved an examination of the “discourse type(s)” used by the participants, such as the evaluative terms, vocabulary, metaphors – and in some cases, sentence structure and grammar. The notion that people largely make sense of their experiences, and communicate their experience to others, through their language, has been central to this study. Thus, specific components of language have been seen as accurately reflecting the specific feelings and behaviours of the individuals at specific times.

Cynthia

An analysis of the language used by Cynthia to describe her “self”, her capacity to regulate her emotions, and her interpersonal relationships prior to treatment – and then post-treatment – indicates definite and marked positive changes in all three CP symptoms initially identified by Cynthia: “Alterations in Self Perception”; “Alterations in Affect Regulation”; and “Alterations in Relationships with Others”. This result is consistent with the results of psychometric assessment.
Alterations in Self Perception

Prior to her treatment, Cynthia indicated that she valued herself little, feeling a sense of worthlessness:

I wouldn’t say I’m a person. I feel that I’m invisible…I feel that what I say and do, no-one is interested or no-one cares. My opinion doesn’t count. I really feel that like I am invisible to the rest of the world.

The words, “worthless” and “invisible” were repeated frequently throughout her discourse. There was also a sense that Cynthia felt defeated: “It doesn’t matter what I do, it’s not going to achieve anything”. Cynthia also expressed a sense of failure, especially as a mother: “I think I’ve let them [my children] down too much, disappointed them.” Cynthia’s pre-treatment discourse is thus one of defeat and self-devaluation.

In contrast to the pre-treatment negative “self” statements, Cynthia’s statements during the post-treatment interview by an independent psychologist (eight months after treatment commenced) indicated a shift from someone who felt “worthless”, “invisible” and “defeated” to someone who felt much stronger, and different in many ways: “I feel like this new person who’s come out of a cocoon.” Cynthia referred to her new feelings of strength: “That’s one thing the therapy has done for me: it’s given me a sense of strength.” Cynthia explained:

I was in situations that people made me feel worthless. But I’ve re-visited some of them since counselling, and I’ve just laughed at them now: ‘Why did I ever care what you thought? Why did you make me feel worthless when you’re the worthless one?’

These statements are suggestive of someone who no longer feels invisible or defeated. The statement, “Really, the best thing it [the program] done was validate
that I’m a human being” is in strong contrast to the statement given pre-treatment: “I wouldn’t say I’m a person”. Although the impact of long-term childhood maltreatment had been an alteration in Cynthia’s self-perception (CP Criterion 4), a change had occurred in the course of the treatment program, with Cynthia feeling validated as a human being. Her discourse post-treatment was one of strength and self-valuing.

*Alterations in Affect Regulation*

Cynthia’s descriptions of her mood prior to treatment indicated marked instability. Cynthia had stated that “it only takes something very, very slight to send me into a downward spiral… All I want to do is shut my eyes and never have to wake up again.” Pre-treatment, Cynthia reported that her mood was mostly very depressed, and when asked to rate her mood generally, she stated: “Most days in the last 12 months have been minus”. Cynthia also expressed some self-blame and guilt regarding her mothering. She also reported that she experienced a great deal of anger: “I get angry inside. Angry like I’m going to burst”. Cynthia stated that her control of this anger was only external: “I’m controlling it on the outside but it’s like a cancer on the inside. It’s eating at me.” Cynthia’s discourse pre-treatment was one of despair, darkness, guilt and self-blame.

Cynthia’s post-treatment descriptions to describe her mood used much more positive language, however. Cynthia described less negativism and a more elevated mood: “So I’ve got a more positive outlook”. She stated that, “the girls and I have not laughed so much the last six to eight weeks. We’ve spent most of our time laughing, dancing and having good chats with each other.” This description is not consistent with someone who is deeply depressed. Post-treatment, there were fewer indicators of depression, with Cynthia reporting, “I am sleeping well” and that her
appetite was “a bit too good”. Cynthia also reported less anxiety and increased energy to achieve things: “Just trying to get it together enough to achieve one thing was a really hard before. Now, I can achieve 20 things in a day.” Cynthia also reported focusing more on the present: “I think I’m the kind of person who needs to ‘stop and smell the roses’.” This is a more positive picture to the one described above, in which Cynthia rated her mood at “minus”.

Cynthia’s discourse also indicated that self-harm was no longer part of her life: “The thought just doesn’t enter my mind – of self destruction – where I want to hurt myself. It’s not there any more – there’s not that need.” Again, this is in stark contrast to a pre-treatment statement: “all I want to do is shut my eyes and never have to wake up again.” Cynthia’s descriptions also indicated an absence of the guilt that predominated previously: “I’ve taken the guilt equation out of my life. That’s the one thing I have done. Before, everything I did was, ‘Oh, I feel guilty because of this’, or ‘Did I say the right thing?’ There’d be guilt. But I’m not guilty – other people are guilty – but they are not going to pay, so I’m not going to let them rule my life.” Cynthia also reported that, although she was still angry, her response had changed: “I still have the anger issues. I’ve just got to learn to manage them – but I have to manage them. And the more I manage them, the better I’ll get. And one day, I’ll wake up and say, ‘Why was I angry?’” This change in attitude had started to lead to changes in Cynthia’s behaviour: “Every time I go to get angry, I tell myself, ‘It’s just not worth it’”. Again, this awareness and capacity to modulate her affect indicates a shift from the “cancer” eating away at Cynthia on the inside.

Although the impact of long-term childhood maltreatment had been an alteration in Cynthia’s capacity to regulate her affect (CP Criterion 2), a change had occurred in the course of the treatment program, with Cynthia reporting an improved
mood, improved capacity to manage her anger, and an absence of suicidal pre-occupation. Cynthia’s discourse had reflected this shift, and post-treatment, her discourse was one of brightness, optimism, and involvement in life.

**Alterations in Interpersonal Relationships**

Pre-treatment, Cynthia reported difficulties with interpersonal relationships, with estrangement from close relatives, including her mother and son. In describing her relationship with her mother, Cynthia expressed anger: “I feel angry that she didn’t protect me.” In discussing her estrangement from her son, Cynthia expressed sadness: “It just devastated me” and “I feel at this moment in time I’ve lost my son.” Pre-treatment, there was also little interest in social interaction or friendships with others. Cynthia’s explanation for this indicated cynicism and lack of trust: “Unless I bow down and do what other people want me to do, they just seem to, like, if I say ‘no’ to them, they get angry with me.” Cynthia’s statements also indicated that she had become cynical about relationships with males: “Well basically, unless you do what the man wants you to do, you can’t have a relationship… I have two choices: not to have a relationship or be used.” She also indicated a loss of trust: “I don’t trust men enough. It’s always one way or another - they are just using me.” Cynthia’s discourse pre-treatment was one of cynicism, distrust, and disempowerment.

Following treatment, a shift was observable in Cynthia’s attitudes towards all relationships. Although there was still little interest in social interaction (“I don’t need much [socialization] because I think I feel good about what I’ve got in my life.”), Cynthia now provided a different reason for maintaining her isolation: that she felt fulfilled and content without others. No longer was she explaining her isolation in terms of faults in other people. Another change was that Cynthia had become more accepting (or perhaps resigned) to the way others close to her treated
her, and was reporting that she no longer allowed these relationships to upset her, and was able to let go of some of the feelings previously held about them. In response to her son’s estrangement, she stated, “So I don’t care what he thinks about me. I’m not going to take that garbage any more.” In response to her mother (and her refusal to acknowledge Cynthia’s past abuse), Cynthia stated, “It’s her problem, not mine… It was eating at me. It was like a cancer. And only I could do anything about it. Once I come to that conclusion, it was easy to let go.” These statements reflect a shift for Cynthia, in that she was no longer prepared to carry all the responsibility for difficulties in her life.

Another major shift was indicated in Cynthia’s changed attitude towards males, and with the commencement of a new relationship: “We’ve become very close. It’s taken a long time to trust this person - of letting someone come into my life.” Again, this is strongly contrasted to previous statements that “I don’t trust men enough”. However, there was also a sense of more assertive behaviour in response to people: “If you came up and pushed me, I’m not going to wear it… And I’m still loving, soft, but I’m not soft enough to be trampled on any more. I will say ‘No’ and I will defend myself.” Cynthia had also described assertive behaviour toward the new male in her life, stating, “There’s one thing you have to understand – you have to be straight with me. I don’t want anyone playing games. If you start playing games, I’m out of there. I’m not taking that sort of garbage any more.”

Although the impact of long-term childhood maltreatment had been an alteration in Cynthia’s relations with others (CP Criterion 6), a change had occurred in the course of the treatment program, with Cynthia having improved relations with others, displaying increased assertion within them, and exhibiting more trust in
others, in particular, with males. Cynthia’s discourse had become one of empowerment and trust.

**Summary**

Cynthia’s use of language during the final independent evaluation is in marked contrast to that used pre-treatment. Cynthia has used more positive descriptive terms when describing her self, her relations with others, and her capacity to regulate her affect (three of the CP symptoms reported at the outset). Her statements are generally bolder and stronger and indicate that some “ego strengthening” had taken place for Cynthia in the course of the 6-month treatment program.

**Maria**

Four CP symptoms were initially identified by Maria (“Alterations in Self Perception”; “Alterations in Affect Regulation”; “Alterations in Belief Systems”; and “Alterations in Interpersonal Relationships”). However, these were identified only during interview, there being no clinically significant score on any scale at the outset (or post-treatment). Perhaps the most meaningful way of ascertaining improvements over the treatment period, therefore, can be obtained by comparing the client’s descriptions about aspects of her self and functioning, at her final interview. As is illustrated below, Maria indicated, through the language used, improvements in all symptoms that were addressed in treatment: “Alterations in Self Perception”; “Alterations in Affect Regulation”; “Alterations in Relationships with Others”; and “Alterations in Consciousness”.

Alterations in Self Perception

Prior to her treatment, Maria’s discourse indicated poor self-identity and low self-confidence. Maria explained the reason for this: “I was never told that I was intelligent or that I was smart, so because I was never told that, I assumed that I wasn’t… so I’ve just spent a lot of time doubting everything that I do.” When asked to provide words that would describe her self in the initial interview, Maria said, “I’m not sure,” which indicates that Maria did not have a strong self-identity.

As a result of the program, Maria’s self-knowledge improved, and she provided numerous positive descriptors, this had lead to increasing self-comfort. In describing her self post-treatment, Maria stated, “I feel more confident now because I know more about myself… I’m more comfortable with me.”

Although the impact of long-term childhood maltreatment had been an alteration in Maria’s self-perception (CP Criterion 4), a change had occurred in the course of the treatment program, with Maria developing a stronger self-identity. Her discourse reflected this, being now about improved self-knowledge.

Alterations in Affect Modulation

Prior to treatment, Maria had stated, “I’m easily angered by small things. I drop something and I get angry. There’s like anxiety there and noise - I can’t handle really loud noise.” Post-treatment, Maria’s discourse was about “control” and she stated, “I know how to deal, for example, with anger. I had a lot of problems with anger, and I’ve been dealing with them better and using different approaches that are more conciliatory, and have helped me to relax more.” Maria reported that her partner had noticed her improved control over her emotions: “I know he’s noticed a change in the way I’m approaching different situations that make me angry.” In these statements is an indication of a shift from someone who is “easily angered by small
things”. Although long-term childhood maltreatment had led to difficulties for Maria in regulating her affect (CP Criterion 2), a change had occurred in the course of the treatment program for Maria, who now reported being more in control of emotions.

**Alterations in Interpersonal Relationships**

Prior to treatment, Maria’s statements relating to sexual relationships revealed a dislike for, and fear of, sexual involvement: “A lot of the time I’m not 100 percent there. I don’t know – it must be better for a lot of other people”. Maria also reported that, during intercourse, she thinks, “Thank goodness it only lasts a few minutes” and explained that this was “because I don’t like to be touched near my genitals” and that she was “uncomfortable” with love-making. However, post-treatment, Maria reported improvements in her relationship with her partner (both generally and sexually), her statements at a follow-up interview indicating a shift from complete lack of interest and fear to enjoyment: “I am not avoiding sex any more – and sometimes I enjoy it”. Thus, although long-term childhood maltreatment had led to difficulties in sexual relationships for Maria (CP Criterion 2 & 6), a change had occurred in the course of the treatment program for Maria, who now reported being less inhibited sexually.

Prior to treatment, Maria had reported her difficulties in accepting her mother’s denial of maltreatment: “She’s in denial about what she’s done to me so I have to live with that… She doesn’t believe that she’s does the wrong thing, but I think I have sorted out the acceptance of that.” However, as the program ensued, I noted that Maria had not completely “sorted out acceptance” of her mother’s denial, as each time this issue was explored, Maria would collapse (feint) in session. Hence, a great deal of work was undertaken in regard to Maria’s relationship with her mother.
After the program, Maria reported that she did not have as much anxiety over her relationship with her mother: “I guess she’s now on the fringe. Before, she was much more a focus… I think that the negative impact that she had on me doesn’t have a hold any more. It’s not that it’s not important – but her actions, and what she’s said in the past – are more comfortable.” Phrases such as “doesn’t have a hold”, “not important”, and “on the fringe” are a strong indication of the reduced level of importance the issues relating to her mother were having a hold for Maria. The words “more comfortable” sums up how Maria was feeling about her relationship with her mother now – and this comfort was evident in the fact that Maria was able to discuss her relationship with her mother without feinting. The discourse was that of acceptance.

**Alterations in Consciousness**

Prior to treatment, Maria reported that she was collapsing (feinting) and dissociating regularly: “I’ll have an incident during the week – either a collapse or a panic attack – so obviously there’s a lot of stuff deep down.” Maria expressed fear and confusion about her collapsing (“At first I thought I was going to die – the very first time it happened” and “It’s like a big puzzle”).

Post-treatment, Maria still reported experiencing these “collapses” (sometimes she referred to them as “panic attacks”), although she reported less intensity: “It still occurs, but with less intensity than before.” The fear expressed previously had also changed (“And it’s less fear of me going… Now it’s just, ‘I’m going to relax for a little while’. I’m less fearful.”), and Maria attributed this reduced fear to greater awareness and confidence about being able to manage her collapsing: I think having knowledge about panic attacks and why I might be collapsing has helped me to go, ‘OK – this is what’s going on – and this is how it manifests itself –
and I think it’s good now, as it alerts you to the fact that there’s stuff you haven’t dealt with.’

Thus, descriptive phrases used post-treatment such as “less intensity”, “less fear”, “having knowledge” and “it’s good now” are clear indicators of a marked change in this area. Although the impact of long-term childhood maltreatment had led to dissociative episodes (CP Criterion 3), a change had occurred in the course of the treatment program for Maria, who now reported being less fearful and more in control of her dissociative states. Her discourse, post-treatment, was therefore around control.

**Alterations in Perception of Perpetrator**

Although Maria did not discuss her perpetrators at the initial interview, her statements during the final evaluation indicated a change: “I came to a conclusion about a month or two ago that I wouldn’t judge them anymore because I haven’t been in their shoes. I don’t know what life was like for them as they were growing up.” Thus, although the impact of long-term childhood maltreatment had led to negative feelings towards the perpetrators of her abuse (CP Criterion 5), a change had occurred in the course of the treatment program for Maria, who now reported some distancing from her previous emotions. It was apparent that she was moving away from a discourse of blame.

**Summary**

On the whole, Maria’s dialogue indicated notable improvements in all CP symptoms treated (self perception, affect modulation, consciousness, and interpersonal relationships), and where symptoms were still present (for example, dissociation), increased knowledge about them and confidence in her ability to
manage these. Thus, the language used by Maria at her final interview indicated that some “ego strengthening” had taken place.

**Eric**

At the initial interview, Eric had identified difficulties in three CP symptoms: “Alterations in Self Perception”, “Alterations in Affect Regulation”, and “Alterations in Relationships with Others”. Psychometric assessment had also indicated “Alterations in Belief Systems” (in particular, ‘Despair/Hopelessness’) and “Somatic Concerns”. Although post-treatment psychometric assessment indicated only limited improvements in terms of some CP symptoms (‘Despair/Sense of Hopelessness’; ‘Alterations in Affect Modulation’; and ‘Somatic Complaints’), Eric indicated during the final interview by an independent psychologist, through his use of language, that the improvements were more far-reaching.

**Alterations in Systems of Meaning**

Eric’s description of his current life in the initial session indicated despair and hopelessness. Eric portrayed “the hopelessness of every agenda – this dull grind of having to do this stuff”. The difficulties moving away from it also demonstrated the hopelessness he felt:

The thing that has been coming home to me is the repression – the inability to feel that I can try or do anything. I often think that there’s a force on my shoulders pulling my heart area shut – closing me down there – as if my arms are pinned to my sides. I get this numb feeling. I have always felt that I could never do anything – physically achieve anything – sporting, or hobby, or academic – or anything. I feel like I’m carrying around two cement bags – I
can’t earn enough to keep my family – or have them at home. There is an inability to say or do what I need to do.

In the language of the final interview, this sense of despair and hopelessness was absent. The following statement is an indication of this:

There comes a time when you just have to get over it, irrespective. It did happen. It was painful. It was hurtful. It has left a lot of emotional nasty scars for me. But hey - that was history – that was yesterday. It’s gone. I fall over often enough when I’m walking forwards. I’m not going to walk backwards for the rest of my life. I’ve got to look to what I’m doing now. It’s like a hurdle in a race. The hurdler has got to concentrate positively on this hurdle that’s coming at him 40km per hour – and take care of it – and then the other one. And that’s what I’ve got to do – deal with each one well, and forget about the things that happened – and things that might happen. So I’ve gone from my focus being 360 degrees to being more like that – and my focus is gradually coming down to being here.

The sense of inertia depicted by phrases such as, “there’s a force on my shoulders pulling my heart area shut…. as if my arms are pinned to my sides” and “I feel like I’m carrying around two cement bags” appeared to have disappeared. This was a discourse of empowerment and moving forward. Thus, although the impact of long-term childhood maltreatment had led to ‘Alterations in Systems of Meaning’ in terms of despair and hopelessness (CP Criterion 7), a change had occurred in the course of the treatment program for Eric. However, Eric qualified his post-treatment statement by stating that he still had little optimism: “I don’t have any real optimism because, my entire life, I’ve never had anything last – so I don’t hope or wish for things.”
Alterations in Affect Modulation

In the initial interview, Eric’s descriptions indicated difficulties with anxiety: “I found that right up until now - that any group situation where I have to speak – I am thinking, ‘How can I answer that? It won’t come out the way it’s supposed to. I’m always scared of saying the wrong bloody thing.’ ” He also stated, “Sometimes when I am in a supermarket, I can feel part of my body not operating properly – freezing up – I’ll struggle to keep walking properly – it’s not too noticeable, because I’m scared bloody witless that people are watching me.” Eric also reported difficulties with other strong emotions: “There is also a lot of anger there. I also have some low-grade depression.”

Post-treatment, Eric reported being more in control: “more steady”, “able to deal with pressure significantly differently” and “not becoming as agitated as I used to.” This indicates a shift from being “always scared” and “scared bloody witless”. Eric also appeared to be able to be managing relapses into depressive states, through attempting to change aspects of his life. He expressed being more focused on “living in the here and now” and dealing with life as it came along, rather than looking backwards or forwards. The statements quoted earlier (“I’m not going to walk backwards for the rest of my life. I’ve got to look to what I’m doing now”, and “the better I take care of today – the better that’ll happen’) are strong indications of someone taking control of his life and emotions. Eric also reported being more proactive, in terms of taking control of his life, career and finances, and this appeared to be empowering for him. He also reported that somatic complaints had disappeared in the course of the program.

Thus although the impact of long-term childhood maltreatment had led to difficulties for Eric in regulating his affect (CP Criterion 2), a change had occurred
in the course of the treatment program for Eric. His discourse was now one of control and remaining present-focused.

With other CP symptoms, however, there appeared to be only mild improvements in the following symptoms: “Alterations in Self Perception”, “Alterations in Relations with Others”, “Alterations in Perception of Perpetrator of Abuse”.

**Alterations in Self Perception**

Pre-treatment, Eric portrayed his feelings about himself in the following: “I have a very, very, very low self worth.” However, post-treatment, he appeared to speak more positively about himself, and expressed greater confidence: “The program has given me the opportunity to say things - and realise – that what I’m saying has just as much validity as anyone else.” He also stated, “I feel more assertive.” There were still indicators, however, that the improvements had only been slight and Eric did not really believe that major changes were possible:

If I’d broken bones, I’d recover. But when you’ve had substantial, constant stuff imposed on the mind AND body for 14 years – and it was so violent and constant – and tense – and unjust – you never ever really recover from it – because the DNA – it’s put down there – and it’s held there.

This latter statement (“you never really recover from it”) was reflected in the results in the SIDES-SR results, in which his score on the “Alterations in Self Perception” scale was clinically significant (but had not been so pre-treatment). Perhaps the realisation regarding the permanent damage had only occurred during the program.
Pre-treatment, Eric expressed extreme negativity in regard to the possibility of relationships with women:

I am not able to relate to women. I have almost come to the point where I have to be brutally honest about meeting a woman who’d like to be with me… I’ve had to turn away from that completely – I don’t go out as I always say something stupid or defensive. I don’t have anything to offer a woman. I’ve just come to that conclusion. The collateral damage. The realisation I can’t think a particular way. It’s like climbing Mt Everest in thongs and a t-shirt.

The language used in his pre-treatment description of his capacity to relate to women is extremely negative, offering little hope for him self in relationships with women. However, post-treatment, Eric reported more confidence in being able to relate to women and people generally: “I’m not so frightened, threatened, and intimidated – not so much. But certainly the edge has been taken off.” Eric’s increased confidence with women was indicated in the following: “I’ve had some very interesting situations in the last couple of weeks. I’ve certainly approached women and asked them if they’d like to go out. I’ve given them my number. That’s pretty good.”

Thus, we see some shift from “I’ve had to turn away from that completely… I don’t have anything to offer women” to “I’m not so frightened, threatened, and intimidated” and “I’ve certainly approached women.” This is a shift from a discourse about inadequacy to one of greater confidence. Despite Eric’s positive statements, there was still some doubt: “But I’m cynical, and I find that, because I
don’t have a lot going for me financially, that’s a big hold back – that money to throw around.”

In the first weeks of the program, Eric had also expressed negativity towards, and distrust of, other people generally. This negativity extended to his own children, about whom he sometimes spoke with scorn. This negativity towards other people, and the distrust, was present post-treatment (although according to SIDES results, the distrust was at a lower level of intensity). This was indicated in Eric’s response to a question about whether he had changed his feelings about other people:

Marginally – and that’s a reflection of Pam’s [the therapist’s] program. It’s a personality thing. I’m a loner. I don’t fit into groups. It’s inordinately difficult for me to go somewhere just for the sake of being there – the social set, I find – it’s a complete waste of time… it’s just chit-chat and laughing about.

This statement also reflected greater self-awareness of his comfort zone, as well as his personality and strengths. Eric also spoke more positively in regard to his children:

All of my children, without exception, you might say, ‘ideal’ children: co-operative, kind, brilliant at school. They socialize well and get on with each other. So even though, in a way, I’ve failed for most of my life in being able to provide for them, they’ve turned out intellectual, robust, vigorous, capable.

They are all quite remarkable intellectually.

The use of such positive language in regard to his children had not occurred throughout most of the program, and so there was, in this description a hint of some shift. Despite such positive statements, however, Eric still seemed to have problems in his relationships with his children: his 17-year old daughter had recently moved out to live with another family.
**Alterations in Perception of Perpetrator**

Eric indicated during sessions that he had “moved on” from the past and had been able to forgive his parents and his wife. In the final interview, he appeared less blaming when discussing his parents’ abuse, stating, “that my mother and the guy she married all had their demons – that they acted in a way that they were programmed to, and there was nothing I could do about it.” However, when describing his ex-wife, there were still indicators of blame and negative thoughts: “I’ve been without a wife ever since I got married. She turned her back on me for 20 years.” There was little compassion expressed, when talking about his ex-wife: “I’m grateful that she’s gone – so for me there is that ‘true separation’. I can start living life.”

**Summary**

Eric’s descriptions in the final interview indicated improvements for Eric in several areas: reduced despair and sense of hopelessness (CP Criterion 7); improved self perception (CP Criterion 4), with certain limitations expressed; reduced depression and anxiety, fewer somatic concerns, more control over emotions (CP Criterion 2); and some improvements in interpersonal relationships (CP Criterion 6). Although some symptoms were still evident, they were at a lower intensity, and there appeared some subtle changes, and consequent “ego strengthening”.

**Lucy**

Four CP symptoms were initially identified for Lucy (“Alterations in Self Perception”; “Alterations in Affect Regulation”; “Alterations in Interpersonal Relationships”; and “Alterations in Belief Systems”), and given that the results provided on post-treatment psychometric inventories indicated marked
improvements in these symptoms, it could be expected that self-report would also indicate this. An analysis of the language used by Lucy to describe her “self”, her capacity to regulate her emotions, and her interpersonal relationships prior to treatment – and then post-treatment – indicates a definite and marked shift in these symptoms.

**Alterations in Self Perception**

Prior to treatment, Lucy described herself in very negative terms:

I think I’m not clever enough, not pretty enough – like I’m faking it. My good marks were really due to study techniques – I’m not really clever. If anyone really knew me, they wouldn’t want anything to do with me. And I can’t objectively look at anything to do with my appearance.

Lucy reported that it was difficult to see anything positive about herself, her extreme negativity in regards to herself being reflected in the following statement: “Why would anyone bother with me? How could I inflict myself on another human being?” Extreme negativity is portrayed in Lucy’s perception that she may be “inflicting” herself on other people. Lucy’s pre-treatment discourse is thus one of self-devaluation.

Post-treatment, Lucy’s descriptions of herself indicated a stronger, more assertive person than pre-treatment: “I tend to [stand up for myself] these days, and it makes me feel better about myself.” Lucy explained that she felt sufficiently empowered to overcome her fear of her father and confront him about the past. She reported no longer feeling the need to please her father: “I don’t seek his approval any more – which is great! In stating that she was more assertive towards others, and not needing others’ approval, Lucy indicated a shift in her self-perception to one of self-valuing.
Thus, although the impact of long-term childhood maltreatment had led to alterations in self-perception for Lucy (CP Criterion 4), a change had occurred in the course of the treatment program for Lucy, whose discourse was now one of empowerment.

**Alterations in Interpersonal Relationships**

Prior to treatment, Lucy described difficulties in forming relationships with others:

I worry that I don’t have good interpersonal skills – that I’m getting it wrong all the time. Or I don’t understand other people. I don’t relate to other people. In friendships I used to have, I was in a cycle where I’d get involved with a group, and they’d be my friends for 2-3 years – and then I’d just disappear. I’d say, ‘I don’t care’. Even friends who’ve lasted a long time – they can come and go. I think it’s something I do.

Lucy described almost a fear of relationships with others, as expressed in the following:

I think without meaning to, I’ve actually run away from people. It’s worse now, being single at my age. I’m loathe to get involved or have friendships. I notoriously let friendships slide and actively hide from people – actively keep to myself. I avoid the telephone. The telephone rings and I shudder.

Lucy also described social anxiety: “I’ve always had trouble in a party atmosphere. I’ve always been horribly shy. Even now, I avoid the whole network scene – I want to go and lock myself in a closet.” Lucy also expressed a lack of trust, stating, “there’s an ulterior motive – especially with men – not so much with females.” In sexual relationships, Lucy also expressed negative thoughts: “Sexually, I see myself as a complete failure.” Prior to treatment, she explained her difficulties in sexual relationships:
After a while, I see any form of intimacy as foreplay essentially – it’s just going to lead from this to this to that – and I can’t enjoy it – so it’s a shocker. From the very first relationship, I have had this trouble where I have become sexually dissatisfied – repulsed – looking for ways out. I feel used. The whole sexual experience makes me feel awful and used. It made me feel uncomfortable.

Lucy referred to her most recent relationship to illustrate her point:

In the last relationship, I detached from the relationship – was quite numb.

After about 12 months – even before that – even going into the sexual thing – I was only ever acting – doing what had to be done. After that, I just felt used. Even a touch would make me feel that way. I got that way that I did not want to touch or kiss or anything, in case it would lead to something else. I blamed him.

Pre-treatment, Lucy’s discourse in regard to relationships with others was around fear and avoidance. Post-treatment, Lucy reported improved interpersonal relationships and was developing and maintaining friendships, as indicated by the following:

I have friends now – females, males and couples – friends that I think will stick by me and stay in my life for many years, which is remarkable for me. Because in the past I have always, kind of, floated and not kept in touch with people. And now staying in touch – and having decent friends who stick around is one of the most important things. I am placing more value on family and friendship support. And when things go wrong, they are the ones who make you feel so much better.

Lucy reported relying on her friends more when she needed support:
I have learned that the best way – the most positive way – to respond to such things [relationship difficulties] is to call my friends – get support – let them prop me up – keep being busy – keep doing things – keep being social, going out again.

These post-treatment statements of “I have friends now”, “I am placing more value on family and friendship support”, “they are the ones who make you feel better” and “the best way… is to call my friends” indicate a more positive attitude to relationships than “I don’t relate to other people”, “I’ve actually run away from other people”, “I’m loathe to get involved or have friendships”, “I notoriously let friendships slide and actively hide from people”, and “I avoid the whole network scene”. Lucy’s discourse here is one of engagement and involvement in friendships.

