Sexual and Relationship Therapy
Vol. 23, No. 4, November 2008, 293–303

Routledge
Taylor & Francis Group

The "HEALTH" model – Part 1: treatment program guidelines for Complex PTSD

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(*Received 21 May 2008; final version received 11 July 2008*)

This paper outlines the development and piloting of the "HEALTH" model for treatment of Complex PTSD in clients who have experienced multiple traumas across childhood and adulthood – particularly child sexual abuse and sexual assault in adulthood. As a guideline-based treatment model, HEALTH outlines six stages of intervention: (1) having a supportive therapist; (2) ensuring personal safety; (3) assisting with daily functioning; (4) self-regulation – learning to manage core PTSD symptoms; (5) treating Complex PTSD symptoms; and, finally, (6) having patience and persistence to enable "ego strengthening". Using a case study approach, we provide both qualitative and quantitative assessment data for the individuals in the study, all of whom displayed numerous pre-treatment symptoms of Complex PTSD. Such programs are different to standard PTSD treatment programs that focus predominantly on core PTSD symptoms of re-experiencing, avoidance and arousal. The results of this study provided support for the use of guideline-based treatment programs that cater specifically for the needs of those who have suffered long-term/multiple trauma experiences by targeting Complex PTSD symptoms.

Keywords: Complex PTSD; therapy; treatment guidelines; multiple traumas

1. What is Complex PTSD?

Many people who experience trauma – potentially overwhelming or horrific life events – appear to adapt and survive without developing a psychiatric disorder or other disability. But despite humans' great capacity to adapt and survive, it is well recognized within the field of psychology that "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" (van der Kolk & McFarlane, 1996, p. 4). Post Traumatic Stress Disorder (PTSD) was a way of recognizing the effects of trauma on the veterans of the Vietnam War, but there was growing recognition that similar stress reactions can be seen in response to other traumatic experiences, including childhood sexual abuse and adult rape. As a diagnostic category, PTSD "created an organized framework for understanding how people's biology, conceptions of the world and personalities are shaped by experience" (van der Kolk & McFarlane, 1996, p. 4).

However, there are a growing number of researchers who have questioned the adequacy of PTSD to capture the characteristics, from a clinical perspective, that are typical features of chronic abuse. For example, Herman (1992) identified three broad areas

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ISSN 1468-1994 print/ISSN 1468-1749 online
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DOI: 10.1080/14681990802342617
http://www.informaworld.com

of disturbance that, she claimed, transcended simple PTSD: a more complex symptom picture (particularly somatic, dissociative and affective symptoms); personality changes; and vulnerability to repeated harm (both self-inflicted and from others). Complex Post Traumatic Stress Disorder (CP) is a term that has been used to refer to a symptom constellation often seen in individuals who have experienced long-term and multiple trauma experiences – either in childhood or in adulthood (Herman, 1992). Individuals with CP, such as sexual abuse survivors, often display a variety of symptomatic and pathological behaviours, rather than one dominant set of symptoms. They typically report alterations in affect regulation, consciousness, self-perception, perception of the perpetrator, interpersonal relations and in systems of meaning (see Table 1). Complex Post Traumatic Stress Disorder is usually co-morbid with PTSD (Herman, 1992).

2. Early development of CP-specific treatment

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 sufferers of long-term or multiple abuse experiences (and who met the criteria for CP). 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" (p. 77). This is the process required in the treatment of Complex PTSD.

Table 1. Herman's seven criteria for Complex PTSD.

Criterion	Symptoms
1	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).
2	Alterations in affect regulation (including persistent dysphoria, chronic suicidal pre-occupation, self-injury, explosive or extremely inhibited anger, compulsive or extremely inhibited sexuality).
3	Alterations in consciousness (including amnesia or hypermnesia for traumatic events, transient dissociative episodes, depersonalization/derealisation, reliving experiences.
4	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).
5	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.
6	Alterations in relations with others (including isolation and withdrawal, disruption in intimate relationships, repeated search for rescuer, persistent distrust, repeated failures of self-protection).
7	Alterations in systems of meaning (loss of sustaining faith, sense of hopelessness and despair).