Lucy also appeared to have overcome some fear/avoidance of close and intimate relationships, expressing a fear of not having such a relationship: “There is a fear of being alone forever”. Lucy had also recently been involved in a brief intimate relationship with a male. This indicated some willingness to let go of her belief that men have an “ulterior motive” in forming an association. It is also perhaps associated with her improved capacity to be assertive: “I tend to [stand up for myself] these days”. However, Lucy predicted difficulties in future intimate relationships: “I can see that it will be a hassle waiting there for me”. When asked at the final interview by the independent psychologist whether there were relationship difficulties currently being experienced, Lucy responded, “Probably only the physical intimacy side.” Again, Lucy’s post-treatment discourse is one of engagement and involvement.

Thus, although the impact of long-term childhood maltreatment had led to difficulties for Lucy in her interpersonal and intimate relationships (CP Criterion 6),
she reported a change in her relationships (and in her attitude to these) in the course of the treatment program.

**Alterations in Affect Modulation**

Although Lucy described anxiety in many forms over many years, this was not present prior to treatment. Lucy reported that it had changed to a form of emotional numbness, stating, “It’s gone. I don’t know where it’s gone – it’s just turned to flatness.” However, post-treatment, Lucy reported a change, that she was able to feel again, as indicated in “able to be excited”. She explained this change as being related to the treatment program:

I know when I came to Pam [therapist], I was in a state of – well I felt like a ‘dull ache’ – and I almost was incapable of having highs and lows. Well I’m certainly capable of experiencing highs these days – and don’t experience too many lows – so that’s a big improvement.

There is a marked contrast between expressions of ‘incapable of having highs and lows’ and ‘able to be excited’. Lucy’s capacity to “feel” again was evident in her renewed interest in relationships with males, and also the development of anger towards her father. Lucy also reported that her mood was “calm” and “pretty good” at the moment, and she reported more optimism about the future (“I’m looking forward to moving forward in life and leaving behind all problems.”). This language indicates that the previously reported sense of hopelessness and despair had disappeared.

Although the impact of long-term childhood maltreatment had led to difficulties for Lucy in regulating her affect, manifesting itself in emotional numbness (CP Criterion 2), a change had occurred in the course of the treatment
program for Lucy, whose discourse was now one of increased optimism and emotional expression.

Alterations in Perception of Perpetrator

Lucy also indicated a major change in the way she perceived the perpetrators of the abuse: her parents. There was no longer the reverence and idealism for her parents previously seen, as illustrated in the following statement by Lucy, comparing past and present attitude:

At times I really hated them – actually – seemed to go from one extreme to the other – a real love-hate sort of thing. I had my father on this pedestal, and I would have done everything for him. But now I can see all his flaws and can see he is overly proud and arrogant – and isn’t as clever as he made out. And I don’t seek his approval any more – which is great! He is really arrogant about it. And I don’t think he knows any other way. I don’t think he knows how to show – it’s almost like he’s too proud to show any remorse or any true feeling – and that’s really sad.

Post-treatment, Lucy’s father no longer appeared to be “on a pedestal” – but someone “with flaws”, “proud and arrogant” and “not as clever as he made out”. Lucy still reported, however, that she had feelings of love for her parents: “I still love my parents – care about them.” Lucy reported at follow-up interview that she felt empowered handing back the guilt and responsibility for the past abuse to her father. Thus, a change had occurred in Lucy’s perception of the perpetrator of abuse (CP Criterion 5).

Summary

The language used by Lucy post-treatment illustrates powerfully that marked improvements had occurred in terms of several CP symptoms: “Alterations in Self
Perception”, “Alterations in Affect Regulation”, and “Alterations in Interpersonal Relationships”. For all symptoms, Lucy’s discourse post-treatment was much more positive than that used pre-treatment and was a strong indicator of “ego strengthening” having occurred in Lucy.

**Diana**

Four CP symptoms were initially identified for Diana (“Alterations in Self Perception”; “Alterations in Affect Regulation”; “Alterations in Relationships with Others”; and “Alterations in Belief Systems”), but given that the results provided on post-treatment psychometric inventories indicated only improvements in some of these symptoms, it could be expected that self-report would also indicate this. An analysis of the language used by Diana to describe her “self”, her capacity to regulate her emotions, and her interpersonal relationships prior to treatment – and then post-treatment – indicates very little shift for Diana in most areas.

**Alterations in Self Perception**

Some improvements in self-perception were indicated in the language used by Diana during her final interview with an independent psychologist. Pre-treatment, Diana had reported on the legacy of many years: “I have grown up with not an ounce of confidence. If it wasn’t physically beaten out of me, it was beaten out of me in other ways.” Diana also reported feeling different: “I do feel different to others – misunderstood. People judge you.” She reported that there were constant fluctuations in her feelings about her self, reporting, “My confidence can be in the pits with one remark”. She explained it in this way:

I feel really good for a week. I think, ‘Gosh I did really well with that speech - everyone said how good that speech was.’ And then I don’t recognise this in
myself. I hate this about myself. As soon as someone says, ‘No, that’s not what I wanted. Can’t you have addressed it in a different way?’, I take it personally.

Diana’s discourse reflected unstable sense of self. Diana reported little hope that she would ever be able to change this unstable sense of self, one dependent on others’ perception:

I just think I am so conditioned, Pam, that I think it’s going to take forever to stop me feeling this way. I even recognize it – and I still can’t stop it. I tell myself to stop being so stupid, but I tend to take it personally. I get angry with myself, and say, ‘There you go, you’re useless’.

Diana’s discourse pre-treatment was one of poor self-identity. Post-treatment, Diana stated, “I think I’m stronger. I’m more assertive”. A change in terms of improved confidence was indicated in the following statement: “I’ve got more confidence. I think I am quite a capable person. Before, people would say, ‘You are a capable person’, but I wouldn’t believe them.”

Diana’s post-treatment descriptive statements of “more confidence”, “quite a capable person” indicate a shift from pre-treatment descriptions of “not an ounce of confidence”, and “useless”, whereas statements about increasing strength (“I’m stronger”, “I’m more assertive”) had developed as buffers against others’ comments, which had previously had a very negative impact: “my confidence can be in the pits with one remark”. Her discourse had shifted to one of empowerment and stability.

Thus, although the impact of long-term childhood maltreatment had led to alterations in self-perception (CP Criterion 4), some change had occurred in the course of the treatment program for Diana, who now described herself in more positive terms.
Alterations in Interpersonal Relationships

Only limited improvements in her relationships were indicated by Diana by the end of the treatment period. Pre-treatment, Diana had reported a sense of isolation, and her descriptions of her relationships and friendships portrayed isolation and aloneness. Diana reported that she had moved away from many of her friendships due to criticisms over her choices in relationships: “Over the years, there have been some relationships I’ve totally divorced myself from. They’ve got nothing more to give… I ended up isolating myself as it is easier – I got sick of the criticism.”

Diana reported having only one true friendship: “I have a new friend, and she is the only person I can really rely on – but even she let me down one time.” Diana had also stated that she had become less trusting of men: “My experiences have changed the way I view males in that they are weak and selfish – and self-centred”. She also stated a lack of interest in future intimate relationships:

I don’t want to experience love with anyone else… have built a wall around me and I am not going to let anyone else in because I’ve said, ‘Nobody is going to hurt me again the way he hurt me… it’s just not going to happen because I’m too scared to let my wall/defences down’.

On the whole, little optimism was expressed in regard to other people: “I really do have the feeling that this is my lot in life [remaining isolated] and I have to wear it.” This discourse was one of defeat.

At the end of the treatment period, however, Diana was still leading a relatively isolated life, and was not seeking a close or intimate relationship. Although she did not refer to her friendships in the final interview with the independent psychologist, the fact that she had not made any changes in this area of
her life was an indication that she had remained “divorced” from them, that she still had “a wall” around her, and that she remained “too scared to let her defences down”. Diana did, however, report that her relationship had resumed with the man from whom she had been estranged for over a year – and perhaps this was an indication of some breaking down of the barriers. Diana also reported that she had developed more strength in managing the difficult relationships in her life, stating, “Generally, I don’t take things as personally as I had in the past… I’ve become better with this too.”

Specifically, Diana reported responding with greater strength to her son:

I’m feeling stronger with him. Less teary about all that. And I’ve been able to think, ‘Well that’s their problem - not mine.’ I know it’s nothing I’ve done – and I get on with what I’m doing. I separate myself. Diana’s discourse here is more one of detachment than defeat.

On the whole, the difficulties with interpersonal relationships experienced by Diana and related to her long-term childhood maltreatment (CP Criterion 6) did not appear to have changed markedly in the course of the treatment program.

*Alterations in Affect Modulation*

The language used by Diana pre- and post-treatment in regard to affect modulation was fairly similar in terms of its negativity. Pre-treatment, Diana used terms such as “sad”, “depressed”, “resentful” and “pessimistic”. In describing her pessimism, she stated, “I’ve always been a pessimist (or a realist?). It’s a defense mechanism. If I expect little, then I’ll be happy if I get more.” Diana also reported social anxiety (“I am quite anxious about social situations”) and describing herself as “anti-social”. Post-treatment, Diana’s use of language was similar to that used pre-
treatment: “I think I still get a bit of depression – and a bit sad about things – Yeah I think I still do – but I’ve lived with it for so many years.” She also stated,

Sometimes the sadness is overwhelming. It sweeps over me like an ocean.

You know it really can, for the most part. It might stay with me for days – or for hours. I think, why am I like this? Why can’t I shake this? I don’t know.

It’s like there’s something missing. I can’t put my finger on it. It’s a really difficult one.

Again, this is the language of pessimism and defeat.

Post-treatment, Diana reported that she had developed strategies for dealing with her depressed moods:

I just tend to shake it off. I go for a walk and I guess I am just coping with that side of it. As I normally would. I just try and take my mind off it. I try to tell myself, ‘There are people who are worse off than you’.

This discourse is one of management and control. However, on the whole, the difficulties with affect regulation experienced by Diana and related to her long-term childhood maltreatment (CP Criterion 2) did not appear to have been reduced significantly in the course of the treatment program.

Another symptom that indicated limited improvements was “Alterations in Belief Systems”. Although Diana reported feeling better about the future, and less despair, she attributed this to the return of her son to her life – not to the treatment program. Diana did, however, indicate that connecting with him again was indirectly associated with the work done as part of the program.

**Summary**

Thus, on the whole, Diana’s language was not noticeably more positive at the end of the program than prior to the commencement of the program. Although the
language used to describe herself indicated a more positive view of herself, that used
to describe her interpersonal relationships and affect was similar to pre-treatment
language. Diana’s use of language, therefore, did not indicate that CP symptoms had
been reduced or that any marked “ego strengthening” had taken place as a result of
the treatment program.

Percy

Four CP symptoms were initially identified for Percy (“Alterations in Self
Perception”, “Alterations in Affect Regulation”, “Alterations in Relationships with
Others”, and “Alterations in Belief Systems”), but given that the results provided on
post-treatment psychometric inventories indicated no improvements in any of these
symptoms, it could be expected that self-report would also indicate this. An analysis
of the language used by Percy to describe his “self”, his capacity to regulate his
emotions, his belief systems and his interpersonal relationships prior to treatment –
and then post-treatment – indicates negligible shift for Percy as a result of the
treatment program.

Alterations in Self Perception

Percy’s language, pre-treatment, indicated a very low self-esteem:

There is total lack of self-esteem: I’m not good enough. I’ve never been good
enough – always comparing to other people. In my eyes, never meeting
expectations that I’m as good as anyone else.

Percy also described himself as “a very insular person – no friends – no connection
with anyone”. This is the discourse of total self de-valuation.

However, post-treatment, Percy’s descriptions about himself were still very
negative, portraying a sense of disappointment in him self for not making progress in
the treatment program (and thereby, not meeting others’ expectations). To illustrate the disappointment he felt in himself, he used a lengthy and descriptive analogy of a swimmer who has difficulty getting out of the change room, then onto the blocks, and then into the pool – and finally heads back to the dressing room. Percy stated that he felt he had managed to get onto the blocks (i.e., engaged in the program), but was heading back to the dressing room:

I got on the block – and now, am standing on the blocks, backing away – and you know it’s not normal, you know it’s not good – but highlighting that ‘not good’ again reiterates to you that you are dysfunctional.

In this final description of himself as “dysfunctional” is an indication that Percy’s view of himself had not changed from being “not good enough” “never meeting expectations”, and “total lack of self esteem”. Post-treatment, Percy also indicated that his sense of identity was still not strong – and was more something he had “created”. He stated, “I am wondering how much of me would have been there had life been normal – and how much has been created, cause I didn’t have an identity – and I created one”.

On the whole, the effects on self-perception related to Percy’s long-term childhood maltreatment (CP Criterion 4), did not appear to have changed markedly in the course of the treatment program. His discourse was still that of self-deprecation and self-devaluation.

*Alterations in Interpersonal Relationships.*

Pre-treatment, Percy’s portrayal of his relationships with others depicted a lack of trust in others, which can best be described in his own words:

There is a total mis-trust of everyone to the present day. I go into a one-on-one connection with someone and it’s like a battleground to me – you’re
going to war every time you meet someone. If you go into a shop to buy a paper, you are going to war. ‘Cause that’s a person and that means hostility. And that’s the same with every situation – at work – or outside of work. You must always be on guard – must never show any sort of weakness.

The use of words “battleground”, “war” and “hostility” is significant, indicating the extent to which Percy perceived others as enemies and as very threatening. This perception not only led to distrust, but also led to social anxiety (and impatience with others in social situations) for Percy, as indicated by his following pre-treatment description:

I also hate being in social situations. There was one Thursday night… didn’t know how to interact. I took a back role. People always talk about TV shows and things like that – and things they’re doing in their personal life – and I don’t know any of those things. So my conversation is limited to crunching numbers… When they try and draw you in to the conversation, I’m not very good at being drawn in.

Again, strong negative words (“hate”) are used in describing relationships with others. Some of this “hatred” could be explained by a feeling that he was being mis-interpreted by others:

People usually think I’m snobby and aloof (not shy). They see me as domineering person and very much in control. They see me as unfriendly, as looking down on them – and I don’t. I just don’t have the social skills, or the ability – and I go the other way and get very protective. And they perceive me as being very cold – not enjoying their company.

On the whole, Percy’s discourse is one of mis-trust, hostility and suspicion. Post treatment, Percy still used strong negative language to discuss his interpersonal
relationships: “I don’t trust anyone really. I am very cynical.” This statement is reminiscent of Percy’s pre-treatment statement of “There is a total mis-trust of everyone to the present day.” The irritability towards others apparent in his pre-treatment (“Ten years ago, it wasn’t so much of an issue – but now it seems to have gotten worse – the irritability and intolerance of other people”) appeared to still be present in Percy’s scornful description of the people in group therapy: “Some people just let it all go – they babble on… I’d sit there for an hour and not say a word and let them have their hour of therapy.”

One relationship pattern described by Percy pre-treatment was his need to one major relationship/friendship (“I always have to be in a relationship. I don’t know why, but there is no-one else whatsoever… but it can’t be that same person forever, so to speak.”) – and then his strong desire to sabotage that relationship was described by Percy during the course of this program. Percy described the way he then sabotaged relationships:

Then that sabotaging –putting a distance between me and the person in an emotional sense – I think of everything under the sun why I don’t enjoy being with that person and why it won’t work. It all starts off internally at first – me feeling very distant from them: ‘This has got to finish, this has got to finish – even on the outside I’m still trying to be close to them and showing affection and saying, ‘Oh yes I love you very much’ – and on the inside it’s sort of crumbling down – and that feeds into the relationship – and how I actually react /come across in the relationship.

Percy had initially described his only relationship with his partner of five years. However, in the course of the program, Percy reported distancing himself from that relationship, and towards the end of the program, Percy ended this
relationship with his only friend of five years. He stated, “We are more friends now – I am trying to mould her that way… she would like more… but I couldn’t meet her expectations.” This statement indicated that, in the course of the program, Percy’s capacity to form and maintain relationships had not noticeably improved. The sabotage, the “putting a distance between me and the person in an emotional sense” (described pre-treatment) was a recurring pattern.

On the whole, the difficulties with interpersonal relationships experienced by Percy that are related to his long-term childhood maltreatment (CP Criterion 6) did not appear to have been reduced significantly in the course of the treatment program.

**Affect Regulation**

Pre-treatment, Percy’s descriptions of his affect indicated strong feelings of depression and self-blame:

As long as I can remember, I’ve always been depressed… I’ve never found enjoyment in anything. It’s always bleak and black. I use it as a tool to prove that everything is bad – and nothing is enjoyable. Only other people have enjoyment. I never have enjoyment. I’m being punished for being me.

The alliterative effect in ‘bleak’ and ‘black’ depicts the darkness and depression. The extreme despair and sense of hopelessness was also expressed in the following:

Depression is a black dog – a weight, a sort of heaviness – you know you’re only one comment away from bursting into tears. I am all or nothing – totally numb. You’re not emotional – you’re numb… it’s a total battle to stay together – to put on this front at work – and then come home and sit there at night. I sit there and think, ‘Christ, I’m 37 now and this is it. What’s the point of being like this? Then you’re 47, then 57.’
Percy’s constant negative thinking patterns were also described by him pretreatment:

I worry about time, about money, about my age. About life. I worry about my depression – and that I’m never going to get that project finished – that I’m tired – that I don’t have enough resources. And that sort of worry paralyses you to a certain extent.

The anxious thoughts also affected his capacity to sleep:

Sleep is a marked problem. That comes down to the worry all the time – the constant worry and regret. You just play things over and over in your mind.

You’ve had all these opportunities and you’ve destroyed them all.

However, Percy’s descriptions of his affect in the final independent evaluation indicated no shift in his mood state. His discourse was still that of despair and hopelessness and Percy still described himself as “depressed, down”, but stated, “it has not been flat throughout the six months – but it has come back down.” Several weeks prior to the end of his attendance, Percy’s ex-partner had contacted me in regard to Percy’s suicidal thoughts. The sense of despair and hopelessness did not appear to have shifted in the course of the program.

However, despite this Percy had been able to develop motivation about some aspects of life: “I have become more motivated to study again – I have started a Masters Degree. I am probably a bit more focused and motivated as far as my work goes, than when I first started. Probably due to going back to the building blocks – the foundation – that gave me the impetus to go ahead and do that.”

*Summary*

An analysis of Percy’s use of language in his descriptions of himself, his mood state, his belief systems, and his interpersonal relationships indicated the use
of negative descriptions in all areas – both pre-and post-treatment. There were no indications, in his language use, that any noticeable reduction of CP symptoms or “ego strengthening” had taken place in the course of the treatment program. The most significant indicator that Percy had not experienced major improvements as a result of the treatment program was that, after completing his sessions, Percy attended my offices to return some books, and was openly hostile toward me. When I asked him whether he thought the program had lead to any improvements, he answered, “No” and stated that he did not wish to continue with the remaining sessions. As explained in Chapter 7, because Percy was not experiencing improvements in his life, it is possible that he viewed this program in the same way that he had viewed previous therapy attempts – ‘useless’. Percy’s initial low expectations about the program were thus fulfilled.

**Geraldine**

Four CP symptoms were initially identified for Geraldine (“Alterations in Self Perception”, “Alterations in Affect Regulation”, “Alterations in Belief Systems”, and “Alterations in Interpersonal Relationships”), and given that the results provided on psychometric inventories indicated marked improvements in these symptoms, it could be expected that self-report would also indicate this. An analysis of the language used by Geraldine to describe her “self”, her capacity to regulate her emotions, her belief systems and her interpersonal relationships prior to treatment – and then post-treatment – indicates a definite and marked shift in all three areas.
**Alterations in Self Perception**

In describing herself pre treatment, Geraldine reported having “an inaccurate picture” of herself (related to the messages given to her by her father), and used terms depicting confusion and lack of self knowledge: “I’ve got a bit of warped perception”. Geraldine’s lack of a strong identity was depicted in her tendency to change her “persona” to suit the situation. This is best described in Geraldine’s statement:

I am not sure about the real “me”. I have a different face for different people. I guess the closest I get to honest is at home with my husband – and he’s the person I’ve know the longest. I behave in different ways around different people… I keep different parts of my life separate – some of it’s about social appropriateness – but some of it – I go beyond that. I take it to an extreme. If there was someone sitting on my shoulder for a month, they’d recognise that there were very different people.

Thus, pre-treatment, Geraldine’s discourse is one of uncertainty in regard to her identity. Post-treatment, Geraldine’s descriptions revealed less confusion and more confidence in herself: “I see myself in a far more positive light than I used to – am not nearly as negative about myself as before.” Geraldine described herself as “a capable person” and “an intelligent human being”. Much of Geraldine’s confidence stemmed from developing the knowledge that she was able to change the way she felt:

One thing I gained was the feeling and the confidence that I could do things to change the way I felt – and thought – my life basically – I had the ability to make those changes that I needed to make – instead of being stuck in a rut –
there’s no way out… The fact that I managed to make some changes made a huge difference to my confidence.

Geraldine acknowledged that having a baby had also contributed to her increased confidence: “Part of it has been facilitated by having a baby. That makes a big difference as to how you see yourself – it changes your focus a lot.” However, despite this, she saw positive changes in her self-confidence. Her discourse post treatment was one of certainty and self-assuredness.

On the whole, Geraldine’s uncertainty in regard to her self identity, and related to her long-term childhood maltreatment (CP Criterion 4), appears to have been improved significantly in the course of the treatment program.

**Alterations in Interpersonal Relationships**

Pre-treatment, Geraldine reported that relationships were difficult for her, especially her marriage. She described the legacy from exposure to her parents’ relationship:

I just don’t know the correct way to behave. My parents always screamed and shouted at each other, and sitting down and sorting out problems for mutual benefit is a sort of foreign process. And I have the bad habit of making fun of my husband, when I shouldn’t as it's the way my father use to treat my mother.

Geraldine indicated, post-treatment, that she had learned more appropriate “ways to behave” within her marriage: “I think we do listen to each other a lot more than we did prior to me doing the program. I know in myself I am a lot more conscious about how Ray [her husband] might be feeling.” Geraldine also reported “going to my husband and saying, ‘I’m a bit annoyed about this’ instead of throwing
something at him or calling him names.” This is a discourse of “feeling informed” and more certain.

Pre-treatment, Geraldine also reported difficulties with honesty within a relationship, in terms of saying what she really thinks. She stated, “I didn’t learn to be honest in relationships in our family. Turning around and telling Dad what I thought would have been a bad experience”. However, post-treatment, Geraldine reported more honesty in relationships and attributed her greater honesty to her increased self-confidence gained during the program.

Pre-treatment, Geraldine also reported difficulties with affection within her relationship: “As my parents were never affectionate towards each other, I also have problems with affection… I used to find it very embarrassing to be affectionate in front of other people.” Geraldine reported that her increased self-confidence had also lead to increased capacity to display affection in her relationship with her husband.

Pre-treatment, Geraldine had also referred to difficulties with trust. She reported that it had always taken her a long time before she could trust people (she stated, “I put up barriers to keep them out of certain areas of my life”) and open up to them – this was especially so with her husband, and has also been the case with friendships. In the course of the program, Geraldine’s trust appeared to have increased, with expansion of friendship groups.

Thus, pre-treatment, Geraldine’s discourse around relationships was one of uncertainty, revealing a lack of knowledge about how a “good” relationship might be. It was also one of dishonesty and mistrust. Post-treatment, Geraldine’s discourse was different – it had become one of honesty, openness and “being informed”.
On the whole, Geraldine indicated quite a marked improvement in many aspects of her interpersonal relationships (CP Criterion 6) in the course of the treatment program.

**Alterations in Affect Regulation**

Geraldine reported suffering from depression from a very early age. Although the episodes had not been as frequent in later years, Geraldine believes that she always feels vulnerable to depression. She described early severe depression:

I’ve come to realise I’ve suffered from depression for a long time. I was always – even in primary school – I was always the loner kid – the bookworm in the library. I didn’t have many friends – and that used to upset me. I can remember, as a kid, wandering around the house at all hours at night – and unable to sleep – while everyone else was asleep… Kids of 9, 10 or 11 shouldn’t have problems sleeping. I also had a bleeding ulcer. It was around exam time – that probably added to my stress… I actually dropped out if high school in year 10 – although I had been a ‘straight A’ student until then. I can remember a teacher ringing Mum, concerned that I was always with books, never talking to other children. I never seemed to play – that went on right through school. Geraldine’s depression had returned several times since those early years and Geraldine reported symptoms of depression when she entered this program.

Post-treatment, Geraldine reported no depression and also reported that she was better able to appraise her moods, stating that she now looked at her mood changes more realistically and objectively: “I feel that I can be a little bit more objective – to stand back and look at myself – and say, ‘No it’s not depression – it’s just a bad day’”. This capacity to appraise her mood more realistically appeared to
stem from having greater understanding of depression, as gained through the program: “I am certainly a lot more aware of individual symptoms and so on that when I first came to Pam [therapist].”

Geraldine reported that she was doing some things that were going to prevent depression occurring, planning who she would talk to and establishing support networks (parent groups). Geraldine also reported that she had planned to walk on a daily basis with some neighbours and attend a hospital ‘shape up’ group. Statements regarding all of the above indicate that Geraldine’s awareness had helped her to put in place some strategies that would help avoid further bouts of depression. Post-treatment, Geraldine’s discourse in regard to her mood was around knowledge, awareness and prevention.

Pre-treatment, Geraldine had also reported that she has had difficulties with anger management over the years:

Sometimes, when I think there is too much to deal with, I’ll get irritable. I’ll lose my temper and get really angry. I have difficulty calming myself down.
I’ve got my father (and my mother’s) temper. I don’t think either of them illustrated that anger was OK, nor illustrated how to deal with it.

Although Geraldine and her partner did quite extensive control around anger management as part of the treatment program, Geraldine did not feel that they had made effective use of this mainly due to tiredness: “I think I still need to work on the control of my temper a bit. There are a couple of times when I have been at the end of the rope [with family members].”

On the whole, the difficulties with affect regulation experienced by Geraldine and related to her long-term childhood maltreatment (CP Criterion 2), appear to have become less of a problem for Geraldine, as with increased self-knowledge,
awareness and management strategies, Geraldine’s confidence in regard to regulating her mood had increased greatly in the course of the treatment program.

*Alteration in Perception of Perpetrator of Abuse*

Geraldine reported a changed attitude towards her father more recently:

“I did tell him to ‘bugger off’ if he did things I didn’t want. I did have the confidence to put my needs before what he wanted. And I don’t think it was something I had done before. Dad always ruled over our lives.

Geraldine also reported being more objective in the way she saw her father – and less easily upset by him. Thus, in the course of the program, a change was indicated for CP Criterion 5.

*Alterations in Belief Systems*

Geraldine attributed most of belief system changes to the birth of her baby:

“The baby has changed that. I very much see him as a gift which has strengthened my spiritual and religious beliefs.”

*Summary*

Geraldine reported notable improvements in all CP symptoms. Her language in her final independent evaluation reflected marked improvements in her self-confidence and her belief that she had the capacity to change her life. Geraldine also reported improved relationships and also greater honesty in her relationships. She also reported an ability to be more assertive with people in general, in particular, her father, attributing this to her increased self-confidence. Geraldine further reported some improvements in her capacity to control her emotions, although believed that this was more difficult with a new baby and little sleep. Despite this, changes were still evident here. On the whole, the discourse of the final interview is indicative of “ego strengthening” having taken place.
Matt

Four CP symptoms were initially identified for Matt (“Alterations in Affect Modulation”, “Alterations in Belief Systems”, “Alterations in Self Perception”, and “Alterations in Relationships with Others”), and as the results provided on psychometric inventories indicated marked improvements in these symptoms, it could be expected that self-report would also indicate this. An analysis of the language used by Matt to describe his capacity to regulate his emotions, his belief systems, his “self” and his interpersonal relationships prior to treatment – and then post-treatment – indicates a definite and marked shift in all areas.

**Affect Modulation**

In his pre-treatment interview, Matt reported depression, anxiety, self-absorption, guilt and self-blame. In describing his guilt, Matt stated, “Recently, in the last month, I was sitting at home, and all of a sudden, there was this massive amount of guilt came out.” He also reported that he had been tearful whenever he thought about the child he had killed. Matt had also displayed strong self-focus and introspection, as expressed in Matt’s words: “I find it hard to focus on other people in my life. My whole focus is on myself.” Matt also reported that he had not really been able to enjoy life much since the accident in which the child was killed. He stated, “Now, I don’t want to go out much. If I go out night clubbing, I feel that I shouldn’t be there.” Matt also described anxiety in some situations: “I hate being in crowded situations. I can feel my heart rate increase and I start to get sweaty.” Matt reported having panic attacks and increasing levels of anger: “I’m not normally an angry person – but more recently, have been snapping at people, and really irritable.” Matt’s discourse, pre-treatment was around introspection, guilt and self-blame, coupled with fear.
Post-treatment, Matt’s language portrayed a more positive picture, someone who has learned and used strategies to regulate his emotional state. He reported, You still have moments when things come up and you still feel really awful, but I am able to deal with it a lot better than I was before. Instead of panicking about the situation, I am able to calm myself down and acknowledge what it is about.

Matt reported that he believed the “release work” had been most effective in helping him modulate his emotion. He explained the process as he viewed it: Through talking, things would come up, and then I would cry. I was brought up a person never to cry, but I’ve never seen so many tears. I must admit, sometimes if I stop myself during the cry, and don’t finish the cry, you can feel it still there. But if you’ve done all that crying, then you feel a lot better. But I’ve done a lot of release work.

Matt also used writing to help modulated his emotions: “Sometimes when things come up I go and write – what I am feeling – and then I write something positive at the end.” Matt explained that, when “things” came up, he needed to do something with them: “If I don’t do something with it, then I don’t sleep that night – it just keeps going round and round and round… When each thing comes up, I’ve ‘gotta do something with it.”

Matt reported that he has not felt depression for quite a while. He stated that, when memories return, or when he starts to think or feel negatively, he uses strategies to help himself maintain a positive mood:

I just have to have some strategies in place – just acknowledging it [the memory/thought] and saying I’ll look at it that afternoon – and do something about it then. As long as I acknowledge it coming up and stuff… instead of
just fighting it, I’ve come to realise you can’t just keep pushing it away. I have got to deal with it now to be able to heal.

Matt is also better able to deal with his negativity. He stated,

the biggest thing for me has been the negativity that’s come up with it [the release of emotion] – and that’s been the hardest thing to deal with. Some days, you really try to work hard to turn the negative around to positive. It’s got easier as we’ve progressed through the six months but in the initial times, looking at it was very painful.

Matt also reported that has been able to deal more effectively with memories of the past/negative thoughts returning, revived by his children: “I have been able to turn that around – like some strategies we’ve put in place – to focus on the present – when I’m with them – just acknowledge that feeling – and focusing on the present.”

Thus, the descriptions used by Matt in his final interview with an independent psychologist are typified by confident statements about being able to manage his emotions: “I am able to deal with it a lot better than I was before – instead of panicking about the situation, I am able to calm myself down and acknowledge what it is about.” Matt indicated a real understanding of the importance of dealing with emotions: “When each thing comes up, I’ve gotta do something with it”, and “I’ve come to realise you can’t just keep pushing it away. I have got to deal with it now to be able to heal.” The overall improvement is indicated in “It’s got easier as we’ve progressed through the six months.”

On the whole, the difficulties with affect regulation experienced by Matt (CP Criterion 2), appeared to have lessened in the course of the treatment program. Matt’s discourse changed from one of fear, self blame and guilt to one of self-empowerment.
Somatic and Health Concerns

Pre-treatment, Matt described a range of somatic concerns, these having intensified more recently, with the revived memories of past traumatic incidents. He stated, “I’ve held it all inside myself for such a long time – just didn’t talk about it. And now I think my body is letting it all out.” There have been gastric complaints: “In the mornings when I wake up, my stomach doesn’t feel right – and then I just vomit. And then when I vomit, my body feels like it’s let go of something – and I feel a lot more relaxed.” Matt also reported a lot of headaches over the past two years, and pain in other parts of his body: “I still felt a lot of tension – day in, day out, all the time.” In the initial stages of his treatment, Matt was disturbed greatly at his bodily symptoms. Post-treatment, however, Matt reported that, “occasionally” it happens, but he has learned to reframe these bodily symptoms – and not to fight them:

I look at it now as if I’m progressing along the line of releasing some stuff. Instead of it being a negative thing, I would try and turn it into a positive thing – that I’m moving along – what I call the gravy train – and get a bit closer to recovery.

He also stated:

I am realising now that it’s part of the healing – and it’s a way of releasing. Some mornings if I don’t throw up or shed a tear, then it burns around my body the whole day – and if I do, I’m calm the rest of the day.

This latter statement indicated greater understanding and awareness of what was happening. Matt’s discourse around his somatic concerns had changed from one of frustration and helplessness, to awareness and understanding. There was also an indication that Matt’s body was responding positively to the treatment: “For 17
years, I didn’t put on any weight – I was 20 kilos underweight. I’ve now put on 15 kilos in the last 6 months.” Matt believes that this weight increase was related to his release of the past.

*Alterations in Belief Systems*

At the commencement of the program, Matt reported “a sense of helplessness”. He stated, “I believe that I deserve to feel better and to ‘live my life’. It seems a burden at the moment.” However, post-treatment his language was much more positive:

> I am a lot more positive about the future now. I realise I have still got a fair bit of work to do with the stuff from my past – but I take one day at a time; and yeah, I used to be discouraged about the future, but I don’t seem to be any more. I set little goals to achieve each day. I’ve worked on this with Pam [the therapist]. I don’t look way not the future – and plan – I just take each day as it comes.

This is a much more positive statement than the initial description, depicting life as a “burden”. Matt’s discourse had changed to one of optimism. On the whole, the alterations in belief systems experienced by Matt (CP Criterion 7), had been affected in the course of the treatment program, with increased positive attitude and reduced despair/hopelessness.

*Alterations in Self Perception*

Matt indicated that he saw himself in a more positive light than prior to treatment: “Basically I see myself as being a lot better than when I first come to Pam”. Much of this was related to developing strategies that allowed him to feel greater control of his symptoms, less helplessness, and reduced guilt and self-blame.
Matt described that he had had “a whole life change”. Thus a change was seen for CP Criterion 4 in the course of the treatment program.

**Alterations in Interpersonal Relationships**

Matt believes that his past experiences have always affected his desire to form friendships. Pre-treatment, he stated, “I’ve only got one really good friend whose been with me – who was a friend of mine when the accident occurred… a lot of other friends just fell through the loopholes.” Matt expressed a great deal of anger in regard to past close relationships (such as that with his ex-wife). However, Matt had more recently formed a new close relationship, and his relationships with his children were also being maintained.

Post-treatment, Matt indicated that he had released much of the anger associated with past negative relationships, and that this had allowed him to move on. He had recently become engaged to his partner. Thus a change was seen for CP Criterion 6 in the course of the treatment program.

**Summary**

Matt’s more positive language in the final interview with an independent psychologist indicated improvements in all CP symptoms identified (affect modulation, and health concerns, his interpersonal relationships, and self perception). The positive language also indicated that “ego strengthening” had taken place for him. Matt stated that there had been “heaps of changes” and that, “it’s been a whole life change.” He stated:

Pam has worked with me really well, and I really appreciate what she has done with me because I have been to other psychologists, and no-one has ever shown me how to deal with things – and I think this has been a very positive experience.
Renee

Five CP symptoms were initially identified for Renee (“Alterations in Self Perception”, “Alterations in Affect Regulation”, and “Alterations in Relationships with Others”, “Alterations in Perception of Perpetrator”, and “Alterations in Belief Systems”). An analysis of the language used by Renee (pre- and post-treatment) to describe her “self”, her capacity to regulate her emotions, her interpersonal relationships, her belief systems, and her perception of her father indicates a marked shift in these areas.

Alterations in Affect Regulation

Renee described the depression she was experiencing prior to her involvement in the treatment program: “I then started to fall into a very big depression - it was hard for me to get out of bed, hard for me to get to school, hard for me to do my homework, and I was worried I would fail in my course.” Renee also described “helplessness” – experienced from an early age – a feeling that has persisted. She also described “emotional numbing”, being unable to connect with emotions. However, Renee has, at times, experienced severe panic attacks. She describe her most recent one, prior to entering the program:

My whole body was going through these waves of panic attacks all the time. My heart was out of control. I felt that I was out of control. I thought that I might kill myself – and that people might think I was insane. I felt I had lost my identity – I didn’t know how to behave – I was completely out of control.

The above descriptions portray someone who has little control over her emotional state. Renee’s discourse around her emotions was one of emotional...
disengagement. Post-treatment, Renee reported an improved state of mind, as indicated in her own words:

And things are getting better. It’s just taking a bloody long time. I feel that now I’m coming to the end of it. Starting to see reality a bit more… I’m definitely a lot better now. I am feeling so much better now. I can’t even tell you what the difference would do on a scale.

This is a much more optimistic statement – and Renee’s repetition in “I’m definitely a lot better. I am feeling so much better” is indicative of someone who is quite certain of her improved state of mind. Renee stated that hypnosis had been useful in helping her embrace a more positive state of mind: “Hypnosis has also been useful – imagining myself in the future has made me feel happy.” Renee also reported that some of the previous emotional numbness had started to disappear. She stated, “I am starting to feel again. But it’s taken a long time – and I didn’t think it would happen.” At another stage in the interview, Renee stated, “I do have them [emotions] come back occasionally – they are starting to come back now – but they are mild.” Renee also reported returning to undertake courses and activities, and reported looking toward the future, and this was not present prior to her treatment. She stated, “I am doing a music course – and I can see some potential there for the future.” This statement expresses an improved state of mind to that expressed in “it was hard for me to get out of bed, hard for me to get to school, hard for me to do my homework”. The discourse around emotional regulation had changed from one of helplessness and emotional disengagement to one of re-engagement, self-empowerment and taking control. However, long-term planning and setting long-term goals still appeared difficult for Renee: “It’s hard to see long-term and it is hard to make realistic goals. I can only really see short term and take one week at a time.”
Despite these difficulties, Renee’s statements indicated that at least there were thoughts of a future, as expressed in the following concerns about the future and the impact of the loss of years due to her mental state: “I want to do singing, and I want to do these things, and … I can’t start doing it when I’m 40 or 50. I’ve got to do it now.” Renee also indicated that she was contemplating a future by stating that she would like to have two children at some stage in the future. All of the above statements are indicative of someone who is no longer feeling little control of her emotions. Renee confirmed in other statements that she was now more in control of her emotions. She stated, “I’ve got more patience than I ever had… I was extremely impatient before – with everything … And now it’s like - oh well - I’ll get there eventually.” She also reported better control over anger and described the change: “I used to be a very angry person – very angry about things because of my past. And now I look back at things that my Dad did to my sisters and my Mum and to me – and I don’t feel anything.”

Although the impact of long-term childhood maltreatment had led to difficulties in regulating affect for Renee (CP Criterion 2), a change had occurred in the course of the treatment program, with Renee developing a greater capacity to manage her emotional states.

*Alterations in Self Perception*

Renee reported believing from an early age that there was something innately wrong with her – that perhaps she is evil. In the period prior to entering the treatment program, Renee portrayed the way she viewed herself in extremely negative terms:

I got to the point where I despised myself fully. I pretty much hated 100% of who I was. I was extremely harsh on myself and other people. But I tried to put on a mask… I felt like the biggest failure… and I didn’t know who I was
at all... I told myself, “You’re pathetic. You’re ugly. You’re a failure. You’re fat. You’re never going to be good enough. You’re stupid.” All those things that had been ingrained into my head – and I hated myself – and deep down I was an evil person.

The above discourse used by Renee to describe herself (with such words as “despise”, “hate”, “pathetic”, “failure”, “ugly”, “stupid”) portrays strong emotions and extreme self-hatred. Renee also indicated some insecurities in regard to her weight, reporting that she had recently increased her weight again.

Post-treatment, the language used by Renee to describe herself was not characterised by the extreme negativity displayed pre-treatment. In describing herself, Renee used the words, “free”, “open”, and “vast”, and reported:

I see my self as being re-born. I am trying to see that in a positive way – to look at is at an evolution. I feel really free... I’ve only got a small part of me that still remained from before.

These statements of being “re-born”, “free” and “open” are a reflection of Renee’s desire to break free of the negative images held of herself in the past. Renee’s discourse is now forward-focused and optimistic. Renee later commented that the work on self-concept was one of the most valuable aspects of the program: “The work on my self concept helped me at the time - and learning how to do affirmations was great.”

Although the impact of long-term childhood maltreatment had been an alteration in Renee’s self-perception (CP Criterion 4), a change had occurred in the course of the treatment program, with Renee developing a more positive self-image.
Alterations in Interpersonal Relationships

Pre-treatment, Renee reported difficulties in her close interpersonal relationships (mother, sisters, and close intimate relationships). Post-treatment, Renee was still experiencing some difficulties in her relationships with friends and family. She reported ongoing difficulties with her older sister. However, she also stated that her relationship with her mother had been improving more recently, “through being with her through this experience – through conversations we’ve had – arguments we’ve had – through her learning and my learning, we’ve become closer than we ever were.” Renee also reported that, as a result of her father’s treatment, she had developed negative views of men:

Men are horrible to women – and women are slaves and do all the work. And you have to do what the man says or he’ll just muscle you… I got really scared of men and put on a lot of weight and tried to look plain and dowdy – and started to wear men’s clothes – I bought men’s clothes – and started covering up.

These statements are an indication of the extent to which Renee had been influenced by her father’s actions towards her and others.

Renee also reported continuing difficulties in relationships with males, and after two relationship breakdowns (in her early twenties), Renee blamed herself for the demise of these relationships, telling herself, “I’m fucked. I’m just fucked. I get all these amazing relationships with people and I can’t hold them down. I’m insecure. I’m unlovable.” Renee also expressed some uncertainty about her sexuality, her decision to look for happiness with a woman being described in the following:
That’s it. I don’t want to be with men any more. I want to be with women. I am going to try and be with a woman as I am sure that has much more chance of working out and I am sure I’ve got less chance of being abused. And I had had enough of men with problems. And I started thinking in other ways – that there were other choices and options.

Renee reported increased feelings of safety when with a woman and stated: “I feel that [being with a woman] is a better option for me right now. I just had so many issues towards men. I just couldn’t face it. I was just sick of it.” However, in the course of the program, Renee once again reported that she was confused about her sexual orientation when she became involved with a young male for a few months – and then another female. She reported that these two experiences had left her still unsure about her sexuality. However, in therapy sessions, Renee was able to gain greater understanding in regard to sexual orientation and to become more comfortable in experiencing different parts of herself and trying out different roles. This lead to increasing self empowerment in regard to her sexuality.

Although many of Renee’s difficulties in interpersonal relationships, related to long-term childhood maltreatment (CP Criterion 6) persisted following the treatment program, there was evidence of some small shifts, and that Renee was gaining more awareness and understanding of herself and others in relationships.

*Alterations in Perception of Perpetrator*

Renee’s statements in regard to her father, made in the final evaluation interview, indicated a shift from anger to “feeling nothing”:

I feel nothing at the moment. I don’t feel the anger I used to. I used to wish he’d die. I rang my grandmother today – and found out it was his birthday –
but you know, I even forgot it was his birthday. I feel nothing towards him now.

Thus, there had been a change for Renee in CP Criterion 5 (“Alterations in Perception of the Perpetrator”) in the course of the treatment program.

*Alterations in Belief Systems*

In an attempt to discover what was happening in her life, Renee developed a faith in the spirit world – and a belief that spirits can guide us in our lives. Prior to treatment, Renee described how her spiritual awareness evolved at a time of deep depression. She stated, “I have learned to trust some of the experiences I have had through people who can channel – and pick up what is happening with my higher self.” The beliefs expressed in the above statements have persisted with Renee and had not altered in the course of the program.

*Core PTSD Symptoms*

Renee also reported a reduction in the number of times she would re-experience the trauma. Although the process had been painful, she had been able to release much of the past:

> I feel the stuff has gone – it has released. But the process of it was so painful and amazingly devastating. It’s like an atomic bomb has come and devastated the person I was – it’s gone – left me – not my body emotionally – left my mind.

Renee reported that EMDR had been useful in assisting with this: “And the EMDR did work - it was brilliant.” Renee also reported: “I am starting to wake up to reality more than I ever have in the past – since I was a little kid. I can remember seeing things in that real way when I was real young.”
Summary

Renee’s language post-treatment indicated improvements in the following CP symptoms areas: “Alterations in Affect Regulation”, “Alterations in Belief Systems”, “Alterations in Perception of the Perpetrator of her Abuse”, “Alterations in Consciousness”, and “Alterations in Self Perception”. However, Renee still appeared confused about the “real Renee”, portraying that she was evolving. There were also limited changes in terms of “Alterations in Relationships with Others”. Although Renee’s relationship with her mother had improved, there were still difficulties in other relationships, and greater withdrawal from people in general. Distrust was also still prevalent, and Renee reported confusion about sexuality.

Beryl

Four CP symptoms were initially identified for Beryl (“Alterations in Self Perception”, “Alterations in Affect Regulation”, “Alterations in Interpersonal Relationships”, and “Alterations in Perception of Perpetrator”). An analysis of the language used by Beryl (pre- and post-treatment) to describe her “self”, her capacity to regulate her emotions, her interpersonal relationships, and her perception of the perpetrator of her abuse indicates some slight shift in these areas.

Alterations in Self Perception

Pre-treatment, Beryl described herself in both positive and negative terms. She stated, “I don’t feel very good about myself. I don’t know whether I don’t have the education to choose wisely. I learnt a lot (but not enough) with the violent people.” However, Beryl was able to point to many positive attributes, describing herself as “honest”, “caring”, “kind”, “caring”, “loving”, and “strong”. Beryl appeared, on the surface, to have a reasonably healthy self-concept. However, early
childhood and youth experiences had lead to a certain vulnerability in Beryl. It seemed that her choices in life, and accepting poor behaviour, was more about emotional neediness. Beryl reported that she believed that she was “emotionally needy”, that she has craved someone to love her, and so has accepted bad treatment from people over the years just to get a hug – something she missed in her childhood. Cognitive therapy was used with Beryl to develop more positive self statements. Post-treatment, Beryl used the following words to describe herself when interviewed by an independent psychologist: “stronger”, “more confident” and “assertive”, and “able to manage my life alone”. Beryl’s discourse had changed from one of inadequacy to one of empowerment.

Thus, although long-term childhood and adult abuse had led to an alteration in Beryl’s self perception (CP Criterion 4), some change in this change had occurred in the course of the treatment program, with Beryl developing a more positive self image.

*Alterations in Affect Modulation*

Beryl reported that, although she had been very depressed some months prior to commencement of the program, she was now able to manage and symptoms of depression. Post-treatment, however, Beryl reported that she is “not always happy”, and often experiences loneliness, living on her own. She stated that, although she usually appears “happy on the outside”, this is not always the case. However, she also indicated an ability to “pick herself up” if her mood declines, and explained that she gains happiness from her extended family. Beryl also appeared optimistic at her final interview.

There does not appear to be any marked improvement here, given Beryl’s earlier statements of being able to manage her depression. It appears, however, that,
as with other areas, Beryl minimized her sad feelings at the outset, and felt more comfortable expressing how she really felt, as she became more trusting of me. Thus, I did not interpret Beryl’s post-treatments declarations of often feeling sad on the inside as a deterioration, but rather an indication of increasing levels of comfort in discussing issues relating to herself.

*Alterations in Interpersonal Relationships*

Pre-treatment, Beryl indicated some vulnerability in regard to her “ex” partner, the perpetrator of her abuse. She reported that she was still spending time with him, and still allowed him to visit her and sleep over. Her discourse in regard to her relationship with her partner displayed some ambivalence. Beryl also reported becoming somewhat more withdrawn from people, although she made some efforts to go out and socialise with others. Most of her reluctance was related to not wishing to intrude on others with partners. Interpersonal psychotherapy was used in approaching interpersonal relationships with Beryl.

Post-treatment, ambivalence still appeared to be present in Beryl’s discourse when discussing her most recent intimate relationship. Although she reported that she was able to “go it alone” and did not need her “ex” any more, at other stages in the interview, information provided indicated that Beryl was still maintaining contact with the perpetrator of her abuse. However, Beryl reported ongoing supportive relationships with her family and some interest in developing new relationships. On the information obtained at the final interview, it has been difficult to assess possible changes that may have occurred in terms of interpersonal relationships.
**Somatic/Health Concerns**

Beryl developed breast cancer toward the last years of her last violent relationship. She believes that the extreme stress of the relationship contributed greatly to her health condition.

**Minimisation**

Beryl demonstrated a tendency to minimise all the abusive relationships in which she had been. When asked why she did this, she replied that this helped her “block it all out”. Beryl also appeared to minimise her symptoms.

**Summary**

As limited relevant information was provided at the final interview, it has been difficult to draw pre-post treatment comparisons for Beryl. This has been further affected by Beryl’s tendency to minimise the impact both pre- and post-treatment.

**Conclusions Drawn From Discourse Analysis**

The language used by all participants provided a very rich source of material from which to draw conclusions about the changes that had occurred in the participants in the course of the six-months program. In most cases, the language used was consistent with, and reflected, the results obtained in psychometric testing. In some cases (for example, Maria), however, the individual’s language exposed greater change than was reflected in the results of the inventories completed. This can perhaps be explained by the fact that, for many, the statements on inventories used unfamiliar vocabulary, and were perhaps not completely understood by participants. For others, the statements were all-encompassing and general, and may
not have allowed for the subtle changes that an individual can portray through his/her own vocabulary.

For most symptoms, changes were observed between pre- and post-treatment discourse themes. These will be discussed symptom by symptom.

With reference to “self”, a marked change was observed. Pre-treatment, the most prevalent discourse themes were around self-devaluation, poor self-identity (the two most common discourse themes), defeat, low self-confidence, uncertainty and inadequacy. Post treatment, the predominating discourse themes were empowerment, self valuing, increased self knowledge, strength, forward focus, optimism, stability, certainty and self-assuredness. Poor self-identity and inadequacy were predominating discourse themes for only two participants.

With reference to “affect”, a change was also observed in the discourse themes predominating at pre-treatment and post-treatment. Pre-treatment, the most prevalent discourse themes were around despair/hopelessness, darkness, guilt, self-blame, pessimism, emotional numbness/disengagement, fear, and defeat. Post-treatment, the most prevalent discourse themes were around optimism/brightness, self-empowerment and control, other discourse themes being life re-engagement and involvement, emotional expression, knowledge and awareness. Two participants still reported pessimism and despair/hopelessness.

In reference to interpersonal relationships, a change was also seen in the discourse themes predominating at pre-treatment and post-treatment. Pre-treatment, the most prevalent discourse themes were around distrust, disempowerment, fear, avoidance, detachment, defeat, feelings of inadequacy, and ambivalence. Post treatment, the most prevalent discourse themes were around empowerment and trust, acceptance, engagement and involvement, feeling informed, openness, honesty,
certainty, self-confidence. Two participants still expressed discourse themes of distrust, hostility, suspicion, and ambivalence.

With reference to “Alterations in Systems of Meaning”, the discourse theme predominating for those who referred to this was despair/hopelessness (pre-treatment), while post-treatment, it was a discourse of empowerment, moving forward, and optimism. A change was seen for one participant in the discourse around somatic concerns: from a discourse of frustration and helplessness to one of awareness and understanding. For another participant, the discourse relating to the perpetrator of abuse changed from one of blame to one where blame did not exist.

On the whole, the language being used by participants in the program was much more positive and forward-looking (for all symptom areas) one month after the treatment program than immediately prior to the program. “Ego-strengthening”, as described by Chu (1998) appears to have taken place for most participants in the program. Further, the descriptions provided by participants appear to be a more meaningful representation of the changes experienced by participants than information obtained from psychometric assessment. These descriptions are reflective of the participants’ own judgement in regard to their situation, and, as such, provide a richness of description, complete with personal connotation, that is not available from any other source.
CHAPTER 10
DISCUSSION

Evaluation of the Treatment Guidelines/Programs

In this chapter, the treatment guidelines used in this study, and also the treatment programs undertaken by the ten participants, are evaluated. In evaluating the programs conducted with the participants, attention is drawn to recurring patterns of departure from the guidelines as well as strengths and weaknesses of the program overall. Another aspect of the program evaluation is a comparison between the programs implemented in this study and standard PTSD treatments addressing core PTSD symptoms. Suggestions are then made for refinements/improvements in such guideline-based treatment programs. The current research is also evaluated, with a discussion of strengths and limitations of the study, and suggestions for future research regarding treatment of CP.

Departures from/Adherence to Treatment Guidelines: An Overview

For several participants, the program did not evolve as planned. As was indicated in individual case studies, many participants did not see the need to develop a safety plan, and reported, at the outset, “feeling safe”. Most participants were able to re-assure the therapist that they had no suicidal ideation and were not likely to self-harm. Although acceptance of this re-assurance was justified for most participants, for whom safety issues did not emerge in the course of the program, this was not the case for all participants. For two participants (Cynthia and Percy), the safety component needed to be re-introduced as the program evolved, when it became clear that safety issues needed to be addressed. The responses of Cynthia and Percy are consistent with those of many who have suffered long-term/multiple
trauma as children (Bifulco, Moran, Baines, Bunn, & Stanford, 2002; Boudewyn & Liem (1995).

Another departure, also indicated in individual case studies, was that many participants (Cynthia, Maria, Eric, Lucy, Diana, and Percy) did not initially wish to undertake work to assist with their daily functioning, reporting their confidence in their level of functioning. However, this confidence appeared to be unfounded for many participants, who indicated throughout the program that there was a need for assistance with aspects of daily functioning. For example, Cynthia regularly needed to discuss issues related to her daily functioning, although she did not identify a need at the outset. Eric also raised issues associated with daily functioning on almost every session, although he did not initially identify this. For Percy also, assistance with aspects of daily functioning was a major component of the work undertaken – and on an ongoing basis. It is possible that many of the participants believed that they were actually functioning well and did not view the regular occurrence of crises in their lives, or the absence of coping strategies at difficult times, as an indication that they were not functioning as effectively as they might have been. Others may have been able to feel better about themselves and their lives by viewing their daily functioning in a positive way, and not “labelling” this as problematic. Regardless of the underlying factors contributing to the denial of difficulties with daily functioning by Cynthia, Eric, and Percy, it is clear that such difficulties are experienced by many who have suffered long-term/multiple trauma as children. Such difficulties in daily functioning appear to be related to the numerous psychological problems associated with long-term/multiple childhood abuse experiences (Baynard, Williams, & Siegel, 2001; Briere & Runtz, 1988; Haj-Yahia, 2001; Higgins & McCabe, 2000;
Dealing with core PTSD symptoms was also not included in many negotiated treatment programs, as participants generally reported that those symptoms were “under control”. Thus, these were often not addressed prior to CP symptoms, as recommended in the guidelines. However, with three participants (for example Maria, Lucy and Matt), it became important to address symptoms of re-experiencing and avoidance (manifested for all as dissociation). The prominence of core PTSD symptoms for Maria, Lucy and Matt, however, lends support to Herman’s claims that “this previously undefined syndrome [CP] may co-exist with simple PTSD” (1992a, p. 387).

Apart from these departures, all participants undertook extensive work on those CP symptoms identified at the outset (either via inventory, or interview) – and in this most important respect, their programs were in keeping with the treatment guidelines for treatment of CP.

Positive Aspects of the Program: An Overview

Participants’ involvement in the program was generally very enthusiastic. Several participants (for example, Cynthia, Maria, Eric, Geraldine, Grant, & Melanie) were very reliable in attendance, and appeared to be taking their involvement in the program very seriously. Several of these participants (Maria, Grant, Geraldine, Renee) worked conscientiously on issues in between sessions, completed homework as requested, and as a result, made significant gains in the course of the program.

The treatment guidelines also allowed for an individualised focus. Careful examination of each participant’s treatment program (see Appendix M) indicates
that individual programs were different (in terms of the symptoms that were included for treatment, and the order in which symptoms were treated) to cater for the individual needs of each participant. The guidelines thus allowed for flexibility in approach, but still keeping the main objectives in sight.

Another positive outcome of the program was that eight of the ten participants (Cynthia, Maria, Eric, Lucy, Matt, Geraldine, Beryl and Renee) reported improvements in terms of CP symptoms, and the discourse of these individuals at final interview indicated that “ego strengthening” had taken place. Five of these eight participants (Cynthia, Maria, Lucy, Geraldine, Matt) improved in all CP symptoms identified at the outset, while one other participant (Beryl) reported improvements in all but one CP symptom identified at the outset. Another participant (Renee) reported improvements in all but two CP symptoms, and even for these two symptoms, mild improvements were noted. One participant (Eric) reported improvements in four identified CP symptoms and mild improvements in another symptom. The improvements described by most participants lend support to Chu’s claims that “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” (1998, p.77).

Only two participants indicated little change as a result of the treatment program: one participant (Diana) reported only limited change as a result of the treatment program. It is possible that the limited change reported by Diana was related to the fact that she was not able to take full advantage of the program being offered. Diana was unable to complete homework given to her and undertake work on issues between sessions. She also needed to use the sessions to relate her problems to me, and thus little structured intervention was possible. Another possible
explanation for Diana’s results may be that her progress may have been impeded during the weeks that she withdrew from the program. Another participant (Percy) also reported no change occurring as a result of the treatment program. As reported earlier, Percy had expectations that the program would not succeed and was also had difficulties completing any of the homework or continuing work in between sessions. These factors may have had an impact on his response to the program. No participants indicated a deterioration in their condition. Thus, on the whole, the reported results have been pleasing.

Most participants also indicated (usually via psychometric assessment) some improvement in core PTSD Symptoms (both number and intensity), even if these symptoms were not directly addressed. It appears that there was some “carry-over” effect from improvements in CP symptoms. For example, work undertaken to assist with affect regulation also assisted with symptoms of arousal. Further work undertaken to address “Alterations in Consciousness” also assisted with dissociative (avoidance) symptoms. For those clients who did undertake some work directly related to core PTSD symptoms (Maria, Lucy, Matt and Renee), greater improvement was reported.