(Source: Herman 1992, p. 121).

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 usually overwhelming. 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 at 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" (p. 77). Here, Chu is referring to the need for therapy that strengthens the individual and his/her capacity to cope with the emotional work involved in remembering the past ("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 CP (see Table 1) 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.

New treatment models are necessary due to the relatively recent realisation that the PTSD formulation is inadequate in providing an understanding of the problems associated with long-term or repeated abuse – in particular, abuse that occurred during childhood (Chu, 1998; Herman, 1992; Leibowitz, Harvey & Herman, 1993). Treatment approaches based solely on a PTSD formulation are, therefore, also inadequate as they fail to address some of the prominent symptomatology. The "SAFER" model made significant steps toward providing an appropriate model on which to base treatment of CP. However, in our view, further refinement was necessary, in order to include important elements of the treatment process (as outlined later). In this way the "HEALTH" program (outlined below) builds on the model proposed by Chu (1998).

3. Development of the HEALTH program

There have been two main influences in the development of this program: the models for treatment of CP by such clinicians and therapists as Chu (1998), Herman (1992) and Lebowitz, Harvey and Herman (1993); and information obtained from the authors' clinical experience in working with sufferers of trauma. Using a case-study approach, the HEALTH program was implemented and evaluated (for further detail, see Connor, 2005). The evaluation was based on both qualitative and quantitative data for the 10 individuals who participated in the study, all of whom 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 trailing 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 CP (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. Those 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: Comprehensive Child Maltreatment Scales (CCMS – Adults: Higgins, & McCabe, 2001); and the Posttraumatic Stress Diagnostic Scale (PDS: Foa, 1995). Many had already completed the SIDES-SR (van der Kolk, 1996) as a preliminary screening tool.

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

Both quantitative and qualitative evaluation of the program took place. The qualitative evaluation of each individual's treatment was based predominantly on data obtained from an analysis of the language (discourse analysis) that was used by participants to describe their symptoms, both pre- and post-treatment. The language used by clients to describe themselves, their behaviour and their relationships prior to treatment was compared to how they described themselves post-treatment. Quantitative data were obtained from the results of psychometric testing post-treatment), using the PDS and also the SIDES-SR to determine whether there had been any reduction in symptomatology in the course of the treatment program.

Post-treatment data from psychometric assessment indicated that eight of the ten participants experienced some improvement in both core PTSD Symptoms (even if these symptoms were not directly addressed) and CP symptoms. Furthermore, in discourse, most of the participants in the 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 multiple experiences of abuse. For example, post-treatment, the predominating discourse themes pertaining to "self" were: empowerment, self-valuing, increased self-knowledge, strength, forward focus, optimism, stability, certainty and self-assuredness. The predominant discourse themes pertaining to "affect" were: optimism/brightness, self-empowerment, control, life re-engagement and involvement, emotional expression, knowledge and awareness, while the most prevalent themes relating to interpersonal relationships were around: empowerment and trust, acceptance, engagement and involvement, feeling informed, openness, honesty, certainty and self-confidence. 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), appeared to have taken place for most participants in the program. Further, the descriptions provided by participants appeared to be reflective of the participants' own judgement in regard to their situation and, as such, provided a richness of description, complete with personal connotation, that was not available from any other source.

The results of this study provide support for the use of guideline-based treatment programs that cater specifically for the needs of those who have suffered

long-term/multiple trauma experiences by targeting CP symptoms directly. Such programs are different to standard PTSD treatment programs that focus predominantly on core-PTSD symptoms of re-experiencing, avoidance and arousal.

The treatment program guidelines for treating CP are presented here 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 are based on a 6-stage model of treatment. The six stages form the acronym "HEALTH":

- **H**aving a supportive therapist;
- **E**nsuring personal safety;
- **A**ssisting with daily functioning;
- **L**earning to manage core PTSD symptoms (self-regulation);
- **T**reating complex PTSD symptoms;
- **H**aving patience and persistence to enable "ego strengthening".