Problems Encountered in Implementing the Program: An Overview

Structure

With many clients (for example Cynthia, Eric, Lucy, Diana, Renee, Percy), it was difficult to undertake sections of work in “neat” blocks according to the negotiated treatment program, as every week, these clients would present with a new crisis (usually related to one of the above problematic areas; for example, self perception, interpersonal relations, affect regulation). It seemed appropriate to work on issues associated with the “crisis” as the client’s level of distress would have
precluded work on any other issues. However, this was often disruptive to other work that may have been commenced in a previous week. The other result of regular crises intervention was, as mentioned previously, that it was difficult to adhere to the treatment plan as negotiated.

**Resistance**

Resistance to change was another major problem for some. In undertaking cognitive work, several participants (Cynthia, Diana, Eric, Percy) experienced difficulties considering more rational alternatives, and continually defended their previous way of thinking. Cynthia often asked for assistance with certain difficulties she was encountering, but rarely acted upon any suggestions, or accepted alternative perspectives. Eric was highly resistant to any suggestions, blocking suggestions or alternative approaches in many ways. There was, on the whole, a lot of resistance to change in these participants. It appeared that there was a feeling of comfort with “old ways” and a fear of new and unfamiliar.

**Difficulties with Highly Traumatised Clients**

The nature of the client group also played a major part in the outcomes. The participants were, in general, a highly emotionally responsive group of people, who often had quite extreme responses to events. This is consistent with the findings of several researchers (Baynard, Williams, & Siegel, 2001; Briere & Runtz, 1988; Haj-Yahia, 2001; Higgins & McCabe, 2000; Molnar, Buka, & Kessler, 2001; Nixon, Resick, & Griffin, 2004; Trocki, 2003) that individuals who have experienced long-term and multiple trauma present with a range emotional and psychological problems. Thus, sensitive issues needed to be approached with extreme care and caution. Several participants (Cynthia, Percy, Diana) were more sensitive than others, reacting strongly to events that occurred in the course of the program. For
example, Cynthia became extremely hostile toward me when she disclosed suicidal ideation late one night on the telephone. In response, I referred her to the Crisis Assessment Team at the local hospital. Cynthia believed that, as her therapist, I should have attended to her myself. She felt betrayed by my actions, stating that, I “didn’t really care” about her. As a result, she did not return to sessions for many weeks. Eventually, Cynthia returned, and the “rift” was healed. Percy also became hostile toward the end of the program, after his ex-girlfriend approached me to come to his assistance late one night when he expressed suicidal ideation. Once again, I referred her to the Crisis Assessment Team. Percy did not return after this and he did not complete the program. Thus, the rift was never healed with Percy, and I suspect that he also felt betrayed and that I did not care. Finally, Diana left the treatment program for many weeks after the first group therapy session. She explained later, after returning to the program, that she had felt extremely vulnerable in the group, and that if this was a requirement for therapy, then she could not continue. However, Diana did return for individual counselling, when I explained that I would not insist on her attending group therapy.

**Transference and Counter Transference**

The responses of the clients referred to in the previous paragraph also highlights the difficulties that can arise in terms of ‘transference’ and ‘counter-transference’, when working with clients who have experienced long-term and or multiple and long-term trauma experiences, and who are often difficult to treat. The therapist therefore needs to be mindful of appropriate responses to clients to ensure that neither transference nor counter-transference undermine or distort the therapeutic relationship.
Homework

Lack of attention to homework was another problem, and several participants (Cynthia, Eric, Percy, Diana and Beryl) did not undertake work /analysis given to them to do between sessions. This could perhaps be explained by the personality styles of many in the group – or to lack of motivation, related to persistent depression (as reported by Bifulco et al., 2002; and Boudewyn & Liem, 1995). The lack of work undertaken between sessions made progress slow for most.

Minimisation

Minimisation of past abuse was yet another problem encountered. Two participants had a tendency to minimise the abuse that had occurred in the past. For example, initially, Lucy minimised the nature of her past abuse – and this continued for most of the period. She avoided any reference to the abuse most of the time, and if I referred to her father, she would state that she did not wish to do anything that may destroy her relationship with him, because she loved him “very much”. Lucy’s minimisation often led to avoidance strategies with any work that may involve discussion of the past. Beryl also minimised the horrific nature of her past abuse and it took quite some time before the full extent of her many years of abuse became clear.

Perpetrator Contact

Ongoing contact with the perpetrator of the abuse also stood in the way of one participant’s improvement. This participant, Beryl, continued to keep in contact with the perpetrator of her most recent abuse. She continued to wear his wedding ring, and to call him “the other half” – and although I encouraged her strongly to move away from this relationship, she claimed that she needed to, in order to “keep an eye on him”, given financial connections. This appeared to be an excuse for
maintaining contact. Even in the final interview, and following their divorce, Beryl indicated that she was still in contact with the perpetrator of her abuse.

**Adherence to Program**

Poor attendance also played a role for one client, Percy, who had irregular attendance at sessions. Percy regularly missed sessions, often phoning on the morning of his appointment and stating that he was too tired, or was not feeling the best – and at other times, he would state that he had work to complete or that he needed to go away for the week-end. This made undertaking of a coherent program very difficult. Another result of this was that, with one or two sessions missed, each time we met, we would spend much of the session discussing how things had been since the last session, and discussing problems encountered during this period.

Adherence to the “treatment program” was also difficult, as the sessions were often directed by some participants and related to issues currently affecting them, rather than lead by the therapist and addressing specific symptoms. Several clients demonstrated a strong need for a listener, rather than a therapist. Eric, Diana, and Renee appeared to have a compelling need to “download” and had a tendency to control most sessions, talking without allowing interruption, and allowing little intervention. While this was apparently beneficial for the participant, from a therapeutic perspective, more specific interventions were often difficult due to this aspect.

**Co-morbidity**

The withholding of information by one client about co-morbid disorders also impacted on the treatment outcome. For example, in the last session, Cynthia mentioned that she had been diagnosed with bi-polar disorder previously, although she had not received treatment related to this diagnosis. This information had never
been disclosed previously – even though Cynthia had been asked whether she had any prior diagnoses. When asked why she had withheld this information, Cynthia said that she thought this may have prevented her from taking part in the program. Although others in the group were aware of previous diagnoses (for example, depression, anxiety disorders), no others in this group indicated other co-morbidity. In Cynthia’s case, her previously diagnosed condition manifested itself in mood instability in the course of the program. Cynthia oscillated between being deeply depressed and with suicidal ideation (initial presentation) and very happy and contented – and “ready to take on the world”. The instability of mood was present over all 24 sessions and lead to some difficulties in terms of undertaking a coherent program of treatment.

**Confounding Variables**

Confounding variables for one client prevented drawing firmer conclusions about the impact of the treatment program. Geraldine became pregnant some time after commencing the program, and in the weeks following this, had several sessions away. The pregnancy also had the effect of lifting Geraldine’s mood to the extent that she had a more positive outlook on life generally, and felt better about her self. It has been difficult, therefore, to determine whether the program (or the pregnancy) was the major factor in her improvements.

**Group Therapy**

Attendance at the group sessions, commenced some time into the individual treatment program, was generally poor, and with a different group being present each week. Thus, it was very difficult to establish a feeling of safety and coherence, necessary for the group process to occur effectively. Further, although all participants had made an initial agreement to participate in the group therapy, several
participants expressed a fear of or dislike for group therapy – and one (Diana) left
the program (temporarily) due to the fears this raised for her. One other participant,
Cynthia, refused to participate in group therapy, as stated that hearing others’
traumatic experiences would only worsen her state of mind. Although I explained to
Cynthia that the focus would not be on re-visiting past traumas (but rather on
“moving forward”), Cynthia was adamant that group therapy would not be helpful to
her and refused to attend. I suspected that there were some deep fears, and
consequent avoidance, taking place here. One other participant (for example Lucy)
came to the initial sessions, but after the first few, made constant excuses for non-
attendance. Another participant had transport difficulties, as lived some distance
from the venue, and regularly arrived late. The poor response to group therapy was
in contrast to the positive responses reported by many researchers (Bradley, 2001;
Boos et al., 1999; Lubin et al., 1998; Simmer-Dvonch, 1999; & Schei & Dahl, 1999).
This poor response may have been related to the fact that the clients in this program
presented with difficult and complex symptoms and case histories, which had
implications for them in being with other people in any setting. The presence of such
complex symptoms may not have been the case in the research cited, undertaken
mostly with PTSD, rather than CP, sufferers.

Comparison with Standard PTSD Treatments Addressing 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, and some associated symptoms also, such a program would not
have been appropriate for addressing the symptoms of Complex PTSD (“Alterations
in Affect Modulation”, “Self Concept”, “Relations with Others”, “Consciousness”, and “Systems of Meaning”).

It is interesting to note that, although the participants in this treatment program identified core PTSD symptoms in their initial psychometric assessment, most did not identify these as priorities for treatment when their treatment plans were being negotiated. Most participants appeared to have been experiencing such difficulties with self-concept, interpersonal relationships, affect modulation, and their belief systems, (the characteristics of CP), that they were insistent that these become the focus of treatment. It is possible that, had the focus been on core PTSD symptoms, the presence of CP symptoms may have prevented effective treatment anyway. Participants appeared to understand intuitively that they needed to be stronger before they could address some of the core PTSD symptoms and past trauma events. The interest by the participants in dealing predominantly with CP symptoms also indicates that these were the areas in which most participants felt some vulnerability, and for which they were in need of assistance. The need to focus on CP symptoms has been referred to (and reported in previous chapters) by Chu (1998) and van der Kolk (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’s 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.

**Summary: Evaluation of Treatment Guidelines/Program**

The results of this program are promising in light of suggestions made by researchers in this field (Chu, 1998; Herman, 1992) indicating that treating CP
symptoms is of major importance in any program dealing with sufferers of long-term/multiple trauma experiences, and essential if further abreactive work is to be undertaken. As survivors of long-term trauma experiences are often highly emotionally responsive (as in this study), and as resistance to change appears to be a major factor standing in the way of recovery (as in this study), 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.

The lack of fidelity to the model that occurred in some areas, however, indicates a need for flexibility in regard to this model (both at the outset when negotiating a treatment program, and throughout the program) when working with sufferers of long-term/multiple abuse experiences. Firstly, as it is possible that many individuals displaying CP symptoms will not need to undertake work around safety issues, there is a need to be flexible in regard to this issue. Careful screening, and ongoing monitoring, around safety issues is important. Secondly, it is also important to note that, as many individuals with CP will not require work to assist with aspects of daily functioning, there is thus a need to also be flexible here, and to be prepared 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 is also important to be flexible in regard to treatment of core PTSD symptoms, with a preparedness 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).

Another possible change relates to group therapy. As many individuals will find group therapy confronting, it is also important that, in any future programs of this nature, it would be advisable to offer group therapy as an optional part of the program – for those who are able to benefit from such therapy. Such persons may include those who are comforted in the knowledge that they are not alone in what they were experiencing; those who are helped by hearing what others have experienced as this allows them to place their own experiences in perspective; those who find that “the group” is a safe place where they do not feel condemned for talking about problems and issues associated with past trauma. The important message from this study, however, is that group therapy, whole useful for many people, may offer no additional benefits for those who are able to make adequate gains from individual programs. Further investigation of the comparative advantages of individual vs group therapy may clarify this issue further.

It is also 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. However, the individuals in this program indicated that maintaining a commitment to weekly therapy over even six months was difficult. It may thus be necessary to work with clients for a few months, allow for a break, and then resume treatment.

Given the difficulties experienced with some clients in this program, it is also important, at the outset, to provide more detailed explanations about “boundary” issues – and where the therapist’s responsibilities ended. This would prevent
disappointment/feelings of betrayal that may be held by those who attempt to seek assistance outside program times.

Evaluation of Research

Limitations

A major limitation of this study has been the small numbers involved in the six-months treatment program. Obtaining participants for a community-based study is always difficult, and despite advertising for volunteers in a range of different sources within the local community, responses were few. Of those who did respond, many did not satisfy the criteria. Others found the commitment to six months of weekly treatment too great. Lack of persistence (and consequent ‘drop-out’) also affected final numbers. Thus, due to the small number of participants \( n = 10 \), the results of this study are not able to be generalised to other populations.

The capacity to generalise the results of this study to other populations has also been impeded by the fact that the experimental treatment was uncontrolled, meaning that it has not been possible to claim with complete confidence that the program itself lead to the improvements observed for several participants, or that specific aspects of the program lead to improvements - rather than other variables such as the passage of time, or attention from a dedicated therapist.

A limitation related to the difficulties of obtaining participants was that it was not possible to commence all individual therapy sessions within the same week, as was the original intention. This would have enabled commencement of the group therapy at the planned time, some weeks into the program when all had experienced a specific number of individual sessions. However, as some participants left the program after a few weeks, new participants needed to be found, screened, and
started in individual therapy. The commencement of group therapy was thus delayed by several weeks.

Another possible limitation of this study relates to retrospective reporting. All information obtained in regard to past abuse experiences came from the participants’ retrospective memories of such experiences. As such, there is heavy reliance on the participants’ accurate remembering of past events. Although information provided retrospectively has often been considered of doubtful value, studies have been referred to in Chapter 2 that support the use of retrospective information. However, it is also important to note that the focus of this study was not on past events, rather on addressing current CP symptoms.

One further limitation was having the researcher as the therapist. This aspect of methodology had been considered carefully prior to commencement of the study, and was assessed as posing fewer problems than having several external therapists undertaking the therapy, the latter process introducing additional confounding variables. Such a process may have posed difficulties in ascertaining whether the program itself, or the therapist, was the key to improvements/non-improvements with participants. Further, the cost of employing external therapists to work with 10 clients over a six-month period (i.e., a total of 240 therapy sessions) would also have been cost-prohibitive at recommended rates for psychologists. Thus, the researcher undertaking the therapist role was considered the most suitable alternative for this study. However, every caution was taken to ensure that participants were aware of the dual role of the therapist, and potential difficulties were averted.

There were some difficulties also in having an independent psychologist undertake the final interviews. Although this psychologist who undertook the final interviews was an experienced psychologist and had been “briefed” well regarding
this study, it was apparent that she did not explore some symptoms with the thoroughness required to obtain sufficiently rich descriptions for use in discourse analysis. This factor highlights a potential lack of understanding many psychologist may have in regard to Complex PTSD, and highlights the need for professional development in this area.

A final limitation related to the measurement tools used. Despite being the most appropriate measurement tools available for measuring PTSD and CP, the PDS and SIDES-SR still were unable to detect adequately the CP symptoms. Interview was a much more appropriate means of detecting CP symptoms.

**Strengths**

Firstly, to the researcher’s knowledge, there has not been any other documented study of this nature, implementing and evaluating a guideline-based program for the treatment of Complex PTSD symptoms over such an extensive period of time.

Further, although there have been numerous treatment guidelines proposed for the treatment of PTSD, there has been only one other published model for the treatment of Complex PTSD (Chu, 1998) and this has not yet, to the researcher’s knowledge, been developed further into more detailed procedural guidelines, and there has thus been no formal evaluation of Chu’s model. Further, the model used for the program guidelines in this study was different in several respects to that proposed by Chu in his SAFER model, 1998 (see Chapter 5), with emphasis placed on safety, daily functioning and self regulation prior to engaging in treatment for CP symptoms. Thus, this is the only documented set of guidelines suggesting a specific and discrete treatment focus on safety, daily functioning, and core PTSD symptoms prior to engaging in work on CP symptoms. Although such specific focus on these
areas was found to be unessential in some cases, for others, it was essential. A model that allows for a specific focus on such areas has advantages over one that does not, as with the former, it is possible for these important areas to be overlooked.

Another strength of this study has been the abundant case detail obtained. Detailed transcripts of interviews with each participant on three separate occasions have formed the basis for information regarding individuals’ trauma experiences, their perception of the impact of the trauma on their lives, and their perception of the impact of the treatment program (both individual and group therapy).

Further, by adopting a qualitative approach to collection and analysis of data, it has been possible to explore the mechanisms and processes by which change occurred (or did not occur). The focus on the individuals’ perspectives, reflected in their discourse (the core data of this qualitative study) has allowed the researcher to discover both subtle and blatant changes occurring as a result of the intervention. In placing such a strong emphasis on the participants’ own judgement in regard to their changes, an insight has been obtained that is not available from any other source.

It is also important to emphasis that few studies investigating treatment approaches have utilised discourse analysis to obtain data. However, the language used by the participants in this study provided a very rich source of material from which to draw conclusions about the changes that had occurred in the participants in the course of the six-months program. In most cases, the language used was consistent with, and reflected, the results obtained in psychometric testing. In some cases, however, the individual’s language exposed greater change than was perhaps reflected in the results of the inventories completed. There is little doubt that a very inaccurate (or at least incomplete) representation of the participants’ progress would have resulted had this analysis not taken place. Such results confirm the claims
regarding the value of discourse analysis by others who have successfully used discourse analysis in their research (Madill & Barkham, 1997)

**Future Research**

As it has not been possible to ascertain the long-term impact of this treatment program, it would be useful to interview the participants in this study in 12-24 months time, in order to evaluate long-term effects of this program on CP symptoms.

Similar studies to the one reported in this paper, and perhaps involving larger numbers of participants, would also be beneficial in providing support for the findings of this research. However, larger studies may be difficult, as there are difficulties involved for one researcher to assume the role of therapist for such large numbers of participants over a long period of time. The alternative of involving several therapists would also present difficulties, as it would be difficult to control for confounding variables, such as personality of therapist, therapeutic style, and so on. However, further studies on a smaller scale may be possible. For similar smaller scale studies, however, assessment via structured clinical interview, based on PTSD/CP symptoms, would be an important aspect of assessment as such a process appears to elicit more accurate information than psychometric inventories.

When considering research design for future studies, consideration should be given to the use of some form of discourse analysis, which, for this kind of research, appears to be preferable to quantitative methods of analysis that do not provide the depth of information and understanding that the individuals’ own language does. Where discourse analysis is used, however, it would also advisable to provide a more thorough briefing to the final independent interviewer, emphasising the importance
of detailed probing in regard to symptoms experienced. In this way, the interviewer’s questioning will encourage participants to provide rich and descriptive data.

As it has been difficult to draw accurate conclusions from this study regarding the advantages of the treatment model used in this study over that suggested by Chu (1998) in his SAFER model, a controlled comparison of the two approaches may extend our knowledge in this area, and allow further conclusions to be reached regarding the importance of placing specific emphasis on areas of safety, functioning and core PTSD symptoms.

Further specific investigation of the relative importance of addressing core PTSD symptoms vs CP symptoms in CP clients may also allow clinicians to further refine their therapeutic processes when working with CP clients. An examination of client resistance to interventions, and effective ways to overcome/manage this resistance, would also be of benefit to clinicians.

Another area of possible future study highlighted as a result of this study relates to the relative efficacy of group vs individual therapy. Further investigation (a controlled comparison) of the comparative advantages of individual vs group therapy may allow some clarification as to whether one method achieves better outcomes than the other – or whether a combination of individual and group treatment is more effective than individual therapy.

One other issue about which this study was unable to provide clarification relates to the role of the therapist's personality/therapy style in effecting a specific outcome. A random control trial comparing outcomes for different therapists using an identical treatment program may add to our knowledge about this issue.
Summary

The study has provided detailed and descriptive insights into the participants’ response to a 6-month individualised treatment program, based on guidelines developed by the researcher. As the only documented study, implementing and evaluating a guideline-based program for the treatment of Complex PTSD symptoms over an extensive period of time, this study has been a valuable contribution to the literature in this area. The use of discourse analysis to gain some insight into program efficacy has also been rare in the field of psychology, and this study has been able to indicate the benefits of engaging in such qualitative methods of analysis when evaluating treatment programs.
References


Achenbach, T.M. *Youth Self-Report Form*, Department of Psychiatry, University of Vermont, Burlington.


APPENDIX A

PARTICIPANT QUESTIONNAIRE

Instructions to participants.

Please complete the following items (attached):

Section 1: Data Information sheet
Section 2: Questionnaire regarding previous trauma-related abuse
Section 3: Trauma-related symptoms experienced prior to treatment.
Section 4: Trauma-related symptoms experienced currently.
Section 5: Informed Consent Form providing permission to contact your therapist. This will be detached from your questionnaire.

Instructions regarding each of the above items will be provided at the beginning of each form.

Please note: Completion and return of the above implies consent to participate in this study.

SECTION 1: DATA INFORMATION SHEET (for ...........- ID number)

1. AGE:...........................................

2. ETHNICITY:..........................................................

3. GENDER (M/F):..........................................................

4. MARITAL STATUS (Single/separated/divorced/de facto relationship)
   ..........................................................................

5. NUMBER OF CHILDREN (if any).................................

6. OCCUPATION.............................................................
SECTION 2: Questionnaire regarding previous trauma-related abuse

1. **Before the age of 13, how frequently did you experience any of the following behaviours?** Please rate the frequency with which the behaviours were directed toward you by your mother, father, or other adult using the following response scale:

   1 = never  
   2 = occasionally  
   3 = sometimes  
   4 = frequently  
   5 = very frequently

   **Behaviours directed to you by:**
   - Yelling at you
   - Ridiculing, embarrassing, using sarcasm (making you feel guilty, silly, or ashamed)
   - Provoking, making you afraid, cruelty

<table>
<thead>
<tr>
<th>Behaviours directed to you by</th>
<th>Your mother</th>
<th>Your father</th>
<th>Another adult*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yelling at you</td>
<td>1 2 3 4 5</td>
<td>1 2 3 4 5</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>Ridiculing, embarrassing,</td>
<td>1 2 3 4 5</td>
<td>1 2 3 4 5</td>
<td>1 2 3 4 5</td>
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<tr>
<td>using sarcasm (making you</td>
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<tr>
<td>feel guilty, silly, or</td>
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<tr>
<td>ashamed)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Provoking, making you</td>
<td>1 2 3 4 5</td>
<td>1 2 3 4 5</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>afraid, cruelty</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

   *Any other older person, such as step-parent, a relative, family friend stranger.

2. **Between the age of 13 and 18 years, how frequently did you experience any of the following behaviours?** Please rate the frequency with which the behaviours were directed toward you by your mother, father, or other adult using the following response scale:

   1 = never  
   2 = occasionally  
   3 = sometimes  
   4 = frequently  
   5 = very frequently

   **Behaviours directed to you by:**
   - Yelling at you
   - Ridiculing, embarrassing, using sarcasm (making you feel guilty, silly, or ashamed)
   - Provoking, making you afraid, cruelty

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</tr>
<tr>
<td>afraid, cruelty</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

   *Any other older person, such as step-parent, a relative, family friend, stranger.

3. **As an adult (over 18 years), how frequently did you experience any of the following behaviours?** Please rate the frequency with which the behaviours were directed toward you by your mother, father, or other adult using the following response scale:

   1 = never  
   2 = occasionally  
   3 = sometimes  
   4 = frequently  
   5 = very frequently
Behaviours directed to you by:  

<table>
<thead>
<tr>
<th>Behaviour</th>
<th>Your mother</th>
<th>Your father</th>
<th>Another adult*</th>
</tr>
</thead>
<tbody>
<tr>
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<td>1 2 3 4 5</td>
<td>1 2 3 4 5</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>Ridiculing, embarrassing, using sarcasm</td>
<td>1 2 3 4 5</td>
<td>1 2 3 4 5</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>(making you feel guilty, silly, or ashamed)</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Provoking, making you afraid, cruelty</td>
<td>1 2 3 4 5</td>
<td>1 2 3 4 5</td>
<td>1 2 3 4 5</td>
</tr>
</tbody>
</table>

*Any other older person, such as step-parent, a relative, family friend, stranger.

4. Before the age of 13, how frequently did you witness any of these behaviours listed in the previous questions directed toward others in the family?

1 = never  
2 = occasionally  
3 = sometimes  
4 = frequently  
5 = very frequently

5. Between the ages of 13 and 18 years, how frequently did you witness any of these behaviours listed in the previous questions directed toward others in the family?

1 = never  
2 = occasionally  
3 = sometimes  
4 = frequently  
5 = very frequently

6. As an adult (over 18 years), how frequently did you witness any of these behaviours listed in the previous questions directed toward others in the family?

1 = never  
2 = occasionally  
3 = sometimes  
4 = frequently  
5 = very frequently

7. Before the age of 13, how frequently did you experience any of the following behaviours? Please rate the frequency with which the behaviours were directed toward you by your mother, father, or other adult using the following response scale:

1 = never  
2 = occasionally  
3 = sometimes  
4 = frequently  
5 = very frequently

<table>
<thead>
<tr>
<th>Behaviour</th>
<th>Your mother</th>
<th>Your father</th>
<th>Another adult*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical punishment for wrongdoing</td>
<td>1 2 3 4 5</td>
<td>1 2 3 4 5</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>Other use of violence (e.g. hitting, punching, kicking)</td>
<td>1 2 3 4 5</td>
<td>1 2 3 4 5</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>Severely hurting you (requiring medical attention)</td>
<td>1 2 3 4 5</td>
<td>1 2 3 4 5</td>
<td>1 2 3 4 5</td>
</tr>
</tbody>
</table>
8. Between the ages of 13 and 18 years, how frequently did you experience any of the following behaviours? Please rate the frequency with which the behaviours were directed toward you by your mother, father, or other adult using the following response scale:

1 = never  
2 = occasionally  
3 = sometimes  
4 = frequently  
5 = very frequently

<table>
<thead>
<tr>
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<th>Your father</th>
<th>Another adult*</th>
</tr>
</thead>
<tbody>
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<td>Physical punishment for wrongdoing</td>
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<td>1 2 3 4 5</td>
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<tr>
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<td>1 2 3 4 5</td>
</tr>
<tr>
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<td>1 2 3 4 5</td>
<td>1 2 3 4 5</td>
<td>1 2 3 4 5</td>
</tr>
</tbody>
</table>

9. As an adult (over 18 years), how frequently did you experience any of the following behaviours? Please rate the frequency with which the behaviours were directed toward you by your mother, father, or other adult using the following response scale:

1 = never  
2 = occasionally  
3 = sometimes  
4 = frequently  
5 = very frequently

<table>
<thead>
<tr>
<th>Behaviours directed to you by:</th>
<th>Your mother</th>
<th>Your father</th>
<th>Another adult*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical punishment for wrongdoing</td>
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<td>1 2 3 4 5</td>
</tr>
<tr>
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</tr>
<tr>
<td>Severely hurting you (requiring medical attention)</td>
<td>1 2 3 4 5</td>
<td>1 2 3 4 5</td>
<td>1 2 3 4 5</td>
</tr>
</tbody>
</table>
10. Before the age of 13 years, how frequently did you witness any of the behaviours listed in question 9 directed toward others in the family?

1 never
2 occasionally
3 sometimes
4 frequently
5 very frequently

10. Between the ages of 13 and 18 years, how frequently did you witness any of the behaviours listed in question 9 directed toward others in the family?

1 never
2 occasionally
3 sometimes
4 frequently
5 very frequently

11. As an adult (over 18 years), how frequently did you witness any of the behaviours listed in the previous three questions directed toward others in the family?

1 never
2 occasionally
3 sometimes
4 frequently
5 very frequently

13. Before the age of 13, how frequently did you experience any of the following behaviours? Please rate the frequency with which the behaviours were directed toward you by your mother, father, or other adult using the following response scale:

1 = never
2 = occasionally
3 = sometimes
4 = frequently
5 = very frequently

<table>
<thead>
<tr>
<th>Behaviours directed to you by:</th>
<th>Your mother</th>
<th>Your father</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not giving you regular meals or baths, clean clothes, or needed medical attention</td>
<td>1 2 3 4 5</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>Shutting you in a room alone for an extended period of time</td>
<td>1 2 3 4 5</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>Ignoring your requests for attention; not speaking to you for extended periods of time</td>
<td>1 2 3 4 5</td>
<td>1 2 3 4 5</td>
</tr>
</tbody>
</table>

14. Between the ages of 13 and 18 years, how frequently did you experience any of the following behaviours? Please rate the frequency with which the behaviours were directed toward you by your mother, father, or other adult using the following response scale:

1 = never
2 = occasionally
3 = sometimes
4 = frequently
5 = very frequently
Behaviours directed to you by: | Your mother | Your father |
---|---|---|
Not giving you regular meals or baths, clean clothes, or needed medical attention | 1 2 3 4 5 | 1 2 3 4 5 |
Shutting you in a room alone for an extended period of time | 1 2 3 4 5 | 1 2 3 4 5 |
Ignoring your requests for attention; not speaking to you for extended periods of time | 1 2 3 4 5 | 1 2 3 4 5 |

15. Childhood sexual experiences: Many people report having had childhood sexual experiences with other children or with older people. The following questions relate only to sexual activities with older people. These “older people” include someone who at the time was either: * at least 5 years older than you; or * an adult (18 years of age or over)

Before the age of 13, did an older person engage in any of the following types of sexual activity with you? Please rate the frequency of each type of sexual activity listed below that was directed toward you by your mother, your father, and other adults or adolescents.

0 = never  
1 = once  
2 = twice  
3 = 3-6 times  
4 = 20 times  
5 = more than 20 times

| Sexual behaviours engaged in by: | Your mother | Your father | Other adult or Older adolescent |
---|---|---|---|
Requested you to do something sexual | 0 1 2 3 4 5 | 0 1 2 3 4 5 | 0 1 2 3 4 5 |
Forced you to watch others having sex | 0 1 2 3 4 5 | 0 1 2 3 4 5 | 0 1 2 3 4 5 |
Showed you his erect penis | 0 1 2 3 4 5 | 0 1 2 3 4 5 | 0 1 2 3 4 5 |
Touched your penis, vagina or breast | 0 1 2 3 4 5 | 0 1 2 3 4 5 | 0 1 2 3 4 5 |
Made you touch his penis or her vagina or breasts | 0 1 2 3 4 5 | 0 1 2 3 4 5 | 0 1 2 3 4 5 |
Put his/her tongue or mouth on his penis/her vagina | 0 1 2 3 4 5 | 0 1 2 3 4 5 | 0 1 2 3 4 5 |
Made you put your tongue or mouth on his penis/her vagina | 0 1 2 3 4 5 | 0 1 2 3 4 5 | 0 1 2 3 4 5 |
Put his penis in your vagina or anus | 0 1 2 3 4 5 | 0 1 2 3 4 5 | 0 1 2 3 4 5 |
Put a finger in your vagina or anus | 0 1 2 3 4 5 | 0 1 2 3 4 5 | 0 1 2 3 4 5 |
Put other object in your vagina or anus | 0 1 2 3 4 5 | 0 1 2 3 4 5 | 0 1 2 3 4 5 |
Made you put your penis inside a vagina or anus | 0 1 2 3 4 5 | 0 1 2 3 4 5 | 0 1 2 3 4 5 |
16. **Between the ages of 13 and 18 years**, did an older person engage in any of the following types of sexual activity with you? Please rate the frequency of each type of sexual activity listed below that was directed toward you by your mother, your father, and other adults or adolescents.

- 0 = never
- 1 = once
- 2 = twice
- 3 = 3-6 times
- 4 = 20 times
- 5 = more than 20 times

<table>
<thead>
<tr>
<th>Sexual behaviours engaged in by:</th>
<th>Your mother</th>
<th>Your father</th>
<th>Other adult or Older adolescent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Requested you to do something sexual</td>
<td>0 1 2 3 4 5</td>
<td>0 1 2 3 4 5</td>
<td>0 1 2 3 4 5</td>
</tr>
<tr>
<td>Forced you to watch others having sex</td>
<td>0 1 2 3 4 5</td>
<td>0 1 2 3 4 5</td>
<td>0 1 2 3 4 5</td>
</tr>
<tr>
<td>Showed you his erect penis</td>
<td></td>
<td>0 1 2 3 4 5</td>
<td>0 1 2 3 4 5</td>
</tr>
<tr>
<td>Touched your penis, vagina or breast</td>
<td>0 1 2 3 4 5</td>
<td>0 1 2 3 4 5</td>
<td>0 1 2 3 4 5</td>
</tr>
<tr>
<td>Made you touch his penis or her vagina or breasts</td>
<td>0 1 2 3 4 5</td>
<td>0 1 2 3 4 5</td>
<td>0 1 2 3 4 5</td>
</tr>
<tr>
<td>Put his/her tongue or mouth on his penis/her vagina</td>
<td>0 1 2 3 4 5</td>
<td>0 1 2 3 4 5</td>
<td>0 1 2 3 4 5</td>
</tr>
<tr>
<td>Made you put your tongue or mouth on his penis/her vagina</td>
<td>0 1 2 3 4 5</td>
<td>0 1 2 3 4 5</td>
<td>0 1 2 3 4 5</td>
</tr>
<tr>
<td>Put his penis in your vagina or anus</td>
<td>0 1 2 3 4 5</td>
<td>0 1 2 3 4 5</td>
<td>0 1 2 3 4 5</td>
</tr>
<tr>
<td>Put a finger in your vagina or anus</td>
<td>0 1 2 3 4 5</td>
<td>0 1 2 3 4 5</td>
<td>0 1 2 3 4 5</td>
</tr>
<tr>
<td>Put other object in your vagina or anus</td>
<td>0 1 2 3 4 5</td>
<td>0 1 2 3 4 5</td>
<td>0 1 2 3 4 5</td>
</tr>
<tr>
<td>Made you put your penis inside a vagina or anus</td>
<td>0 1 2 3 4 5</td>
<td>0 1 2 3 4 5</td>
<td>0 1 2 3 4 5</td>
</tr>
</tbody>
</table>

17. **As an adult (over 18 years)**, were you ever forced by another person to engage in any of the following sexual behaviour against your consent. Please rate the frequency of each type of sexual activity listed below that was directed toward you by other adults.
0 = never  
1 = once  
2 = twice  
3 = 3-6 times  
4 = 20 times  
5 = more than 20 times

<table>
<thead>
<tr>
<th>Sexual behaviours engaged in by:</th>
<th>Other adult</th>
</tr>
</thead>
<tbody>
<tr>
<td>Requested you to do something sexual</td>
<td>0 1 2 3 4 5</td>
</tr>
<tr>
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<tr>
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<td>0 1 2 3 4 5</td>
</tr>
</tbody>
</table>

SECTION 3: Trauma-related symptoms experienced prior to treatment.

Below is a list of problems that people sometimes have after experiencing a traumatic event. Read each one carefully and circle the number (0-3) that best describes how often the problem bothered you in the period prior to engaging in treatment. Rate each problem with respect to the traumatic event you described in Item 14.

0 Not at all or only one time  
1 Once a week or less/once in a while  
2 2 to 4 times a week/half the time  
3 5 or more times a week/almost always

18. 0 1 2 3 Having upsetting thoughts or images about the traumatic event that came into your head when you didn’t want them to
19 0 1 2 3 Having bad dreams or nightmares about the traumatic event
20 0 1 2 3 Reliving the traumatic event, acting or feeling as if it was happening again.
21. 0 1 2 3 Feeling emotionally upset when you were reminded of the traumatic event (for example, feeling scared, angry, sad, guilty etc)
22. 0 1 2 3 Experiencing physical reactions when you were reminded of the traumatic event (for example, breaking out in sweat, heart beating fast etc.)
23. 0 1 2 3 Trying not to think about, or have feelings about the traumatic event
24. 0 1 2 3 Trying to avoid activities, people, or places that remind you of the traumatic event
25. 0 1 2 3 Not being able to remember an important part of the traumatic event
26. 0 1 2 3 Having much less interest or participating much less often in important activities
27. 0 1 2 3 Feeling distant or cut off from people around you
28 0 1 2 3 Feeling emotionally numb (for example, unable to cry or being unable to have loving feelings)
29. 0 1 2 3 Feeling as if your future plans or hopes will not come true (for example, you will not have a career, marriage, children, or a long life)
30. 0 1 2 3 Having trouble falling or staying asleep
31. 0 1 2 3 Feeling irritable or having fits of anger
32. 0 1 2 3 Having trouble concentrating (for example, drifting in and out of conversations, losing track of a story on television, forgetting what you read)
33 0 1 2 3 Being overtly alert (for example, checking to see who is around you, being uncomfortable with your back to a door etc)
34 0 1 2 3 Being jumpy or easily startled (for example, when someone walks up behind you)

35. How long have you experienced the problems that you reported above?
1. Less than one month
2. 1 to 3 months
3. More than 3 months

36. How long after the traumatic event did these problems begin? (Circle one)

Indicate below if the problems you rated above interfered with any of the following areas of your life in the period prior to your treatment. Circle Y for Yes and N for No

37. Y N Work
38. Y N Household chores and duties
39. Y N Relationships with friends
40. Y N Fun and leisure activities
42. Y N Schoolwork
43. Y N Relationships with your family
44. Y N Sex life
45. Y N General satisfaction with life
46. Y N Overall level of functioning in all areas of your life

What follows are descriptions of some more difficulties that some people experience. After each statement please indicate: whether it has been true for you; if yes, how much were you bothered by that problem prior to treatment.
(If no, choose NA for “Not Applicable” as the severity rating for the past month).
47. Small problems made me very upset. For example, I got angry at a minor frustration. I cried easily.

This was true for me  Yes  No

How much were you bothered in the period prior to treatment?

None; not at all  0
Sometimes I overreacted a little  1
Sometimes I got very upset, or everything upset me more than it used to  2
Often I got extremely upset, had tantrums  3
Not applicable  NA

48. I found it hard to calm myself down after I became upset and had trouble getting back on track.

This was true for me  Yes  No

How much were you bothered in the period prior to treatment?

None; not at all  0
I became momentarily upset  1
It kept coming back to me hour after hour  2
I became completely consumed by it  3
Not applicable  NA

49. When I felt upset, I had trouble finding ways to calm myself down

This was true for me  Yes  No

How much were you bothered in the period prior to treatment?

None; not at all  0
I needed to make special efforts to calm myself  1
I needed to stop everything and focus all my energy on calming down  2
I needed to resort to extreme measures, like getting drunk, taking drugs, or doing other harmful things to my body  3
Not applicable  NA

50. I felt angry most of the time

This was true for me  Yes  No

How much were you bothered in the period prior to treatment?

Nine; not at all  0
I felt quite angry but I was able to shift to other matters  1
My anger got in the way of doing things  2
My anger dominated my daily life  3
Not applicable  NA

51. I had thoughts or images of hurting somebody else.

This was true for me  Yes  No
How much were you bothered in the period prior to treatment?

None‘ not at all 0
Yes, fleeting thoughts 1
I thought about hurting people every day 2
I could not stop thinking about hurting people 3
Not applicable NA

52. I had trouble controlling my anger.

This was true for me  Yes  No

How much were you bothered in the period prior to treatment?

None/ not at all 0
I snapped at people 1
I yelled or threw things 2
I actually attacked people physically 3
Not applicable NA

53. I worried about people finding out how angry I am.

This was true for me  Yes  No

How much were you bothered in the period prior to treatment?

None ; not at all 0
I have trouble confronting someone when they hurt me 1
I do not confront the person I’m angry at, but I show my anger in other ways 2
I do not let anyone know in words or actions that I am angry 3
Not applicable NA

54. I was in accidents or near accidents

This was true for me  Yes  No

How much were you bothered in the period prior to treatment?

None; not at all 0
Occasional accidents causing harm or pain but not requiring medical attention 1
One accident or episode requiring medical attention 2
More than one serious accident or episode requiring medical attention 3
Not applicable NA

55. I found myself careless about making sure that I am safe.

This was true for me  Yes  No

How much were you bothered in the period prior to treatment?

None; not at all 0
I thought about the risks involved in relationships or situations, but did it anyway 1
I took undue risks regarding the people I was with or places I visited 2
I kept company with people who I knew could be dangerous; not taking measures to protect myself in dangerous situations 3
Not applicable NA

56. I deliberately tried to hurt myself (like burning or cutting myself)

This was true for me Yes No

How much were you bothered in the period prior to treatment?

None; not at all 0
I hit or kicked at objects 1
I hurt myself deliberately (pinching, scratching, hitting, banging) without serious damage 2
I hurt myself deliberately in ways that caused serious physical damage 3
Not applicable NA

57. I thought about killing myself.

This was true for me Yes No

How much were you bothered in the period prior to treatment?

None; not at all 0
I was preoccupied, but had no pain 1
I made gestures, or was chronically pre-occupied with plans 2
I made one or more serious suicide attempts 3
Not applicable NA

58. I made active efforts to keep myself thinking about sex.

This was true for me Yes No

How much were you bothered in the period prior to treatment?

None; not at all 0
I tried not to think about sex 1
I worked very hard not to think about sex 2
I would not tolerate any thoughts about sex 3
Not applicable NA

59. It bothered me to be touched in general.

This was true for me Yes No

How much were you bothered in the last month?

None; not at all 0
It sometimes bothered me 1
It often or regularly bothered me 2
I simply could not stand it 3
Not applicable NA

60. It bothered me to be touched in a sexual way.

This was true for me Yes No

How much were you bothered in the period prior to treatment?

None; not at all 0
<table>
<thead>
<tr>
<th>Question</th>
<th>Response</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sometimes it bothered me</td>
<td></td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>It often or regularly bothered me</td>
<td></td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>I simply could not stand it</td>
<td></td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Not applicable</td>
<td></td>
<td>NA</td>
<td></td>
</tr>
</tbody>
</table>

61. I actively avoided sex

This was true for me

How much were you bothered in the last month?

None; not at all
I found myself making excuses
I tried not to have sex
I did not have sex
Not applicable

62. I found myself thinking about sex more than I wanted to

This was true for me

How much were you bothered in the period prior to treatment?

None; not at all
I thought about it too much
It distracted me from what I should have been doing
I was obsessed with it
Not applicable

63. I found myself driven to engage in sexual activities without really feeling that I had a choice.

This was true for me

How much were you bothered in the period prior to treatment?

None; not at all
I felt the urge, but I did not act on it
I felt compelled to, but I forced myself to stop
I engaged in compulsive sex
Not applicable

64. I was active sexually in ways that I knew put me in danger.

This was true for me

How much were you bothered in the period prior to treatment?

None; not at all
I was a bit careless
I talked myself into ignoring the danger or I only saw the danger afterwards
I knowingly put myself in danger
Not applicable
65. I exposed myself to situations that might be dangerous, e.g. I got involved with people who might hurt me. I went to places that were not safe. I drove too fast.

This was true for me       Yes    No

How much were you bothered in the period prior to treatment?

None; not at all          0
I was a bit careless       1
I talked myself into ignoring the danger or I only saw the danger afterwards 2
I knowingly put myself in danger 3
Not applicable           NA

66. There are parts of my life that I could not remember, or I was confused about what happened, or I was unsure whether certain important things did or did not happen to me.

This was true for me       Yes    No

How much were you bothered in the period prior to treatment?

None; not at all          0
There were a few memory lapses 1
There were important gaps in my memory; there were missing periods 2
I had no memory for days, months, or years of my life 3
Not applicable           NA

67. I had difficulty keeping track of my daily life.

This was true for me       Yes    No

How much were you bothered in the period prior to treatment?

None; not at all          0
At times, I had difficulty making or keeping track of schedules 1
I regularly showed up at the wrong place at the wrong time 2
I was unable to keep track of my daily life 3
Not applicable           NA

68. I “spaced” out when I felt frightened or under stress.

This was true for me       Yes    No

How much were you bothered in the period prior to treatment?

None; not at all          0
I was withdrawn at times 1
I went into my own world and did not let people in 2
I felt like I stopped existing 3
Not applicable           NA

69. I sometimes felt so unreal that it was as if I was living in a dream, or not really there, or behind a glass wall.

This was true for me       Yes    No

How much were you bothered in the period prior to treatment?

None; not at all          0
I felt unreal at times but I could easily be brought back  
I felt unreal a lot and had difficulty getting back  
I regularly felt totally disconnected from my surroundings  
Not applicable

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>70. I sometimes felt that there were two people living inside me who controlled how I behaved at different times.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>This was true for me</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>How much were you bothered in the period prior to treatment?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>None; not at all</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>I was a very different person in different settings</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>It felt like different parts of me were in competition over how I should behave</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>There were separate parts of me that took control at different times</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Not applicable</td>
<td>NA</td>
<td></td>
</tr>
</tbody>
</table>

71. I had the feeling that I basically had no influence on what happened to me in my life

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>This was true for me</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>How much were you bothered in the period prior to treatment?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>None; not at all</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>I did not take initiative in routine activities</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>At times, I did not bother to keep appointments, did not go out, did not return phone calls, did not take care of myself (e.g. personal hygiene, shopping, eating)</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>I simply did not bother to take care of myself</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Not applicable</td>
<td>NA</td>
<td></td>
</tr>
</tbody>
</table>

72. I felt that I had something wrong with me, after what happened to me, that could never me fixed.

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>This was true for me</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>How much were you bothered in the period prior to treatment?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>None; not at all</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>I felt wounded, but that I could get better</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>I felt that parts of me were damaged, but that some parts of me still functioned</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>I felt that I was a permanently damaged person</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Not applicable</td>
<td>NA</td>
<td></td>
</tr>
</tbody>
</table>

73. I felt chronically guilty about all sorts of things.

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>This was true for me</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>How much were you bothered in the period prior to treatment?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>None; not at all</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>I felt more responsible than I needed to for things that went wrong</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>I blamed myself for things that went wrong even when I had nothing to do with it</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>I blamed myself and punished myself for whatever went wrong, even when I had nothing to do with it</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Not applicable</td>
<td>NA</td>
<td></td>
</tr>
</tbody>
</table>
74. I was too ashamed of myself to let people get to know me.

This was true for me

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
</table>

How much were you bothered in the period prior to treatment?

| None; not at all | 0 |
| I made up stories to hide things I was ashamed of | 1 |
| I avoided letting most people know who I really was for fear they’d get to know me | 2 |
| I let no one get close to me to make sure they wouldn’t find out who I really was | 3 |
| Not applicable | NA |

75. I felt set apart and very different from other people.

This was true for me

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
</table>

How much were you bothered in the period prior to treatment?

| None; not at all | 0 |
| I felt quite different from people around me | 1 |
| I felt different from others and distant, estranged, or alienated from them | 2 |
| I felt like I was from another planet and did not belong anywhere | 3 |
| Not applicable | NA |

76. I felt that other people made too big a deal of my having been exposed to potentially dangerous or violent situations.

This was true for me

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
</table>

How much were you bothered in the period prior to treatment?

| None; not at all | 0 |
| (Minimal) | 1 |
| (Moderate) | 2 |
| (Severe) | 3 |
| Not applicable | NA |

77. I had trouble trusting people.

This was true for me

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
</table>

How much have you been bothered in the last month?

| None; not at all | 0 |
| I was guarded and suspicious of people’s motives | 1 |
| People needed to prove themselves over and over again before I let my guard down | 2 |
| I did not return phone calls, reply to letters. I stopped conversations as soon as I could | 3 |
| Not applicable | NA |

78. I had difficulty working through conflicts in relationships.

This was true for me

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
</table>

How much were you bothered in the period prior to treatment?

| None; not at all | 0 |
| I was guarded and suspicious of people’s motives | 1 |
| People needed to prove themselves over and over again before I let my guard down | 2 |
| I did not return phone calls, reply to letters. I stopped conversations as soon as I could | 3 |
| Not applicable | NA |
None; not at all 0
I was quiet or avoided situations that might cause conflict, or I was easily hurt and offended 1
I had trouble hearing other viewpoints or had difficulty standing up for myself 2
I quit jobs and relationships without negotiating, I threatened to sue people if they offended me, I couldn’t stand it if people disagreed with me 3
Not applicable NA

79. I found that other traumatic experiences kept happening to me.

This was true for me Yes No

How much were you bothered in the period prior to treatment?

None; not at all 0
I found myself occasionally hurt in relationships 1
I repeatedly found myself hurt in relationships 2
I was seriously hurt by people I loved or thought I could trust 3
Not applicable NA

80. I hurt other people in ways similar to how I was hurt

This was true for me Yes No

How much were you bothered in the period prior to treatment?

None; not at all 0
People told me once or twice that I was hurtful 1
People told me several times that I was hurtful, or I deliberately hurt people 2
I seriously hurt or injured other people in ways that were similar to the ways I had been hurt myself 3
Not applicable NA

81. I had trouble with (circle item that apply), yet doctors had not found a clear cause for it.

<table>
<thead>
<tr>
<th>Option</th>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>NA</th>
</tr>
</thead>
<tbody>
<tr>
<td>a) vomiting</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>b) abdominal pain</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>c) nausea</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>d) diarrhoea</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>e) intolerance of food</td>
<td></td>
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</tbody>
</table>

This was true for me Yes No

How much were you bothered in the period prior to treatment?

None; not at all 0
I had some trouble – did not require regular medical attention 1
I went to the doctor and was prescribed more than one medication without relief 2
I had several doctor visits, hospital admissions, and/or invasive diagnostic tests 3
Not applicable NA
81. I suffered from chronic pain (circle items that apply), yet doctors could not find a clear cause for it.

a) in your arms and legs  
b) in your back  
c) in your joint  
d) during urination  
e) headaches  
f) elsewhere  

This was true for me  

How much were you bothered in the period prior to treatment?

None; not at all  
I had some trouble – did not require regular medical attention  
I went to the doctor and was prescribed more than one medication without relief  
I had several doctor visits, hospital admissions, and/or invasive diagnostic tests  
Not applicable  

82. I suffered from (circle the items that apply), yet doctors did not find a clear-cut cause for it.

a) shortness of breath  
b) palpitations  
c) chest pain  
d) dizziness  

This was true for me  

How much were you bothered in the period prior to treatment?

None; not at all  
I had some trouble – did not require regular medical attention  
I went to the doctor and was prescribed more than one medication without relief  
I had several doctor visits, hospital admissions, and/or invasive diagnostic tests  
Not applicable  

83. I suffered from trouble with (circle items that apply), yet doctors did not find a clear cut cause for it.

a) remembering things  
b) swallowing  
c) losing your voice  
d) blurred vision  
e) actual blindness  
f) fainting and losing consciousness  
g) seizures and convulsions  
h) being able to walk  
i) paralysis or muscle weakness  
j) urination  

This was true for me  

How much were you bothered in the period prior to treatment?

None; not at all  
I had some trouble – did not require regular medical attention  
I went to the doctor and was prescribed more than one medication without relief  
I had several doctor visits, hospital admissions, and/or invasive diagnostic tests  
Not applicable
84. I suffered from (circle the items that apply), yet doctors did not find a clear-cut cause for it.

a) burning sensations in your sexual organs or rectum (not during intercourse)
b) impotence
c) irregular menstrual periods
d) excessive pre-menstrual tension
e) excessive menstrual bleeding

This was true for me       Yes  No

How much were you bothered in the period prior to treatment?
None; not at all          0
I had some trouble – did not require regular medical attention   1
I went to the doctor and was prescribed more than one medication without relief 2
I had several doctor visits, hospital admissions, and/or invasive diagnostic tests 3
Not applicable         NA

85. I felt hopeless and pessimistic about the future.

This was true for me       Yes  No

How much were you bothered in the period prior to treatment?

None; not at all          0
I became discouraged and lost interest in planning for myself   1
I didn’t see a future and went through the motions of living   2
I felt condemned and that I had no future left     3
Not applicable         NA

86. I did not expect to be able to find happiness in love relationships.

This was true for me       Yes  No

How much were you bothered in the period prior to treatment?

None; not at all          0
I sometimes felt distant and disconnected from my loved ones   1
I went through the motions of relationships, but felt numb 2
I didn’t feel part of the human race, and could not ever imagine loving somebody 3
Not applicable         NA

87. I was unable to find satisfaction in work.

This was true for me       Yes  No

How much were you bothered in the period prior to treatment?

None; not at all          0
Sometimes it was a routine; but I could forget about my troubles by working 1
Work was a burden, and I had trouble keeping my interest up   2
I did not care less about my work      3
Not applicable         NA

88. I believed that life had lost its meaning.

This was true for me       Yes  No
How much were you bothered in the period prior to treatment?

None; not at all 0
Sometimes it seemed pointless 1
I could not think of a good reason, but I kept living 2
I lived in a huge void 3
Not applicable NA

89. There were changes in my philosophy or religious beliefs – or in the religious beliefs or philosophical beliefs I grew up with.

This was true for me Yes No

How much were you bothered in the period prior to treatment?

None; not at all 0
My beliefs changed, but it was a normal progression of life 1
I was disillusioned with the religious beliefs I grew up with 2
I hated the religious beliefs I grew up with 3
Not applicable NA

SECTION 4: Trauma-related symptoms experienced currently.

Below is the same list of problems that people sometimes have after experiencing a traumatic event. Read each one carefully and circle the number (0-3) that best describes how often the problem bothers you currently. Rate each problem with respect to the traumatic event you described in Item 14.

0 Not at all or only one time
1 Once a week or less/once in a while
2 2 to 4 times a week/half the time
3 5 or more times a week/almost always

91. 0 1 2 3 Having upsetting thoughts or images about the traumatic event that came into your head when you didn’t want them to

92. 0 1 2 3 Having bad dreams or nightmares about the traumatic event

93. 0 1 2 3 Reliving the traumatic event, acting or feeling as if it was happening again.

94. 0 1 2 3 Feeling emotionally upset when you were reminded of the traumatic event (for example, feeling scared, angry, sad, guilty etc)

95. 0 1 2 3 Experiencing physical reactions when you were reminded of the traumatic event (for example, breaking out in sweat, heart beating fast etc.)

96. 0 1 2 3 Trying not to think about, or have feelings about the traumatic event

97. 0 1 2 3 Trying to avoid activities, people, or places that remind you of the traumatic event

98. 0 1 2 3 Not being able to remember an important part of the traumatic event

99. 0 1 2 3 Having much less interest or participating much less often in important activities

100. 0 1 2 3 Feeling distant or cut off from people around you

101. 0 1 2 3 Feeling emotionally numb (for example, unable to cry or
391

102. 0 1 2 3 Feeling as if your future plans or hopes will not come true (for example, you will not have a career, marriage, children, or a long life)
103. 0 1 2 3 Having trouble falling or staying asleep
104. 0 1 2 3 Feeling irritable or having fits of anger
105. 0 1 2 3 Having trouble concentrating (for example, drifting in and out of conversations, losing track of a story on television, forgetting what you read)
106. 0 1 2 3 Being overtly alert (for example, checking to see who is around you, being uncomfortable with your back to a door etc)
107. 0 1 2 3 Being jumpy or easily startled (for example, when someone walks up behind you)

108. How long have you experienced the problems that your reported above?
1. Less than one month
2. 1 to 3 months
3. More than 3 months

109. How long after the traumatic event did these problems begin? Circle one)
1. Less than 6 months
2. 6 moths or more

Indicate below if the problems you rated above interfere with any of the following areas of your life currently. Circle Y for Yes and N for No

110. Y N Work
111. Y N Household chores and duties
112. Y N Relationships with friends
113. Y N Fun and leisure activities
114. Y N Schoolwork
115. Y N Relationships with your family
116. Y N Sex life
117. Y N General satisfaction with life
118. Y N Overall level of functioning in all areas of your life

What follows are some more difficulties that some people experience. After each statement please indicate: whether it has been true for you; if yes, how much have you are bothered by that problem currently.
119. Small problems get me very upset. For example, I get angry at a minor frustration. I cry easily.

This has been true for me: Yes No

How much have you been bothered in the last month?

None; not at all
Sometimes I overreact a little
Sometimes I get very upset, or everything upsets me more than it used to
Often I get extremely upset, have tantrums
Not applicable

120. I find it hard to calm myself down after I become upset and have trouble getting back on track.

This has been true for me: Yes No

How much have you been bothered in the last month?

None; not at all
I get momentarily upset
It keeps coming back to me hour after hour
I get completely consumed by it
Not applicable

121. When I feel upset, I have trouble finding ways to calm myself down

This has been true for me: Yes No

How much have you been bothered in the last month?

None; not at all
I need to make special efforts to calm myself
I need to stop everything and focus all my energy on calming down
I need to resort to extreme measures, like getting drunk, taking drugs, or doing other harmful things to my body
Not applicable

122. I feel angry most of the time

This has been true for me: Yes No

How much have you been bothered in the last month?

None; not at all
I feel quite angry but I am able to shift to other matters
My anger gets in the way of doing things
My anger dominates my daily life
Not applicable

123. I have thoughts or images of hurting somebody else.

This has been true for me: Yes No

How much have you been bothered in the last month?
None’ not at all 0
Yes, fleeting thoughts 1
I think about hurting people every day 2
I can’t stop thinking about hurting people 3
Not applicable NA

124. I have trouble controlling my anger.

This has been true for me Yes No

How much have you been bothered in the last month?

None/ not at all 0
I snap at people 1
I yell or throw things 2
I actually attack people physically 3
Not applicable NA

125. I worry about people finding out how angry I am.

This has been true for me Yes No

How much have you been bothered in the last month?

None; not at all 0
I have trouble confronting someone when they hurt me 1
I do not confront the person I’m angry at, but I show my anger in other ways 2
I do not let anyone know in words or actions that I am angry 3
Not applicable NA

126. I have been in accidents or near accidents

This has been true for me Yes No

How much have you been bothered in the last month?

None; not at all 0
Occasional accidents causing harm or pain but not requiring medical attention 1
One accident or episode requiring medical attention 2
More than one serious accident or episode requiring medical Attention 3
Not applicable NA

127. I find myself careless about making sure that I am safe.

This has been true for me Yes No

How much have you been bothered in the last month?

None; not at all 0
I think about the risks involved in relationships or situations, but do it anyway 1
I take undue risks regarding the people I am with or places I visited 2
I keep company with people who I know could be dangerous; not taking measures to protect myself in dangerous situations 3
Not applicable NA

128. I have deliberately tried to hurt myself (like burning or cutting myself)
This has been true for me  Yes  No

How much have you been bothered in the last month?

None; not at all 0
I hit or kick at objects 1
I hurt myself deliberately (pinching, scratching, hitting, banging) without serious damage 2
I hurt myself deliberately in ways that cause serious physical damage 3
Not applicable NA

129. I have thought about killing myself.

This has been true for me  Yes  No

How much have you been bothered in the last month? None; not at all 0
I was preoccupied, but had no pain 1
I made gestures, or was chronically pre-occupied with plans 2
I made one or more serious suicide attempts 3
Not applicable NA

130. I make active efforts to keep myself thinking about sex.

This has been true for me  Yes  No

How much have you been bothered in the last month?

None; not at all 0
I try not to think about sex 1
I work very hard not to think about sex 2
I will not tolerate any thoughts about sex 3
Not applicable NA

131. It bothers me to be touched in general.

This has been true for me  Yes  No

How much have you been bothered in the last month?

None; not at all 0
It sometimes bothers me 1
It often or regularly bothers me 2
I simply could not stand it 3
Not applicable NA

132. It bothers me to be touched in a sexual way.

This has been true for me  Yes  No

How much have you been bothered in the last month?

None; not at all 0
Sometimes it bothers me 1
It often or regularly bothers me 2
I simply could not stand it 3
Not applicable NA

133. I actively avoid sex

This has been true for me  Yes  No
How much have you been bothered in the last month?

None; not at all 0
I find myself making excuses 1
I try not to have sex 2
I don’t have sex 3
Not applicable NA

134. I find myself thinking about sex more than I want to

This has been true for me Yes No

How much have you been bothered in the last month?

None; not at all 0
I think about it too much 1
It distracts me from what I should be doing 2
I am obsessed with it 3
Not applicable NA

135. I find myself driven to engage in sexual activities without really feeling that I had a choice.

This has been true for me Yes No

How much have you been bothered in the last month?

None; not at all 0
I feel the urge, but I do not act on it 1
I feel compelled to, but I force myself to stop 2
I engage in compulsive sex 3
Not applicable NA

136. I am active sexually in ways that I know put me in danger.

This has been true for me Yes No

How much have you been bothered in the last month?

None; not at all 0
I am a bit careless 1
I talk myself into ignoring the danger or I only see the danger afterwards 2
I knowingly put myself in danger 3
Not applicable NA

137. I expose myself to situations that might be dangerous, e.g. I get involved with people who might hurt me. I go to places that are not safe. I drive too fast.

This has been true for me Yes No

How much have you been bothered in the last month?

None; not at all 0
I am a bit careless 1
I talk myself into ignoring the danger or I only see the danger afterwards 2
I knowingly put myself in danger 3
138. There are parts of my life that I cannot remember, or I am confused about what happened, or I am unsure whether certain important things did or did not happen to me.

This has been true for me

How much have you been bothered in the last month?

None; not at all 0
There are a few memory lapses 1
There are important gaps in my memory; there are missing periods 2
I have no memory for days, months, or years of my life 3
Not applicable NA

139. I have difficulty keeping track of my daily life.

This has been true for me

How much have you been bothered in the last month?

None; not at all 0
At times, I have difficulty making or keeping track of schedules 1
I regularly show up at the wrong place at the wrong time 2
I am unable to keep track of my daily life 3
Not applicable NA

140. I “space” out when I feel frightened or under stress.

This has been true for me

How much have you been bothered in the last month?

None; not at all 0
I am withdrawn at times 1
I go into my own world and do not let people in 2
I feel like I stop existing 3
Not applicable NA

141. I sometimes feel so unreal that it is as if I am living in a dream, or not really there, or behind a glass wall.

This has been true for me

How much have you been bothered in the last month?

None; not at all 0
I feel unreal at times but I can easily be brought back 1
I feel unreal a lot and have difficulty getting back 2
I regularly feel totally disconnected from my surroundings 3
Not applicable NA

142. I sometimes feel that there are two people living inside me who control how I behave at different times.

This has been true for me
How much have you been bothered in the last month?

None; not at all 0
I am a very different person in different settings 1
It feels like different parts of me are in competition over how I should behave 2
There are separate parts of me that take control at different times 3
Not applicable NA

143. I have the feeling that I basically have no influence on what happens to me in my life

This has been true for me Yes No

How much have you been bothered in the last month?

None; not at all 0
I do not take initiative in routine activities 1
At times, I do not bother to keep appointments, do not go out, do not return phone calls, do not take care of myself (e.g. personal hygiene, shopping, eating) 2
I simply do not bother to take care of myself 3
Not applicable NA

144. I feel that I have something wrong with me, after what happened to me, that can never me fixed.

This has been true for me Yes No

How much have you been bothered in the last month?

None; not at all 0
I feel wounded, but that I can get better 1
I feel that parts of me are damaged, but that some parts of me still function 2
I feel that I am a permanently damaged person 3
Not applicable NA

145. I feel chronically guilty about all sorts of things.

This has been true for me Yes No

How much have you been bothered in the last month?

None; not at all 0
I feel more responsible than I need to for things that go wrong 1
I blame myself for things that go wrong even when I had nothing to do with it 2
I blame myself and punish myself for whatever goes wrong, even when I have nothing to do with it 3
Not applicable NA

146. I am too ashamed of myself to let people get to know me.

This has been true for me Yes No

How much have you been bothered in the last month?

None; not at all 0
I make up stories to hide things I’m ashamed of 1
I avoid letting most people know who I really am for fear they’ll get to know me 2
I let no one get close to me to make sure they won’t find out who I really am 3
Not applicable NA

147. I feel set apart and very different from other people.
This has been true for me Yes No
How much have you been bothered in the last month?
None; not at all 0
I feel quite different from people around me 1
I feel different from others and distant, estranged, or alienated from them 2
I feel like I am from another planet and do not belong anywhere 3
Not applicable NA

148. I feel that other people make too big a deal of my having been exposed to potentially dangerous or violent situations.
This has been true for me Yes No
How much have you been bothered in the last month?
None; not at all 0
(Minimal) 1
(Moderate) 2
(Severe) 3
Not applicable NA

149. I have trouble trusting people.
This has been true for me Yes No
How much have you been bothered in the last month?
None; not at all 0
I ma guarded and I am suspicious of people’s motives 1
People need to prove themselves over and over again before I let my guard down 2
I do not return phone calls, reply to letters. I stop conversations as soon as I can 3
Not applicable NA

150. I have difficulty working through conflicts in relationships.
This has been true for me Yes No
How much have you been bothered in the last month?
None; not at all 0
I am quiet or avoid situations that might cause conflict, or I am easily hurt and offended 1
I have trouble hearing other viewpoints or have difficulty standing up for myself 2
I quit jobs and relationships without negotiating, I threaten to sue people if they offend me, I can’t stand it if people disagree with me 3
Not applicable NA
151. I find that other traumatic experiences keep happening to me.

This has been true for me

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
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How much have you been bothered in the last month?

<table>
<thead>
<tr>
<th></th>
<th>None; not at all</th>
<th>0</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>I find myself occasionally hurt in relationships</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>I repeatedly find myself hurt in relationships</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>I am seriously hurt by people I love or thought I could trust</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Not applicable</td>
<td>NA</td>
</tr>
</tbody>
</table>

151. I have hurt other people in ways similar to how I was hurt

This has been true for me

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
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How much have you been bothered in the last month?

<table>
<thead>
<tr>
<th></th>
<th>None; not at all</th>
<th>0</th>
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<tbody>
<tr>
<td></td>
<td>People have told me once or twice that I am hurtful</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>People have told me several times that I am hurtful, or I deliberately hurt people</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>I seriously hurt or injure other people in ways that are similar to the ways I have been hurt myself</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Not applicable</td>
<td>NA</td>
</tr>
</tbody>
</table>

152. I have trouble with (circle item that apply), yet doctors have not found a clear cause for it.

a) vomiting
b) abdominal pain
c) nausea
d) diarrhoea
e) intolerance of food

This has been true for me

<table>
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<tr>
<th></th>
<th>Yes</th>
<th>No</th>
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</table>

How much have you been bothered in the last month?

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<tr>
<th></th>
<th>None; not at all</th>
<th>0</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>I have had some trouble – did not require regular medical attention</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>I went to the doctor and was prescribed more than one medication without relief</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>I had several doctor visits, hospital admissions, and/or invasive diagnostic tests</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Not applicable</td>
<td>NA</td>
</tr>
</tbody>
</table>

153. I suffer from chronic pain (circle items that apply), yet doctors cold not find a clear cause for it.

a) in your arms and legs
b) in your back
c) in your joint
d) during urination
e) headaches
f) elsewhere

This has been true for me

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
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</table>

How much have you been bothered in the last month?

|   | None; not at all | 0 |
I have had some trouble – did not require regular medical attention 1
I went to the doctor and was prescribed more than one medication without relief 2
I had several doctor visits, hospital admissions, and/or invasive diagnostic tests 3
Not applicable NA

156. I suffer from (circle the items that apply), yet doctors have not found a clear-cut cause for it.

a) shortness of breath
b) palpitations
c) chest pain
d) dizziness

This has been true for me Yes No

How much have you been bothered in the last month?

None; not at all 0
I have had some trouble – did not require regular medical attention 1
I went to the doctor and was prescribed more than one medication without relief 2
I had several doctor visits, hospital admissions, and/or invasive diagnostic tests 3
Not applicable NA

157. I suffer from trouble with (circle items that apply), yet doctors have not found a clear-cut cause for it.

a) remembering things
b) swallowing
c) losing your voice
d) blurred vision
e) actual blindness
f) fainting and losing consciousness
g) seizures and convulsions
h) being able to walk
i) paralysis or muscle weakness
j) urination

This has been true for me Yes No

How much have you been bothered in the last month?

None; not at all 0
I have had some trouble – did not require regular medical attention 1
I went to the doctor and was prescribed more than one medication without relief 2
I had several doctor visits, hospital admissions, and/or invasive diagnostic tests 3
Not applicable NA

158. I suffer from (circle the items that apply), yet doctors have not found a clear-cut cause for it.

a) burning sensations in your sexual organs or rectum (not during intercourse)
b) impotence
c) irregular menstrual periods
d) excessive pre-menstrual tension
e) excessive menstrual bleeding

This has been true for me Yes No
How much have you been bothered in the last month?

<table>
<thead>
<tr>
<th>Option</th>
<th>Code</th>
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<tbody>
<tr>
<td>None; not at all</td>
<td>0</td>
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<td>I have had some trouble – did not require regular medical attention</td>
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<tr>
<td>I went to the doctor and was prescribed more than one medication without relief</td>
<td>2</td>
</tr>
<tr>
<td>I had several doctor visits, hospital admissions, and/or invasive diagnostic tests</td>
<td>3</td>
</tr>
<tr>
<td>Not applicable</td>
<td>NA</td>
</tr>
</tbody>
</table>

159. I feel hopeless and pessimistic about the future.

This has been true for me

<table>
<thead>
<tr>
<th>Option</th>
<th>Code</th>
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<tbody>
<tr>
<td>Yes</td>
<td></td>
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<tr>
<td>No</td>
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How much have you been bothered in the last month?

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<tr>
<th>Option</th>
<th>Code</th>
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</thead>
<tbody>
<tr>
<td>None; not at all</td>
<td>0</td>
</tr>
<tr>
<td>I get discouraged and lose interest in planning for myself</td>
<td>1</td>
</tr>
<tr>
<td>I don’t see a future and go through the motions of living</td>
<td>2</td>
</tr>
<tr>
<td>I feel condemned and have no future left</td>
<td>3</td>
</tr>
<tr>
<td>Not applicable</td>
<td>NA</td>
</tr>
</tbody>
</table>

160. I do not expect to be able to find happiness in love relationships.

This has been true for me

<table>
<thead>
<tr>
<th>Option</th>
<th>Code</th>
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<tbody>
<tr>
<td>Yes</td>
<td></td>
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<tr>
<td>No</td>
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How much have you been bothered in the last month?

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<tr>
<th>Option</th>
<th>Code</th>
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</thead>
<tbody>
<tr>
<td>None; not at all</td>
<td>0</td>
</tr>
<tr>
<td>I sometimes feel distant and disconnected from my loved ones</td>
<td>1</td>
</tr>
<tr>
<td>I go through the motions of relationships, but feel numb</td>
<td>2</td>
</tr>
<tr>
<td>I don’t feel part of the human race, and cannot ever imagine loving somebody</td>
<td>3</td>
</tr>
<tr>
<td>Not applicable</td>
<td>NA</td>
</tr>
</tbody>
</table>

161. I am unable to find satisfaction in work.

This has been true for me

<table>
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<th>Option</th>
<th>Code</th>
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<tbody>
<tr>
<td>Yes</td>
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<tr>
<td>No</td>
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How much have you been bothered in the last month?

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<th>Option</th>
<th>Code</th>
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<tbody>
<tr>
<td>None; not at all</td>
<td>0</td>
</tr>
<tr>
<td>Sometimes it is a routine; but I can forget about my troubles by working</td>
<td>1</td>
</tr>
<tr>
<td>Work is a burden, and I have trouble keeping my interest up</td>
<td>2</td>
</tr>
<tr>
<td>I could not care less about my work</td>
<td>3</td>
</tr>
<tr>
<td>Not applicable</td>
<td>NA</td>
</tr>
</tbody>
</table>

162. I believe that life has lost its meaning.

This has been true for me

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<tr>
<th>Option</th>
<th>Code</th>
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<tbody>
<tr>
<td>Yes</td>
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<tr>
<td>No</td>
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How much have you been bothered in the last month?

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<th>Option</th>
<th>Code</th>
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</thead>
<tbody>
<tr>
<td>None; not at all</td>
<td>0</td>
</tr>
<tr>
<td>Sometimes it seems pointless</td>
<td>1</td>
</tr>
<tr>
<td>I cannot think of a good reason, but I keep living</td>
<td>2</td>
</tr>
<tr>
<td>I live in a huge void</td>
<td>3</td>
</tr>
<tr>
<td>Not applicable</td>
<td>NA</td>
</tr>
</tbody>
</table>
163. There have been changes in my philosophy or religious beliefs – or in the religious beliefs or philosophical beliefs I grew up with.

This has been true for me

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
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</table>

How much have you been bothered in the last month?

<table>
<thead>
<tr>
<th></th>
<th>None; not at all</th>
<th>My beliefs have changed, but it was a normal progression of life</th>
<th>I am disillusioned with the religious beliefs I grew up with</th>
<th>I hate the religious beliefs I grew up with</th>
<th>Not applicable</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>NA</td>
</tr>
</tbody>
</table>

164. Have you experienced a traumatic event in your life not related to physical, sexual or other forms of abuse?

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<tr>
<th></th>
<th>Yes</th>
<th>No</th>
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</table>

If “Yes, briefly describe that trauma
SECTION 5: Informed Consent Form

INFORMED CONSENT FORM

A Study of the Relationship Between Standard Interventions Used to Address the Symptoms of PTSD or Complex PTSD and Reduced/Persistent Symptomatology.

Researcher: Pam Connor   Supervisor: Dr Daryl Higgins

I, ........................................................................ of
.................................................................................................................................
hereby give permission for Ms Pam Connor to obtain information from my therapist, ................................................................., regarding treatment I am receiving for symptoms associated with past trauma.

Yours sincerely

........................................................................(signature)

........................................................................ NAME (printed)

........................................................................ (DATE)
Dear XXXXXXXXX

Thank you to all those who have already submitted the items sent to you as part of the above-mentioned study. The response to date has been very encouraging. For those who have not yet had the opportunity to complete the items requested, I would appreciate your responses as soon as possible.

Please do not hesitate to phone me on 0417 452 365 if you have any questions regarding this study.

Thank You

Yours sincerely

Pam Connor
APPENDIX C

ADVERTISEMENT for NEWSPAPERS

Deakin University Logo inserted here

ARE YOU SUFFERING FROM POST-TRAUMATIC STRESS?

Any person over the age of 18 years who has been a victim of trauma (childhood, adolescent or adult) and who is currently undergoing (or who has recently completed) treatment as a result of this trauma, is invited to participate in a research study.

The purpose of the study is to examine the relationship between standard treatments used to address the symptoms of trauma and reduced/persistent symptomatology.

This study has been authorised by Deakin University Ethics Committee, Melbourne.

If you are interested in finding out more about this study, please contact Pam on 0417 452 365.
DO YOU SUFFER FROM POST-TRAUMATIC STRESS?

Any person over the age of 18 years who has been a victim of trauma (childhood, adolescent or adult) and who is currently undergoing (or who has recently completed) treatment as a result of this trauma, is invited to participate in a research study.

The purpose of the study is to examine the relationship between standard interventions used to address the symptoms associated with trauma and reduced/persistent symptomatology.

If you are interested in finding out more about this study, please contact Pam Connor on 0417 452 365.
APPENDIX E

LETTER TO REGISTERED PSYCHOLOGISTS

Researcher’s Name

Psychologist’s Name/Address

Dear XXXXXXXX

Re PTSD Clients

I am currently undertaking studies for the award of Doctor of Health Science at Deakin University. As part of the requirements for this study, I am undertaking research under the supervision of Dr. Daryl Higgins, who is a lecturer in the School of Psychology, at Deakin University. This research will examine the relationship between standard Interventions used to address the symptoms of PTSD or Complex PTSD and reduced/persistent symptomatology.

I am, therefore, seeking participants for this study – in particular, participants who are undergoing, or who have recently completed, treatment for PTSD. In order to obtain participants for the study, I will be contacting all registered psychologists in the ACT, and also placing advertisements (see copy attached) in local newspapers and Health Centres.

In the study, participants will be sent a questionnaire and reply-paid envelopes. This questionnaire will take approximately two hours to complete and will provide information regarding past abuse-related experiences, and also current (and pre-treatment) trauma-related symptoms. I expect that the overall study will lead to recommendations regarding treatment of Complex PTSD.

I would appreciate it if you could provide the attached statement, containing details of my study, to any patients who have presented with trauma-related symptoms and display the attached poster in your waiting room. The statement provides contact details should any patients wish to participate in the study.

Please contact me on 0417 452 365 if you wish to discuss any matters pertaining to this study or if you wish to obtain a copy of the questionnaire.

Yours sincerely
Pam Connor
Pam Connor
Psychologist
BA, B.Sc.(Psychology), Masters in Counselling
APPENDIX F: PLAIN LANGUAGE STATEMENT

Plain Language Statement: A Study of the relationship between standard Interventions used to address the symptoms of Post Traumatic Stress Disorder (PTSD) or Complex PTSD and reduced/persistent symptomatology.

My name is Pam Connor. I am currently undertaking studies for the award of Doctor of Health Science at Deakin University. As part of the requirements for this study, I am undertaking research under the supervision of Dr. Daryl Higgins, who is a lecturer in the School of Psychology, at Deakin University. This research will examine clients’ perceptions of the effectiveness of standard Interventions used to address their symptoms of Post Traumatic Stress Disorder (PTSD) or Complex PTSD. The study will also investigate the differences in symptoms, depending on the type of trauma experienced. As you are currently undergoing (or have recently concluded) treatment, I would like to invite you to participate in the study.

If you choose to participate in the study, you will be asked to complete a number of questions concerning types of trauma experienced, for example, “How often were you physically punished for wrongdoing (e.g. smacking, grabbing, shaking). You’ll also be asked to rate whether you’ve experienced a range of symptoms (currently and also prior to treatment) (for example, “I find it hard to calm myself down after I become upset” [Answer Yes or No]. Your responses will take approximately two hours of your time. You will also be asked to sign an informed consent form giving permission to contact your therapist to obtain some brief information about the methods employed during your therapy. I expect that the overall study will lead to recommendations regarding treatment of Complex PTSD – treatment that may differ according to type and severity of abuse.

I will make every effort to ensure confidentiality of information gathered, and to secure the anonymity of each participant’s data. The only form on which identifying information will be placed will be the informed consent form described above. This form will be stored separately from all other data, which will bear only an identifying code number. Following collection and collation of data, participant responses will be stored in a locked cabinet in the researcher’s office. Due to the sensitive nature of issues surrounding personal and childhood experiences, should you become distressed at any stage of the study, or have any concerns regarding the nature of the research, please feel free to withdraw your participation at any stage of the research. You may also wish to contact one of the counselling services listed on the attached sheet.

A statement detailing the overall results of the research will be available at the conclusion of the study on request. Should you require such details, or any other details regarding this research, please phone on (03) 5227 2924 or send your request to Dr Daryl Higgins, Deakin University, Geelong, 3217. Should you have any concerns about the conduct of this research project, please contact the Chair, Mr Keith Wilkins, Deakin University Ethics Committee. Telephone 03 9251 7123

Thank you for devoting your time to reading this statement. If you are interested in taking part in the study, please contact the researcher, Pam Connor on 6258 4014 or 0417 452 365 to obtain a copy of the questionnaires and reply-paid envelopes.

Thank You
Pam Connor
Psychologist
BA, B.Sc.(Psychology), Masters in Counselling
MEMORANDUM

TO: Ms Pam Connor
    Psychology
    Geelong

FROM: Secretary, Deakin University Human Research Ethics Committee (DU-HREC)

DATE: 24 January 2005

SUBJECT: PROJECT: EC 179-2000 (Please quote this project number in future communication.)
A STUDY OF THE RELATIONSHIP BETWEEN STANDARD INTERVENTIONS USED TO ADDRESS THE SYMPTOMS OF PTSD OR COMPLEX PTSD AND REDUCED/PERSISTENT SYMPTOMATOLOGY

This application was considered at the DU-HREC meeting held on 25 September 2000.

THAT APPROVAL BE GIVEN FOR MS PAM CONNOR, UNDER THE SUPERVISION OF DR DARYL HIGGINS, PSYCHOLOGY, TO UNDERTAKE THIS PROJECT FROM 1 OCTOBER 2000 TO 1 OCTOBER 2001.

The approval given by the Deakin University Human Research Ethics Committee is given only for the project and for the period as stated in the application and approval. It is your responsibility to contact the Secretary immediately should any of the following occur:
- Serious or unexpected adverse effects on the participants
- Any proposed changes in the protocol, including extensions of time.
- Any events which might affect the continuing ethical acceptability of the project.
- The project is discontinued before the expected date of completion.

In addition you will be required to report on the progress of your project at least once every year and at the conclusion of the project. Failure to report as required will result in suspension of your approval to proceed with the project.

Victoria Emery
Secretary, DU-HREC
(03) 9251 7123
MEMORANDUM

TO: 
Ms Pam Connor
Psychology
Geelong

FROM: 
Secretary, Deakin University Human Research Ethics Committee (DU-HREC)

DATE: 
24 January 2005

SUBJECT: PROJECT: EC 237-2002 (Please quote this project number in future communication.)
A STUDY OF THE CAPACITY OF AN INDIVIDUALISED TREATMENT PROGRAM TO ASSIST PATIENTS WITH SYMPTOMS ASSOCIATED WITH LONG-TERM / MULTIPLE TRAUMA EXPERIENCES AND ENHANCE 'EGO STRENGTHENING'.

This application was considered at the DU-HREC meeting held on 9 December 2002.

APPROVAL HAS BEEN GIVEN FOR MS PAM CONNOR, UNDER THE SUPERVISION OF DR DARYL HIGGINS, SCHOOL OF HEALTH SCIENCES, TO UNDERTAKE THIS PROJECT FROM 1 APRIL 2003 TO 31 DECEMBER 2003.

The approval given by the Deakin University Human Research Ethics Committee is given only for the project and for the period as stated in the application and approval. It is your responsibility to contact the Secretary immediately should any of the following occur:

- Serious or unexpected adverse effects on the participants
- Any proposed changes in the protocol, including extensions of time.
- Any events which might affect the continuing ethical acceptability of the project.
- The project is discontinued before the expected date of completion.

In addition you will be required to report on the progress of your project at least once every year and at the conclusion of the project. Failure to report as required will result in suspension of your approval to proceed with the project.

Victoria Emery
Secretary, DU-HREC
(03) 9251 7123
Plain Language Statement: A Study of the capacity of an individualised treatment program to assist clients with symptoms associated with long-term/multiple trauma.

My name is Pam Connor. I am currently undertaking studies for the award of Doctor of Health Science at Deakin University. As part of the requirements for this study, I am undertaking research under the supervision of Dr. Daryl Higgins, who is a lecturer in the School of Psychology, at Deakin University. This research will examine the usefulness of an individualised treatment program in assisting patients with symptoms associated with long-term/multiple trauma. I would like to invite you to participate in the study.

If you choose to participate in the study, you will be asked, at the outset, to participate in a brief interview and complete an inventory to assess current symptomatology. This will take approximately one hour of your time. If you are selected for the study, you will have the opportunity to negotiate an individualised treatment program for yourself. The treatment program will take place over a six-month period and will involve a combination of individual therapy (approximately one session per week) and group counselling. The treatment will be provided free of cost over this six-month period. You will then be provided with the opportunity for further assessment and will receive feedback regarding the outcomes of the program. You will also have the opportunity to discuss with me referral options for ongoing therapy, should this be required.

I will make every effort to ensure confidentiality of information gathered, and to secure the anonymity of each participant’s data. Throughout the six-month treatment period, participants’ files will be stored in a locked cabinet in the researcher’s home. In the writing up of the study, no names or identifying information will be used.

Due to the sensitive nature of issues surrounding personal and childhood experiences, should you become distressed at any stage of the study, or have any concerns regarding the nature of the research, please feel free to withdraw your participation at any stage of the research.

A statement detailing the overall results of the research will be available at the conclusion of the study on request. Should your require such details, or any other details regarding this research, please phone on (03) 5227 2924 leaving your details, or send your request to Dr Daryl Higgins, Deakin University, Geelong, Victoria, 3217. Should you have any concerns about the conduct of this research project, please contact the Chair, Deakin University Ethics Committee. Telephone 03 9251 7123

Thank you for devoting your time to reading this statement. If you are interested in taking part in the study, please contact the researcher, Pam Connor on 6251 5692 or 0417 452 365 to obtain a copy of the questionnaires and reply-paid envelopes.

Thank You
Pam Connor
Psychologist
BA, B.Sc.(Psychology), Masters in Counselling
AGREEMENT TO TAKE PART IN RESEARCH EVALUATING A TREATMENT PROGRAM FOR SUFFERERS OF LONG-TERM/MULTIPLE TRAUMA

I---------------------------------------- agree to take part in research of Psychologist, Pam Connor, who is undertaking an evaluating of an individualised treatment approach for individuals who are suffering from long-term/multiple trauma. I have read the plain language statement outlining details of the research study, and have discussed the nature of the treatment program with Ms Connor.

I understand that

☐ Ms Connor is undertaking this research as part of the requirements for her award of Doctor of Health Science (Psychology) through Deakin University.

☐ I will be receiving treatment over a six-month period, which involves a combination of individual (approximately one session per week) and group therapy.

☐ The treatment program will be negotiated with me prior to commencement.

☐ The treatment will be provided free of cost over this six-month period.

☐ I will be provided with the opportunity for further assessment at the conclusion of the research period, and will receive feedback regarding outcomes of the program.

☐ I understand that, at the conclusion of the six-month period, Ms Connor will discuss with me the referral options for ongoing therapy, should this be needed.

Signature-----------------------------
Date-----------------------------
Witness-----------------------------
APPENDIX J

SUMMARY of TREATMENT PROGRAM GUIDELINES SENT TO PARTICIPANT

A SUMMARY of TREATMENT PROGRAM GUIDELINES

By Pam Connor
SUMMARY of TREATMENT PROGRAM GUIDELINES

1 Introduction: Goals of Early Stage Treatment of Complex PTSD

The goal of early stage treatment of Complex Post-Traumatic Stress Disorder is to help you gain a sense of stability, so that you can approach “remembering” and integration of the past with a stronger sense of self, and with a range of coping strategies to assist when overwhelmed.

This program aims to assist you develop the capacity to do the following:

- Take adequate self care;
- function more effectively on a day-to-day basis;
- achieve control over your internal feelings and impulses (and PTSD symptoms);
- develop improved interpersonal relationships and increased social supports or networks: and
- achieve a more positive sense of self-identity and worth, with improved insight into/understanding of your own “systems of meaning”.

2 Six-Step Program for early stage treatment of Complex PTSD.

A six-step program is recommended as most suitable in treating complex PTSD in the early stages. The six steps involve the following:

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”
2.1 First Stage: Having a Supportive and Experienced Therapist

It is important, when entering treatment, to ensure that the therapist is someone who has extensive experience in working with sufferers of long-term and multiple forms of trauma. The therapist will need to assess carefully for symptoms of Complex PTSD as well as PTSD, and to understand the importance of dealing with the associated symptoms of Complex PTSD, prior to discussing past traumatic experiences. The therapist will also need to be available regularly, and over a long period of time, to allow sufficient time for “ego strengthening” to take place.

2.2 Second Stage: Ensuring Personal Safety

It is probable that many of you have developed a range of self-destructive coping behaviours such as self-mutilation (non-lethal), substance abuse, eating disorders, and addiction to risk-taking behaviours. Re-victimisation may also have occurred for many of you. If this is the case, then such self-destructive behaviour and vulnerability to re-victimisation needs to be controlled prior to the exploratory therapy undertaken in the next stage of therapy. If this does not occur, the likelihood of further self-harming behaviour, when traumatic material is re-visited, is high. Thus, it is important that, together with the therapist, you develop strategies for creating an environment of personal safety prior to any exploratory work.

Although many of you will find self-care difficult, and will often have lapses in achieving adequate self-care, it is important that you commit to the principles of self-care and make agreements with your therapist in regard to preventing your own destructive impulses and understanding why you are vulnerable to re-victimisation. Such “agreements” will involve contracting to either “doing your best to keep safe” or (when this is not possible), “seeking help in order to achieve safety”.
At this stage, it is also important that you develop your own comprehensive safety plan with your therapist’s help. In this way, you can feel free from harm or the immediate threat of harm. Elements of the safety plan will be discussed and will include making lists of possible contacts, preventive measures, and also identifying patterns of behaviour (for example withdrawing, staying in bed, not being bale to concentrate, feeling “spaced out”, feeling angry) which predict dangerous or impulsive behaviour.

2.3 Third Stage: Assisting with Daily Functioning

Maintaining an appropriate level of functioning is essential to the success of therapy. Thus, therapists will encourage you to continue your involvement in paid employment, a volunteer job, regular activities at home, and other extra-curricular activities. Such functional activity provides much-needed daily structure, and also assists your social networking. You may also begin to feel better about yourselves if you maintain a reasonable level of functioning.

Your therapist will also assist you with strategies for relaxation and sleep-enhancing strategies. Having strategies to assist in gaining a good night’s sleep, and also in relaxing effectively will help you in the maintenance of an adequate level of functioning.

2.4 Fourth Stage: Learning to Manage Symptoms of PTSD

Many of you may be experiencing a range of symptoms, including re-experiencing the trauma (in the form of flashbacks, intrusive thoughts, nightmares). On the other hand, such memories may be so painful for you, that you avoid people, situations and things that remind you of them. You may also have developed a range of other “coping” strategies to assist with the avoidance process. Many of you may be experiencing loss of memory (amnesia) for past events, or you may sometimes feel that you are detached from reality. Others may have developed feelings that you are not really in your own body and are viewing events from outside your person. Many of you will also be experiencing states of extreme arousal and will feel agitated and
restless. If any of the above symptoms occur frequently, then you are likely to remain in a state of crisis, and this will inhibit later treatment. Thus, it is important, at this stage, to learn strategies to control these symptoms. Such control can occur gradually through a range of interventions, which can be seen as a form of self-regulation.

Self–regulation is a term that is used to describe the process of becoming more aware of emotions and other internal experiences and managing the intensity of feelings so that they don’t dominate your life. Self-regulation is really self-management, as the skills learned can help you tolerate (sit with) and control the emotions that may have previously lead to avoidance. This will, in turn, help reduce the frequency and intensity of traumatic stress symptoms and experiences.

Self-regulation involves the following:

*Experiencing* (noticing how you feel - pleasurable as well as uncomfortable feelings; observing without judging; taking note of physical sensations).

*Expressing:* describing to yourself what you are noticing; this expression can be achieved through writing, drawing, or speaking to someone.

*Containing:* consciously postponing dealing with the overwhelming part of what you are experiencing; dealing with only what you are able to.

*Retrieving:* bringing back a small part of what was stored and repeating the process of experiencing and processing that piece. This should take place at a later stage – either with a friend, in therapy, or in a journal.

The following “tools” will be provided for assisting with self-regulation:

**2.4.1 Grounding**

Grounding is used to:

- increase present focused awareness;
- facilitate clear contact with reality;
• reduce post-traumatic experiences (for example, flashbacks, hyper-vigilance, intrusive recollections);

• reduce dissociative experiences (for example, spontaneous trance, depersonalisation, time loss) (Vermilyea, 1969).

The basic tools of grounding will help you know the following: who you are; where you are; when you are. If you can answer these questions and connect with the answers, you will be less likely to lose track of the differences between past and present, have a flashback, or a dissociative experience. Numerous grounding exercises will be worked through. Some of these will be more useful than others for you.

2.4.2 Reality Checking

Reality checks are tools to help you become aware of and connected to the facts about what is really happening. Reality checks involve paying attention to one’s own reactions in relation to events around.

• What has just happened?
• Who was involved in terms of present-day people?
• Which stress response am I experiencing right now?
• Where are my resources (internal – self talk, strengths); external – friends, therapist, hot line)
• How can I get help right now if I need to?

Reality checks thus involve being able to assess safety accurately and should be used when you experience old familiar feelings that remind him/her of the ways he/she used to feel when in a dangerous situation or environment. Strategies for undertaking effective reality checking will be provided in this early stage.
2.4.3 Imagery/Safe Places

Imagery is used to reduce the intensity and frequency of unpleasant and frightening imagery, and to increase the use and effectiveness of positive, comforting and helpful imagery.

Sometimes, when individuals are under a great deal of stress, traumatic stress responses and dissociative experiences often emerge (as flashbacks) through unconsciously driven imagery. In such circumstances, an individual may feel that he/she is not be able to control the frightening images. When imagination frightens someone, that person may actually think that the frightening person or event is there. Thus, it is important for individuals to use their mind (imagination) to fight these flashbacks and get them under control.

Safe place imagery can be used to soothe oneself, to solve a problem, or to visualise a goal. Safe places are real or imaginary places that a person can visualise in order to take a break from intense thoughts, feelings, or impulses.

Several exercises for imagery use will be worked through at this early stage. These will also include exercises to assist with regulation of thoughts, feelings and impulses.

2.4.4 Journal Writing

During this first preliminary phase of treatment, it is important to gain assistance with developing journal writing skills, as these are important in the recovery from trauma, but especially at this stage, in the containment of your feelings. At later stages, journal writing can be used for self-expression and recording present-day thoughts, experiences and feelings, as through this, you can gain greater understanding and self-acceptance). It can also be used for support: often, writing down thoughts and feelings can provide a form of self-soothing, and the journal becomes a “safe place”.

NOTE:

- You may, however, prefer to record your thoughts orally rather than in writing.
- It is important to have developed grounding and self-regulation techniques before commencing journal writing.

2.5  

**Fifth Step: Treating Symptoms of Complex PTSD**

Once the above process of assisting you with trauma symptoms has taken place, it is then appropriate to move towards working on some of the other symptoms you are experiencing – and the order in which you proceed will depend on your individual needs. Areas for further work may include all – or some of – the following: dealing with your emotions, dealing with the way you see yourself, improving your relations with others, and reviewing your beliefs about the way you see the world.

Prior to commencing treatment, however, a treatment plan will be negotiated which will cater for your individual needs. Negotiating a suitable treatment plan may involve discussing in greater depth the information initially provided regarding symptoms, and then prioritising treatment areas.

The following guidelines are purely a guide and will not be providing detailed instructions regarding treatment, as the options for treatment of each symptoms area are diverse, and need to be appropriate to the individual concerned. Nevertheless, some suggestions for approaches will be provided.

2.5.1  

**Dealing with Emotions**

In assisting you in the development of emotional regulation skills, it is important to determine which aspect of emotional regulation is most prominent and causing most dysfunction. Although some of the earlier work on self-regulation may have helped you in dealing more effectively with your emotions, it is important to determine whether any of the following are still
present: persistent low mood, anxiety, explosive/inhibited anger, compulsive or inhibited sexuality, and self injury or suicidal pre-occupation. Clearly, those symptoms that are causing most dysfunction will need to be dealt with first.

2. 5. 2  *Dealing with the way you see yourself (self-perception)*

You may also realise that you are confused about who you are, and feel that you don’t really know yourself very well. If this is the case, you may need to receive assistance with any or all of the following areas in order to strengthen the way you see yourself: poor sense of self; low self esteem; sense of stigma; sense of complete difference; sense of helplessness; shame/guilt; and self-blame. This is perhaps the area that will require most time, and by devoting adequate time to issues associated with self-perception, you will be laying a solid foundation for any other work undertaken.

2. 5. 3  *Improving Relations with Others*

As with other areas of focus, it is important to determine the key factors in any perceived disruption to your intimate relationships. Is the main problem one of persistent distrust? Or is there a problem with inability to self-protect? Or perhaps the basis of difficulties is that the patient is involved in a repeated search for a rescuer? Once this has been ascertained, it will be possible to assist you with strategies for developing more functional relationships. Further work on self-protection may also be necessary.

2. 5. 4  *Dealing with the way you see the world*

You may also need time and space to talk through how you can make sense of the world and your experiences. Many of you will have suffered a loss of faith (in people, society, in themselves). Or perhaps you have experienced a sense of despair. With support and encouragement, you may be able to develop a restored faith in previously held beliefs, or develop a new set of beliefs.

It is also important to remember that dealing with any of the above “areas” as a discrete entity will not be possible, as all areas are inter-related in some way.
For example, dealing with self-perception may also form part of the cognitive work used to deal with feelings of depression. It may also form an important component of the treatment of sexually compulsive behaviour. It may also assist the patient in improving interpersonal relations. However, for the sake of clarity, each of the symptomatic areas will be dealt with as a discrete entity within these guidelines.

2.6 Having patience and persistence to allow “ego-strengthening” to take place

It is important that you feel re-assured that changes will not occur within a few therapy sessions, and that sometimes, there will be set-backs. For many of you, when faced by such set-backs, it may appear that no progress has been made, and that there is no hope of ever maintaining any changes. Thus, it is important to focus on the many changes that have occurred, and to remind yourself that becoming stronger and healthier will take time.

3. Conclusion

It is hoped that when the negotiated treatment period has been completed, you will be in a more stable state in which to approach the task of “remembering” and integrating past memories into your life.

At this stage, it will be important to assess your symptoms again, as at the commencement of the treatment program, in order to determine level of stability.
APPENDIX K
SEMI-STRUCTURED INTERVIEW FOR INITIAL INTERVIEW

Instructions to Interviewer
The interviewer will welcome the participant, and spend some initial time gaining rapport and assisting the participant to feel at ease. The interviewer will then outline the format of the interview, explaining that, if at any time, he/she feels uncomfortable, or is unable to continue with the interview to indicate this to the interviewer.

Gaining Information Regarding Participants’ Trauma Experience

The interviewer will seek clarification of the participants’ trauma experience(s) – both childhood experiences, and adult experiences (some details of these have already been provided during the screening interview and also on the Foa scale.)

Possible question with which to commence: Can you tell me about the traumatic experience(s) that have prompted you to respond to my advertisement?

The interviewer may seek further clarification/expansion of details provided so that a complete understanding of the trauma experience(s) is gained.

Gaining Information Regarding Participants’ Perception of the Impact of the Trauma Experience(s)

The examiner will then ask the participant: “What have been the most significant problems faced by you as a result of the trauma experienced?” Participants will have the opportunity to speak generally about the problems that have been most significant to them.

The interviewer will seek to gain further understanding from the participant regarding the following (where necessary):
o Client self perception (initial question may be, “How do you currently see yourself?”)
o Client mood (may include information regarding sad/depressed mood, anger, irritability etc.)
o Client’s sense of reality (initial question may be, “Do you often feel that you are not “real” or that other people/things around you are not real?”)
o Client perception of relationships you have with significant others? With people in general?
o Client feelings toward the perpetrator of your abuse? (if applicable)
o Client’s feelings regarding the failure (is there a sense of hopelessness? despair? vulnerability? loss of faith?)

The interviewer will then seek to clarify the changes that the participant would like to see for him/herself.
APPENDIX L
SEMI STRUCTURED INTERVIEW FOR FINAL INTERVIEW

Instructions to Interviewer
The interviewer will welcome the participant, and spend some initial time gaining rapport and assisting the participant to feel at ease. The interviewer will then outline the format of the interview, explaining that, if at any time, he/she feels uncomfortable, or is unable to continue with the interview to indicate this to the interviewer.

Gaining Information to Inform Researcher About Possible Changes as Result of the Treatment Program

The interviewer will ask the participant to provide information relating to a number of different “symptoms” previously identified. The following are to be used as “prompts”, although the interviewer is expected to probe further, where inadequate information is provided.

Questions Regarding Self Regulation?

- What are some ways you now know to help manage difficult feelings?
- How effective are these for you?

It would be expected that some of the following strategies will be covered: grounding, reality checking, use of imagery/safe places, journal writing, relaxation strategies, and strategies to assist with sleep.

Questions Regarding Affect Regulation

The following may be used as prompts for encouraging discourse in this area:

- Difficulties currently being experienced in controlling difficult emotions;
- Strategies now used to attempt to control difficult feelings;
o Most significant changes (in terms of managing difficult emotions) in the course of this program;
  o Changes in mood over past weeks; and
  o What has helped most in bringing about these changes.

Questions Regarding Self Perception

o The following may be used as prompts for encouraging discourse in this area:
  o How the participant currently sees him/herself;
  o The most significant changes in the way the participant sees him/herself;
  o What has helped most in effecting these changes (treatment/non-treatment).

Questions Regarding Relationships with Others

The following may be used as prompts for encouraging narrative in this area:
  o A description of relationships with significant others, others in general.
  o Beliefs regarding capacity to trust other persons.
  o The most significant changes in the way the participant relates to others.
  o What has helped most in effecting these changes?

Questions Regarding “Systems of Meaning” (beliefs related to the participant’s future)

The following may be used as prompts for encouraging discourse in this area:
  o The way the participant views his/her future (is their a sense of hopelessness/despair detected? A sense of vulnerability? Or optimism?)
  o Has there been a loss/change of previously held beliefs?
Clients Feelings Towards Perpetrator of Abuse?

- Have these Changed over the Course of the Treatment Program?

General Questions Regarding Treatment Program Overall

- The most positive aspects of the last six months of therapy. What aspects have been most helpful?
- The worst aspects of the last six months of therapy. What aspects have been hardest?
- What changes have occurred (if any) as a result of this program?
- What trauma-related problems still being experienced?

Conclusion to Interview

- The interviewer will thank the participant for his/her attendance and for sharing information about him/herself.
Cynthia

On initial presentation, Cynthia reported current suicidal ideation, and indicated that she had made one previous suicide attempt many years ago. Cynthia also reported that she had more suicidal thoughts when her two daughters were on access visits with their father. As Cynthia had identified suicidal ideation, it was important to develop a safety plan at the outset, to which she could refer when suicidal thoughts developed. One week was allotted to discussing safety aspects.

As Cynthia had also identified difficulties in her daily functioning, assisting her with improving her daily life and functioning was also an important aspect of the initial stages of her treatment. Four sessions were allocated to this aspect of the program. As marked PTSD symptoms (re-experiencing, avoidance, arousal) had been identified on the Foa PDS scale, and also on the “Alterations in Consciousness” scale of the SIDES-SR, assistance with controlling these symptoms of PTSD was also seen as important, prior to any work on CP symptoms. Four sessions were thus allocated to self-regulation work.

The remaining 15 sessions were allocated to the CP symptoms identified most strongly on the SIDES-SR and also during the initial interview: “Alterations in Affect Regulation” (depression, anxiety, anger, self-harm activities/impulsive behaviour), “Alterations in Self Perception” (low self confidence, feelings of worthlessness, sense of stigma, sense of complete difference, shame/guilt and self blame), and “Alterations in Interpersonal Relationships” (disruption in close relationships, persistent distrust, and search for a rescuer). As difficulties with interpersonal relationships appeared to pervade Cynthia’s life, and provide a basis for other difficulties, more time (six sessions) was allocated to addressing these issues. The other two symptoms were each allocated 4 weeks.

The table below summarises the negotiated program for Cynthia:
**Cynthia’s Treatment Program**

<table>
<thead>
<tr>
<th>TREATMENT FOCUS (CP SYMPTOM)</th>
<th>STRATEGIES</th>
<th>PLANNED TIME FRAME</th>
</tr>
</thead>
<tbody>
<tr>
<td>SAFETY</td>
<td>Developing a safety plan</td>
<td>1 session</td>
</tr>
<tr>
<td>FUNCTIONING</td>
<td>Improving daily life/functioning</td>
<td>4 sessions</td>
</tr>
<tr>
<td>SELF REGULATION (Control of PTSD symptoms)</td>
<td>Journal writing/expressive therapy</td>
<td>4 sessions</td>
</tr>
<tr>
<td></td>
<td>Relaxation exercises</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Sleep?</td>
<td></td>
</tr>
<tr>
<td>SAFETY</td>
<td>Developing a safety plan</td>
<td>1 session</td>
</tr>
<tr>
<td>FUNCTIONING</td>
<td>Improving daily life/functioning</td>
<td>4 sessions</td>
</tr>
<tr>
<td>SELF REGULATION (Control of PTSD symptoms)</td>
<td>Journal writing/expressive therapy</td>
<td>4 sessions</td>
</tr>
<tr>
<td></td>
<td>Relaxation exercises</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Sleep?</td>
<td></td>
</tr>
<tr>
<td>AFFECT REGULATION</td>
<td>CBT – to help with negative core beliefs/irrational thoughts</td>
<td>4 sessions</td>
</tr>
<tr>
<td></td>
<td>Anger management strategies</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Strategies to assist with panic attacks</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Strategies to assist with impulsive behaviour</td>
<td></td>
</tr>
<tr>
<td>SELF PERCEPTION</td>
<td>Cognitive Therapy (to challenge negative automatic thoughts and cognitive errors – involved)</td>
<td>4 sessions</td>
</tr>
<tr>
<td></td>
<td>Self Concept Inventory</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Use of Affirmations</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Behavioural analysis – Behavioural Therapy</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Work/employment</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Involvement in programs/courses/activities</td>
<td></td>
</tr>
<tr>
<td>RELATIONS WITH OTHERS</td>
<td>Interpersonal Psychotherapy</td>
<td>6 sessions</td>
</tr>
<tr>
<td></td>
<td>Discussions/analysis of interpersonal relationships</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Assertiveness training</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Cognitive therapy around issues of trust</td>
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<td></td>
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</tbody>
</table>
Maria

In negotiating the treatment plan, Maria reported that she had no suicidal ideation and did not need to develop a safety plan with me. Further, Maria appeared to be functioning well in her daily life, as was in a close relationship, undertook regular employment, and was engaged in non-work-related activities.

However, a major problematic area for Maria related to the dissociation (collapsing, panic attacks) that occurred on a regular basis. Maria suggested that this was an area on which she would like to focus initially. Thus, six weeks was allocated to undertaking self regulatory work, (involving grounding, containment), and relaxation strategies.

Three CP symptoms were identified during the interview as also requiring attention: the first CP symptom concerned “Alterations in Self Perception”, including low self-confidence, increased self-knowledge, sense of shame/guilt, and sense of stigma. Eight weeks were allocated to this symptom, as Maria indicated strongly during interview that low self-confidence and lack of self-knowledge were major problems for her. The second CP symptom concerned “Alterations in Affect Regulation” (assistance with anger management, irritability, anxiety/panic attacks, and self-harm). Six weeks were allocated to this symptom, as Maria reported at interview some difficulties modulating anger and sexual involvement - and also with ongoing panic attacks. Difficulties with arousal symptoms were also indicated on the Foa scale. The other CP symptom concerned “Alterations in Interpersonal Relations” (disruption in close relationships, relationship with her mother, inhibited sexuality, and search for a rescuer). Four weeks was allocated to working on this symptom. Although this was not indicated strongly on psychometric scales, Maria indicated some difficulties in interpersonal relationships during her initial interview.

The table below summarises the negotiated program for Maria:
Maria’s Treatment Program

<table>
<thead>
<tr>
<th>TREATMENT FOCUS (CP Symptom)</th>
<th>STRATEGIES</th>
<th>TIME FRAME</th>
</tr>
</thead>
</table>
| SELF REGULATION             | o Dissociation  
|                             | o grounding  
|                             | o use of imagery,  
|                             | o containment/regulating  
|                             | o Relaxation | 6 sessions |
| SELF PERCEPTION             | o Self knowledge  
|                             | o Low self confidence  
|                             | o Sense of stigma  
|                             | o shame/guilt | 6 weeks |
|                             | o Self Concept Inventory  
|                             | o Ensuring that statements have a basis (examples)  
|                             | o Affirmations  
|                             | o Writing self description  
|                             | o Group work | 2 weeks |
| AFFECT REGULATION           | o anger  
|                             | o anxiety/panic attacks  
|                             | o irritability/annoyance  
|                             | o self harm | 6 weeks |
|                             | o Learned Conflict Resolution Process  
|                             | o Anger management techniques (for examples, time out)  
|                             | o Strategies for dealing with panic attacks  
|                             | o Breathing  
|                             | o Meditation  
|                             | o Distraction(OCD) | 4 weeks |
| RELATIONS WITH OTHERS       | o disruption in close rels.  
|                             | o Inhibited sexuality  
|                             | o Relationship with mother  
|                             | o search for rescuer? | 4 weeks |
|                             | o Anger control in relationship  
|                             | o Relationship with partner  
|                             | o Mother- narrative  
|                             | o Writing/gestalt therapy  
|                             | o Grounding techniques (talking  
|                             | o openly (sexuality) |

Eric

Eric reported no suicidal ideation or self-harm behaviours – and did not see a need to develop a safety plan. Further, he did not see a need for assistance with “daily functioning” – although this became the focus of most sessions. Despite indications on psychometric assessment that Eric displayed marked PTSD symptoms, Eric was insistent that these symptoms were not problematic in his life, and that he wanted the focus of the program to be on CP symptoms.
Thus, the treatment program was developed with a focus on the symptoms identified on the SIDES-SR – and also during interview:

**Alterations in Self Perception** (Sense of worthlessness, low self-worth, self-dislike, sense of stigma, sense of being different to others, sense of helplessness, self blame, sense of permanent damage, lack of self knowledge, little understanding of him by others). Six weeks were allocated to this symptom, as Eric’s interview indicated that feelings of worthlessness pervaded his life experiences, and also contributed to other symptomatology.

**Alterations in Affect Regulation** (depression, irritability, anger management, social anxiety). Four weeks were allocated to this symptom, as the above symptoms were indicated during interview.

**Alterations in Interpersonal Relationships** (lack of close relationships, inability to sustain close relationships, avoidance of people, lack of trust, dislike of others, negative view of others, relationships with children). Five weeks were allocated to this symptom, as difficulties with interpersonal relationships was indicated strongly during the interview - and also on the SIDES-SR.

**Perception of Perpetrator of Abuse.** Two weeks was allocated to this symptom, as, although this was not indicated on the SIDES-SR, information provided during the interview indicated some problems in this area still.

**Alterations in Belief Systems** (sense of hopelessness and despair; loss of optimism). Three weeks were allocated to this symptom, a sense of despair and hopelessness indicated strongly on the SIDES-SR and also during interview. It was also expected that work on other symptoms may contribute to improvements here.

**Somatic Complaints.** Eric had indicated some somatic problems during the initial interview – and also on the SIDES-SR. Two weeks was allocated to these symptoms.

The order of treating the above areas was suggested by Eric. The following table summarises the negotiated treatment plan for Eric:
### Eric’s Treatment Program

<table>
<thead>
<tr>
<th>TREATMENT FOCUS (CP SYMPTOM)</th>
<th>STRATEGIES</th>
<th>TIME FRAME</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>SELF PERCEPTION</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Low self confidence/feelings of worthlessness</td>
<td>o Self Concept Inventory</td>
<td>6 weeks</td>
</tr>
<tr>
<td>- Self dislike</td>
<td>o (Cognitive approach-reframing)</td>
<td></td>
</tr>
<tr>
<td>- Sense of stigma</td>
<td>o Use of affirmations</td>
<td></td>
</tr>
<tr>
<td>- Sense of helplessness</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Self blame</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Sense of being different to others</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Lack of Self knowledge</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>AFFECT REGULATION</strong></td>
<td></td>
<td>4 weeks</td>
</tr>
<tr>
<td>- depression</td>
<td>o “Behavioural” therapy-discussion of different approaches - ways he can make changes to his life (in family, with work options, money situation etc)</td>
<td></td>
</tr>
<tr>
<td>- irritability/annoyance</td>
<td>o Reframing negative thoughts.</td>
<td></td>
</tr>
<tr>
<td>- anger</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>RELATIONS WITH OTHERS</strong></td>
<td></td>
<td>5 weeks</td>
</tr>
<tr>
<td>- No close relationships.</td>
<td>o Narrative Therapy- re-writing story of relationship with wife</td>
<td></td>
</tr>
<tr>
<td>- Unable to sustain</td>
<td>o Relationship work with his family</td>
<td></td>
</tr>
<tr>
<td>- relationships</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Avoiding people</td>
<td>o Discussion around relationships with others – interpersonal psychotherapy</td>
<td></td>
</tr>
<tr>
<td>- Lack of trust</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Dislike of others</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Criticism of others</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>PERCEPTION of PERPETRATOR(s)</strong></td>
<td>o Narrative therapy</td>
<td>2 weeks</td>
</tr>
<tr>
<td><strong>BELIEF SYSTEMS</strong></td>
<td></td>
<td>3 weeks</td>
</tr>
<tr>
<td>- Sense of hopelessness/despair</td>
<td>o Discussion.</td>
<td></td>
</tr>
<tr>
<td>- Loss of optimism</td>
<td>o CBT – reframing negative thoughts</td>
<td></td>
</tr>
<tr>
<td><strong>SOMATIC COMPLAINTS</strong></td>
<td>o Discussion</td>
<td>2 weeks</td>
</tr>
</tbody>
</table>

### Lucy

Lucy reported that she had no suicidal ideation and did not need to develop a safety plan with me. Further, Lucy appeared to be functioning relatively well in her daily life – undertook regular employment, and was coping with basic life issues and did not wish to gain assistance with aspects of daily functioning.
Initially, Lucy did not believe that the core PTSD symptoms were causing her difficulties in her life (This was later seen to be an inaccurate assessment). Thus, the treatment program developed for Lucy focused most strongly on the CP symptoms identified both through psychometric assessment and at interview:

Alterations in Self Perception (low self confidence/feelings of worthlessness, sense of stigma, sense of being different from others, sense of helplessness, guilt/shame, self blame, improved self knowledge). Six weeks were allocated to this area, SIDES-SR and in interview.

Alterations in Affect Regulation (including management of depression, anxiety/panic attacks, irritability/annoyance, self-harm). Six weeks was also allocated to this symptom, given the number of different aspects involved here, and the fact that it was strongly indicated and during interview.

Alterations in Interpersonal Relationships (no close relationships, inability to sustain relationships, avoidance of people, inhibited sexuality). Six weeks was also allocated to this symptom, as again, this was indicated on both the SIDES-SR and during interview as an area of significant problems.

Alterations in Belief Systems (sense of hopelessness/despair, loss of optimism). Two weeks was allocated to this symptom, as it was expected that work in other areas would lead to changes also in this symptom.

Somatic Complaints Two weeks was allocated to this, as this did not appear to be as marked a problem currently, as other symptoms.

Work on self regulation was included after some weeks into the program, when dissociation was seen as a major problem.

The following table summarises Lucy’s treatment program:
**Lucy’s Treatment Program**

<table>
<thead>
<tr>
<th>TREATMENT FOCUS (CP Symptom)</th>
<th>STRATEGIES</th>
<th>TIME FRAME</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>SELF PERCEPTION</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>o low self confidence/feelings of worthlessness</td>
<td>o Self Concept Inventory – writing positives- reframing negatives-</td>
<td>6 weeks</td>
</tr>
<tr>
<td>o Sense of stigma</td>
<td>o Affirmations</td>
<td></td>
</tr>
<tr>
<td>o Sense of helplessness</td>
<td>o Intent: hypnosis to confirm</td>
<td></td>
</tr>
<tr>
<td>o shame/guilt</td>
<td></td>
<td></td>
</tr>
<tr>
<td>o self blame</td>
<td></td>
<td></td>
</tr>
<tr>
<td>o sense of being different to others</td>
<td></td>
<td></td>
</tr>
<tr>
<td>o Self knowledge</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

| **AFFECT REGULATION**       |            |            |
| o depression                | o Emotional Regulation- Martia Lineman - handouts- to examine emotions recognised/felt | 6 weeks |
| o anxiety/panic attacks     |            |            |
| o irritability/annoyance    |            |            |
| o self harm                 |            |            |

| **RELATIONS WITH OTHERS**    |            |            |
| o No close relationships.   | o Relationship counselling/discussion – provision of literature | 6 weeks |
| o Unable to sustain         | o Planned desensitisation thru hypnosis |            |
| relationships               | o Future sexual relationships-honesty |            |
| o Avoiding people           |            |            |
| o Inhibited sexuality****   |            |            |

| **BELIEF SYSTEMS**          |            | 2 weeks    |
| o Sense of hopelessness/despair |            |            |
| o Loss of optimism          |            |            |

| **SOMATIC COMPLAINTS**      |            | 2 weeks    |

The following segment was included after some weeks into the program, when dissociation was seen as a major problem:

<table>
<thead>
<tr>
<th>SELF REGULATION</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>o Dissociation – providing education re dissociation</td>
<td>(added in half way through the program)</td>
<td></td>
</tr>
<tr>
<td>o Examination of ADD? More so dissociation?</td>
<td>2 weeks</td>
<td></td>
</tr>
<tr>
<td>o Grounding- assistance with strategies for remaining focussed – active listening.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>


Diana

The treatment program developed departed slightly from the program recommended in the guidelines. As Diana reported that she had no suicidal ideation/self harm behaviours she did not need to develop a safety plan with me. Further, Diana appeared to be functioning relatively well in her daily life – undertook regular employment, and was coping with basic life issues and did not wish to undertake work in this area. Thus, there were departures in terms of not including these two treatment areas.

However, in general, the planned treatment program adhered to the guidelines, in that some work was done on core PTSD symptoms, with Diana stating that the main problematic areas were associated with difficulties relaxing and sleeping. Thus two sessions were allocated to these aspects of Self Regulation. The remaining sessions were devoted to CP symptoms. The four main symptoms identified, both at interview, and on the SIDES-SR, were as follows:

*Alterations in Self Perception* (low self-confidence, feelings of worthlessness, sense of stigma and complete difference to others, shame and guilt, invisibility, betrayal, being misunderstood, self blame). Six sessions were allocated to working on this area.

*Alterations in Relationships with Others* (disruption in all close relationships; search for a rescuer). Eight sessions were allocated to working on relationship issues, given the large number of close relationships that had been severed.

*Alterations in Affect Modulation* (dysthymia and anxiety). Three sessions were allocated to working on dysthymic mood and anxiety.

*Alterations in Systems of Belief* (despair/hopelessness and loss of optimism). Three sessions were allocated specifically to dealing with feelings of despair and hopelessness. However, work in other areas was also likely to assist Diana with these feelings.

The following table summarises Diana’s treatment program.
Diana’s Treatment Program

<table>
<thead>
<tr>
<th>TREATMENT FOCUS (CP SYMPTOM)</th>
<th>STRATEGIES</th>
<th>TIME FRAME</th>
</tr>
</thead>
<tbody>
<tr>
<td>SELF REGULATION</td>
<td>o Relaxation/Stress reduction</td>
<td></td>
</tr>
<tr>
<td></td>
<td>o Sleep?</td>
<td>4 sessions</td>
</tr>
<tr>
<td>SELF PERCEPTION</td>
<td>o self-blame</td>
<td></td>
</tr>
<tr>
<td></td>
<td>o Low self confidence/feelings of worthlessness</td>
<td></td>
</tr>
<tr>
<td></td>
<td>o sense of stigma</td>
<td></td>
</tr>
<tr>
<td></td>
<td>o sense of helplessness</td>
<td></td>
</tr>
<tr>
<td></td>
<td>o shame/guilt</td>
<td></td>
</tr>
<tr>
<td></td>
<td>o sense of being different to others</td>
<td></td>
</tr>
<tr>
<td></td>
<td>o invisibility</td>
<td></td>
</tr>
<tr>
<td></td>
<td>o betrayal</td>
<td></td>
</tr>
<tr>
<td></td>
<td>o misunderstood</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Self-concept inventory – addressing issues of feelings of worthlessness/ being “invisible” etc etc.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Assertiveness training</td>
<td>6 weeks</td>
</tr>
<tr>
<td>AFFECT REGULATION</td>
<td>o CBT</td>
<td>3 weeks</td>
</tr>
<tr>
<td>RELATIONS WITH OTHERS</td>
<td>o dysthymia</td>
<td></td>
</tr>
<tr>
<td></td>
<td>o anxiety</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Discussion re effective interpersonal relations (Interpersonal psychotherapy) – with son/ daughter in law, Partner etc.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Discussion re relationship with sister/others in family.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Strategies for dealing with “too much openness”</td>
<td>8 weeks</td>
</tr>
<tr>
<td>ALTERATIONS IN SYSTEMS of MEANING</td>
<td>o CBT</td>
<td>3 sessions</td>
</tr>
<tr>
<td></td>
<td>o Helplessness/despair</td>
<td></td>
</tr>
<tr>
<td></td>
<td>o Loss of optimism</td>
<td></td>
</tr>
</tbody>
</table>

Percy

In conjunction with Percy, an initial treatment plan was developed, but revised it after several sessions. Although Percy had had suicide attempts previously, he claimed that there was currently no need for a Safety Plan – and that he was not really interested in assistance with daily functioning. He stated that the priorities for him were working on self-esteem – “acceptance that I am
not worthless, that I do have attributes that people find likeable, that I’m not this hideous grotesque creature” – and “learning how to form relationships at a different sort of level”. He stated, “I think that’ll probably help the depression. I don’t think it will work the other way. I don’t think I can just get rid of the depression, so if I can come up from the other way – by having the ability to have a life – I’ve never really tried “having a life”.

Thus, given that the most prominent symptoms identified by Percy at interview (and also supported by the results of the SIDES-SR) related to self perception, interpersonal relationships, affect modulation and despair/hopelessness, the treatment program planned focussed on these areas.

However, prior to dealing with these CP symptoms, it was important to undertake work on some Core PTSD responses. Four weeks were thus allocated to dealing with self regulation (as Percy had identified marked dissociation, insomnia and intrusive experiences).

The rest of the treatment program was allocated to dealing with CP symptoms. Six weeks were allocated to dealing with “Alterations in Self Perception” (low self confidence, feelings of worthlessness, sense of stigma and of being different to others, sense of helplessness). Four weeks were allocated to working on “Alterations in Interpersonal Relationships” (no close relationships, inability to sustain close relationships, avoidance of people, difficulties with social skills, sabotage in relationships, inhibited sexuality). Three weeks were allocated to working on “Alterations in Affect Modulation” (depression, anxiety and panic attacks, irritability/annoyance, self-harm (through sabotage of positions, relationships). Three weeks was allocated to “Alterations in Systems of Belief” (despair/hopelessness/loss of optimism). It was also expected that work in other areas would impact on these feelings. Four weeks were left unallocated for other issues that may evolve.

The following table summarises Percy’s negotiated treatment plan:
### Percy’s Original Treatment Program

<table>
<thead>
<tr>
<th>TREATMENT FOCUS (CP SYMPTOM)</th>
<th>STRATEGIES</th>
<th>TIME FRAME</th>
</tr>
</thead>
<tbody>
<tr>
<td>SELF REGULATION</td>
<td>o Dissociation</td>
<td>4 weeks</td>
</tr>
<tr>
<td></td>
<td>o Intrusive Experiences</td>
<td></td>
</tr>
<tr>
<td></td>
<td>o Insomnia</td>
<td></td>
</tr>
<tr>
<td>SELF PERCEPTION</td>
<td>o Low self confidence/feelings of worthlessness</td>
<td>6 weeks</td>
</tr>
<tr>
<td></td>
<td>o Sense of stigma</td>
<td></td>
</tr>
<tr>
<td></td>
<td>o Sense of helplessness</td>
<td></td>
</tr>
<tr>
<td></td>
<td>o sense of being different to others</td>
<td></td>
</tr>
<tr>
<td>AFFECT REGULATION</td>
<td>o depression</td>
<td>4 weeks</td>
</tr>
<tr>
<td></td>
<td>o anxiety/panic attacks</td>
<td></td>
</tr>
<tr>
<td></td>
<td>o irritability/annoyance</td>
<td></td>
</tr>
<tr>
<td></td>
<td>o self harm (through sabotage of positions/work/relationships)</td>
<td></td>
</tr>
<tr>
<td>RELATIONS WITH OTHERS</td>
<td>o No close relationships.</td>
<td>3 weeks</td>
</tr>
<tr>
<td></td>
<td>o Unable to sustain relationships</td>
<td></td>
</tr>
<tr>
<td></td>
<td>o Avoiding people</td>
<td></td>
</tr>
<tr>
<td></td>
<td>o Difficulties with social skills</td>
<td></td>
</tr>
<tr>
<td></td>
<td>o Sabotage in relationships</td>
<td></td>
</tr>
<tr>
<td></td>
<td>o Inhibited sexuality</td>
<td></td>
</tr>
<tr>
<td>BELIEF SYSTEMS</td>
<td>o Sense of hopelessness/despair</td>
<td>3 weeks</td>
</tr>
<tr>
<td></td>
<td>o Loss of optimism</td>
<td></td>
</tr>
<tr>
<td>OTHER?</td>
<td></td>
<td>4 weeks</td>
</tr>
</tbody>
</table>

After two weeks, the treatment plan was revised. Following further discussions with Percy about what were the greatest areas of need for him. The revision led to a re-ordering of priorities, and with a deletion of work associated with Core Symptoms. Percy claimed that these were not as important as the other issues.
The revised treatment plan is contained on the following page:

<table>
<thead>
<tr>
<th>TREATMENT FOCUS (CP SYMPTOM)</th>
<th>STRATEGIES</th>
<th>TIME FRAME</th>
</tr>
</thead>
<tbody>
<tr>
<td>AFFECT REGULATION</td>
<td>- Increase emotional tolerance to fearful situations through desensitisation - graded exposure to fearful situations (through hypnosis (and learning self hypnosis) – then in vivo) – to extinguish avoidant behaviour and reduce anxiety.</td>
<td>6 weeks</td>
</tr>
<tr>
<td></td>
<td>- Anxiety management around fearful situations</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Reframe Fearful situations</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Decatastrophising disapproval and rejection: disapproval=(not) rejection</td>
<td></td>
</tr>
<tr>
<td>RELATIONS WITH OTHERS</td>
<td>- Social skills Training – role playing; modelling; instruction, group therapy</td>
<td>4 weeks</td>
</tr>
<tr>
<td></td>
<td>- (Shyness)</td>
<td>and</td>
</tr>
<tr>
<td></td>
<td>- Assertive skills</td>
<td>3 weeks</td>
</tr>
<tr>
<td></td>
<td>- Couple therapy – sacrifice benefits of maladaptive behaviour for new risks</td>
<td></td>
</tr>
<tr>
<td>SELF PERCEPTION</td>
<td>- Cognitive - Challenge Negative automatic thoughts/schemas</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- (I am different; I am defective)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Reframe Fearful situations</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Decatastrophising disapproval and rejection: disapproval=(not) rejection</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Focus on positives-emphasising/affirming</td>
<td></td>
</tr>
</tbody>
</table>
Geraldine

As Geraldine did not have any safety issues currently, she did not see a need to develop a safety plan as part of this program. Further, Geraldine was generally functioning well in her daily life (being employed permanently in a high-level job, and “running” her house). Geraldine did not see a need for assistance with daily functioning. Hence, no work was included in this area in the treatment plan.

Geraldine was interested to do some work on self regulation (in particular, dissociation, insomnia, difficulties with relaxation), these areas being identified at interview. Three weeks were allocated to dealing with “Self Regulation”.

The focus of the treatment program, however, was on CP symptoms, as identified at interview:

*Alterations in Self Perception* (low self confidence/feelings of worthlessness, sense of helplessness, guilt/self blame, sense of being different to others). Six weeks were allocated to dealing with these symptoms.

*Alterations in Interpersonal relationships* (difficulties trusting people, re-victimisation, dishonesty in relationships). Five weeks were allocated to dealing with these symptoms.

*Alterations in Affect Regulation* (depression, anger/irritability/annoyance). Five weeks were allocated to dealing with these symptoms.

*Alterations in Belief Systems* (loss of optimism, sense of hopelessness/despair, change in belief systems). Four weeks were allocated to dealing with these symptoms.
The following table summarises Geraldine’s negotiated treatment program:

### Geraldine’s Treatment Program

<table>
<thead>
<tr>
<th>TREATMENT FOCUS (CP SYMPTOM)</th>
<th>STRATEGIES</th>
<th>TIME FRAME</th>
</tr>
</thead>
</table>
| **SELF REGULATION** | o Dissociation (Grounding, Reality checks, use of imagery)  
  o Relaxation  
  o Sleep?? | 3 weeks |
| **SELF PERCEPTION** | o Low self confidence/feelings of worthlessness  
  o Sense of helplessness  
  o Guilt/self blame  
  o Sense of being different to others | o Self Concept Inventory (use of CBT to challenge negative automatic thoughts/reframe)  
  o Affirmations  
  o Psycho-education - reading material to assist understanding of how low self confidence has emerged | 6 weeks |
| **AFFECT REGULATION** | o depression  
  o anger/irritability/annoyance | o Psycho-education (reading materials provided re Anger Management)  
  o Anger Management strategies  
  o Assertiveness training  
  o Conflict Resolution Strategies (Couples therapy)  
  o Depression – looking at preventive strategies | 5 weeks |
| **RELATIONS WITH OTHERS** | o Re-victimsiation  
  o Difficulties trusting people  
  o Own dishonesty in rels  
  o Being difficult in relationships | o Interpersonal psychotherapy - discussion and analysis of interpersonal relationships.  
  o CBT | 5 weeks |
| **BELIEF SYSTEMS** | o Change in belief systems  
  o Sense of hopelessness/despair  
  o Loss of optimism | | |

---

*Note: CBT stands for Cognitive Behavioral Therapy.*
Matt did not identify and concerns regarding his own safety, and did not see that this should be included in his treatment program. Further, it did not appear that, in general, Matt required to undertake work to assist him with daily functioning, as he ran a successful fitness program for children at the YWCA, and also seemed to be able to assist himself in this area.

Matt did, however, require some work around some core PTSD symptoms (dissociation and also re-experiencing, as identified on the Foa scale). Thus, four weeks was allocated to “Self Regulation” work.

Other sessions were to be devoted to CP symptoms, as identified in interview:

_Affect Regulation_ (dysthymia, negative thoughts, anxiety/panic attacks, stress reduction, anger management). Six weeks were allocated to work in this area.

_Alterations in Self Perception_ (low self confidence, feelings of worthlessness, sexual inadequacy, self-consciousness, sense of guilt/self-blame, sense of shame, sense of helplessness, improved self knowledge). Six weeks was allocated to these symptoms.

_Alterations in Interpersonal Relations_ (difficulties committing in relationships, loss of interest in people/avoidance). Three weeks were allocated to these symptoms.

_Somatic Concerns_ (nausea, morning vomiting, stomach pains). Three weeks were allocated to dealing with these symptoms.
Alterations in Belief Systems (Two weeks was allocated to these symptoms). It was also expected that work in other areas would assist with these symptoms.

The following table summarises Matt’s negotiated treatment program:

**Matt’s Treatment Program**

<table>
<thead>
<tr>
<th>TREATMENT FOCUS (CP SYMPTOMS)</th>
<th>STRATEGIES</th>
<th>TIME FRAME</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>SELF REGULATION</strong></td>
<td>o Grounding strategies, o EMDR – re-experiencing</td>
<td>4 weeks</td>
</tr>
<tr>
<td>o Re-experiencing</td>
<td></td>
<td></td>
</tr>
<tr>
<td>o Dissociation</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>AFFECT REGULATION</strong></td>
<td>o Lot of CBT work, o Much work on reframing negative thought patterns and affirmations, o Behavioural approaches – managing panic attacks, o managing anxiety (relaxation, meditation, hypnosis), o Grief counselling</td>
<td>6 weeks</td>
</tr>
<tr>
<td>o dysthymia</td>
<td></td>
<td></td>
</tr>
<tr>
<td>o anxiety/panic attacks</td>
<td></td>
<td></td>
</tr>
<tr>
<td>o stress</td>
<td></td>
<td></td>
</tr>
<tr>
<td>o irritability/annoyance</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>SELF PERCEPTION</strong></td>
<td>o Self Concept Inventory – reframing negative thoughts re self – affirmations, o Hypnosis to assist here, o EMDR</td>
<td>6 weeks</td>
</tr>
<tr>
<td>o Low self confidence/feelings of worthlessness</td>
<td></td>
<td></td>
</tr>
<tr>
<td>o Sexual inadequacy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>o Appearance (thin legs)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>o Self conscious</td>
<td></td>
<td></td>
</tr>
<tr>
<td>o Sense of helplessness</td>
<td></td>
<td></td>
</tr>
<tr>
<td>o shame/guilt</td>
<td></td>
<td></td>
</tr>
<tr>
<td>o self blame</td>
<td></td>
<td></td>
</tr>
<tr>
<td>o Self knowledge</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>RELATIONS WITH OTHERS</strong></td>
<td>o Interpersonal psychotherapy – discuss re different approaches to the different relationships in life (son, partner, mother, ex wife)</td>
<td>3 weeks</td>
</tr>
<tr>
<td>o Difficulties committing in relationships</td>
<td></td>
<td></td>
</tr>
<tr>
<td>o Avoiding people/loss of interest</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>SOMATIC COMPLAINTS</strong></td>
<td>o Discussion, o Assistance with managing anxiety to assist with nausea in ams</td>
<td></td>
</tr>
</tbody>
</table>
Renee

As Renee regularly had cause for concern about her safety, it was seen as important to develop a safety plan – and regularly review this work.

Renee also appeared to be extremely “lost” in life - and reported needing assistance with functioning. Thus, this aspect was included as an ongoing aspect of the treatment program – with the intent to deal with aspects associated with daily functioning as they arose.

Renee also reported a need for “Self Regulatory” work – as indicated on the Foa scale (assistance with re-experiencing, dissociation, relaxation, and sleep). Four weeks was allocated to Self Regulation work.

Information provided by interview and inventories had also indicated marked symptomatology in the following areas:

Alterations in Affect Modulation (depression, anxiety and panic attacks, and self-harm). Four weeks were allocated to working on these symptoms.

Alterations in Self Perception (loss of self knowledge, feelings of worthlessness, low self confidence, shame/guilt, self blame, sense of being different to others, sense of helplessness). Six weeks were allocated to these symptoms, as Renee’s problems seemed to emanate from many of these symptoms.

Alterations in Relationships with Others (difficulties in close relationships, inability to sustain relationships, lack of boundaries in new relationships). Three weeks was allocated to work on these symptoms.
### Alterations in Perception of Perpetrator of Abuse

One week was devoted to this symptom).

### Alteration in Belief Systems

Two weeks were allocated to dealing with despair/hopelessness/loss of optimism issues).

The following table summarises the negotiated treatment program for Renee:

**Renee’s Treatment Plan**

<table>
<thead>
<tr>
<th>TREATMENT FOCUS (CP Symptom)</th>
<th>STRATEGIES</th>
<th>TIME FRAME</th>
</tr>
</thead>
<tbody>
<tr>
<td>SAFETY</td>
<td>o Development of safety plan</td>
<td>Ongoing</td>
</tr>
</tbody>
</table>
| DAILY FUNCTIONING           | o Behavioural Therapy  
                             | o Decision making process | Ongoing   |
| SELF REGULATION             | o Dissociation (Grounding, Reality checks, use of imagery)  
                             | o Relaxation  
                             | o Sleep??   | 4 weeks |
| SELF PERCEPTION             | o low self confidence/feelings of worthlessness  
                             | o sense of stigma  
                             | o sense of helplessness  
                             | o shame/guilt  
                             | o self blame  
                             | o sense of being different to others  
                             | o self knowledge | 6 weeks |
| AFFECT REGULATION           | o CBT  
                             | o Hypnosis – around motivation/positive self concept  
                             | o Strategies for managing panic attacks | 4 weeks |
| RELATIONS WITH OTHERS       | o Interpersonal psychotherapy – analysis/discussion  
                             | o Revictimisation issues  
                             | o Assertive skills  
                             | o Boundary setting  
                             | o Sexuality issues | 3 weeks |


**BELIEF SYSTEMS**

- Sense of hopelessness/despair
- Loss of optimism

| CHANGE IN BELIEFS RE PERPETRATOR OF ABUSE | CBT | 3 weeks
|-----------------------------------------|----|-----

**Beryl**

The treatment program was developed in discussion with Beryl. From discussion with Beryl, it appeared that the areas in which she needed most assistance were CP symptoms:

*Alterations in Self Perception* (‘Ineffectiveness as a person’; ‘Permanent damage’; ‘Guilt/responsibility’; ‘Shame’; ‘Nobody can understand’). These were also indicated on the SIDES-SR (although at a low level). Four weeks were allocated to this symptom.

*Alterations in Interpersonal Relationships* (‘Inability to Trust’, ‘Re-victimisation’), these also being indicated on the SIDES-SR. Ten weeks were allocated to discussing difficulties in relationships, given that this had been a recurring theme throughout Beryl’s life.

*Affect Regulation* (depression, anxiety) - indicated on the Foa scale.

*Alterations in Belief Systems* (‘Despair/ Hopelessness’; ‘Loss of Optimism’) – also indicated on SIDES-SR. Three sessions were allocated to this symptom.

Prior to commencing work on these symptoms, some self-regulatory work was undertaken, in terms of assistance with relaxation strategies, and strategies to assist with sleep.
Beryl did not see any need to develop a Safety Plan, or to gain assistance with Daily functioning, and was functioning reasonably well on a day-to-day basis, being involved in social groups, and in several other activities (Breast Cancer Support group, volunteer work).

The following table summarises Beryl’s negotiated treatment plan:

*Beryl’s Treatment Program*

<table>
<thead>
<tr>
<th>TREATMENT FOCUS (CP SYMPTOM)</th>
<th>STRATEGIES</th>
<th>TIME FRAME</th>
</tr>
</thead>
<tbody>
<tr>
<td>SELF REGULATION</td>
<td>o Relaxation/Stress reduction</td>
<td>2 sessions</td>
</tr>
<tr>
<td></td>
<td>o Sleep?</td>
<td></td>
</tr>
<tr>
<td>SELF PERCEPTION</td>
<td>o Cognitive Behaviour Therapy</td>
<td>4 weeks</td>
</tr>
<tr>
<td></td>
<td>o Self Concept Inventory</td>
<td></td>
</tr>
<tr>
<td></td>
<td>o Affirmations</td>
<td></td>
</tr>
<tr>
<td>AFFECT REGULATION</td>
<td>o Psycho-education</td>
<td>3 weeks</td>
</tr>
<tr>
<td></td>
<td>o Behavioural therapy</td>
<td></td>
</tr>
<tr>
<td></td>
<td>o Anxiety reduction</td>
<td></td>
</tr>
<tr>
<td>RELATIONS WITH OTHERS</td>
<td>o Interpersonal Psychotherapy</td>
<td>10 weeks</td>
</tr>
<tr>
<td></td>
<td>o Assertiveness training</td>
<td></td>
</tr>
<tr>
<td>ALTERATIONS IN SYSTEMS of MEANING</td>
<td>CBT</td>
<td>3 sessions</td>
</tr>
<tr>
<td>Helplessness/despair</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Loss of optimism</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
APPENDIX N
HANDOUT PROVIDED to PARTICIPANTS in GROUP THERAPY, EXPLAINING THE GROUP PROCESS (Carl Rogers): Person-Centred Approach to Groups

The person-centred approach to group therapy (originally known as client centred therapy) was developed by the late Carl Rogers. It is grounded on the assumption that human beings tend to move toward wholeness and self-actualisation, and that individual members, as well as the group as a whole, can find their own direction with a minimal degree of help from the facilitator. The person-centred approach emphasises the personal qualities of the group leader rather than techniques of leading because the primary function of the facilitator is to create a fertile and healing climate within the group. Rogers best capture the essence of the approach:

The person-centred approach is primarily a way of being that finds its expression in attitudes and behaviours that create a growth-producing climate. It is a basic philosophy rather than simply a technique or method. When this philosophy is lived, it helps the person expand the development of his or own capacities. When it is lived, it also stimulates constructive change in others. It empowers the individual, and when this personal power is used, experience shows that it tends to be used for personal and social transformation. (1986,)

So – a therapeutic climate is established in the group by the facilitator’s creating a relationship based on certain attitudes such as

- accurate empathic understanding,
- acceptance,
- non-possessive warmth (unconditional positive regard),
- caring, and
- genuineness.
As the facilitator projects these attitudes and an accepting and caring climate emerges, it is presumed, members will drop their defences and move toward personally meaningful goals, a process that will eventually lead toward appropriate and useful behavioural change.

One basic assumptions Roger challenged: that the therapist is the expert and the client should be in a passive role. Rogers had faith in the client’s ability to move forward of the appropriate conditions fostering growth are present.

**The Group Process**

Rogers makes it clear that the person-centred approach rests on a basic trust in human beings’ tendency to realise their full potential. Similarly, person-centred therapy is based on a sense of trust in ten group’s ability to develop its own potential by moving in a constructive direction. For a group to move forward, it must develop a trusting and accepting atmosphere in which members can show aspects of themselves that they usually conceal and move into new behaviours. For example they move:

- from playing roles to expressing themselves more directly;
- from being out of contact with internal and subjective experience to becoming aware of it;
- from looking from answers outside themselves to a willingness to direct their own lives from within; from a lacking trust and being somewhat closed and fearful in interpersonal relationships to being more open and expressive toward others;
- from being relatively closed to experience and uncertainty to becoming more open to, and tolerant of, ambiguity.
Rogers believed that individuals have within themselves vast resources for self-understanding and for altering their self-concepts. Basic attitudes, and self-directed behaviour; these resources can be tapped if a definable climate of facilitative psychological attitudes can be provided. That is, if the facilitator can provide the appropriate atmosphere, then change will occur!
APPENDIX O
NOTES/ACTIVITIES USED AS BASIS FOR GROUP SESSIONS ON SELF

THE VALUE OF AN INDIVIDUAL

How do we work this out?

- It is normal for people to judge themselves and judge others.
- We usually evaluate our own behaviours by the standard of how we most would like to be.
- Similarly, we usually judge others by the standard of how we most would like them to be.
- When we fall short of our own expectations in every day, healthy shame can motivate us to try harder without destroying our basic sense of worth.
- When the basis sense of self-esteem is damaged or destroyed, we need to consider what fundamental things give value to a person.
- What are these?? What IS a “good” person or a “bad” person?

This is difficult to determine for a number of reasons:

- Different people would probably mean different things by these words, and
- Most ways of evaluating people are not absolute.
- Taken as a whole, each individual is neither good nor bad, worthy or unworthy, but rather a complex assortment of strengths and weaknesses, abilities and inabilities, talents and inadequacies, ignorance and expertise.

What then does it mean to be worthy, to have value, to merit esteem?

The answer is complex because the meaning of value and worth can itself shift and change (e.g. is a person who takes his time making decisions thorough or indecisive? Is this behaviour a strength or weakness? Both answers could be correct depending on the circumstances. There is no single right answer.)
The answer depends on the following:

- Who is doing the valuing?
- What is the overall situation?
- What standards are being used?

Other examples:

- An ability to work on our own can be a weakness in a situation demanding teamwork, but the same characteristic can be strength if the situation requires you to work independently.
- Behaviour called flexible by one person wishy-washy. Thus, different people can judge differently, and these judgements can all be valid. Why? Because value is usually based on what an evaluator wants, and this may or may not be the same thing you want or need.

Two important points:

- It is difficult to value yourself when no-one else does, BUT if you base your self-esteem only on how others judge you, it is based on shifting sands.
- Only YOU know what you want and need. Only YOU know what is important for you. This is why you need to have a firm sense of your own values.

Your self-esteem depends on the following:

- What YOU think and feel about yourself;
- How YOU value yourself.

A poor sense of your own self worth is a barrier to realising the importance of your basic needs – you may believe that you are fundamentally undeserving – you may
believe that other people’s needs and wishes have more weight and importance than your own – you may believe that the judgements and wishes of others have more value than your own.

**Remember:** You do not have to accept such a person’s values

- You have the right to choose your own values
- Other’s values, of course influence our own – and it is valid to decide that you agree with the values of others around you.
- What matters, though, is that you sort out and decide for yourself what is important to you.

---

**ACTIVITY : DISCUSS the VALUE of**

Money

Power

In assessing someone’s value

---

**ACTIVITY: WHAT DO LIKE ABOUT YOURSELF?**

List your five best qualities:

1.

2.

3.

4.

5.
LIKING YOURSELF WARTS and ALL

- Building a firm foundation of self-esteem means coming to terms with those aspects of yourself you may not like but cannot change.
- Self-esteem does not require that you like every part of yourself.
- Having self-esteem means that, on the whole, you feel your value outweighs your shortcomings.

(In doing this, be fair – exclude those things over which you have no control, and grant yourself some basic human rights)

ACTIVITY: The five qualities I like least about myself are as follows:

1. 
2. 
3. 
4. 
5. 

- Write list on piece of paper.
- Tell one other person about these things. (I choose couples)
- Choose two and decide between yourselves:
  - Is it realistic? Or is it an overstatement?
  - Provide proof.
  - Are there exceptions when you are not ““
  - Is the other person convinced?
  - Back to the group- anyone who was unable to convince?
Then with a different person—again—list the aspects least liked about
yourself. This time—decide between yourselves:

○ Can this be changed? Is it behavioural?
○ Is it something that can’t be changed?
○ How many of your least liked aspects are behavioural and can be changed?

Back to the group—who had a preponderance of traits that they believed
can be changed? Who felt they had traits that can’t be changed—are locked
in—innate? Can you accept them?

DISCUSSION: HOW OTHERS SEE YOU?
(Paper/pen feedback)

WHERE HAS OUR LOW SELF ESTEEM COME FROM??  Group discussion—
write up on board.

WE ARE MORE THAN OUR PAST
Discuss passage from DALI LAMA - his belief that the more honest and open we are
about ourselves, the more confident we are because then we have no fear of being
exposed.

DISCUSS THE CAPACITY of CBT to change the way people behave.
Discuss - positives – develop into affirmations
Work on negatives – either change (behavioural) or accept - WARTS and all)

DISCUSS “AFFIRMATIONS” for DISCUSSION
Which is the most inspiring to you. In small groups - or in large group - discuss what you think is the one you are going to “take on board” this week - and how might you do that.