Each of these stages is described in detail below.

Individual therapy

Stage 1: Having a supportive and experienced therapist

As with all psychotherapy, it is important to have a therapist who is skillful in building rapport and providing a supportive environment for vulnerable clients. In keeping with relevant codes of professional and ethical conduct, it is important that the treating therapist is someone who is not only qualified to treat psychological disorders generally, but, where possible, has had extensive experience in working with sufferers of long-term and multiple forms of trauma. For those who are newer to the field of trauma treatment it is important to gain supervision by those who do have expertise in the field of trauma treatment and to commence with less complex cases. The therapist working with individuals who have experienced long-term/multiple trauma experiences will need to assess carefully for symptoms of CP as well as PTSD and to understand the importance of dealing with the associated symptoms of Complex PTSD, prior to engaging in abreactive work. The therapist will also need to be available regularly and over a long period 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 client develops 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 effects 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 (i.e. further experiences of childhood abuse and/or sexual assault in adulthood) is also very common (Chu & Dill, 1990; Follette, Polusny, Bechtle, & Naugle, 1996; Higgins & McCabe, 2001). 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, it is important to create an environment where they eventually can 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 client 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 CP. It is also worth noting that several participants in our study 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 experiences of 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 and support clients to seek out (where appropriate) or continue involvement in paid employment, a volunteer role, regular activities at home and other extra-curricular activities. Such functional activity provides much-needed daily structure and assists with social networking opportunities. 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 support 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 clients 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, we argue 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 (self-regulation)

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, depersonalization, de-realisation, 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, such as grounding, self-regulation, relaxation and stress reduction. 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 (or "sit with") and control the emotions that may have previously led to avoidance. This will help, in turn, to 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 (1998), 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 focused 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 stage of treatment to ensure that when clients reach this stage, they are able to achieve their goals more easily, due to increased feelings of safety and improved daily functioning.

Stage 5: Treating CP 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 CP 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 and 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.[1]

Although negotiation of a treatment plan has not been suggested by Chu in his SAFER model, we believe that this is an important aspect and will ensure that any treatment that follows will be relevant and appropriate. Many of the participants in the pilot study used to develop the HEALTH model reported that prior to their participation in the study, they had often been 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 might have catered more appropriately for their needs. As the treating therapist, the first author also noted that when clients were included in discussions regarding their future treatment plan, they reported this as a positive experience and welcomed the opportunity to take an active role in directing the course of therapy.

The HEALTH model has allowed for a wide range of symptoms to be treated in this stage. The model is therefore, somewhat different to the SAFER model 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, this is based on suggestions from participants in the pilot study, for whom "alterations in self-perception" and "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 change will often not occur until after a number of 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. Self-analysis is a useful starting point in "ego strengthening" and can be used to help clients examine and identify their strengths and weaknesses and gain a healthy self-knowledge. Affirmations can be used to assist clients reinforce positive self-messages and these can be reinforced with hypnotherapy. Cognitive strategies such as cognitive restructuring or cognitive reframing are also appropriate in assisting clients provide themselves with self-appraisals that are more realistic. Assisting clients with taking a more pro-active role in changing behaviours that they see as undermining their capacity to move forward can also be useful in gaining a sense of empowerment when a change takes place.

Concurrent group therapy

As part of the HEALTH treatment model, it is important that, in addition to individual therapy sessions, clients take part in group therapy. Numerous authors have referred to the benefits of group therapy for survivors of trauma (South & Wallis, 2003; Wallis, 2002; Williams & Nuss, 2002) and there appears to be very strong support for this form of therapy as a means of providing additional benefits to adult survivors of trauma. Specifically, 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. Groups are also 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.

Qualitative evidence from the current study supports the view that concurrent group therapy is helpful and therefore 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 commence several weeks into the individual treatment program, to allow participants to become accustomed to therapy and the therapist.

Reflections on trial implementation of the HEALTH program

From a therapists' perspective, implementation of the HEALTH program highlighted the benefits of working within a framework such as this when assisting individuals who had experienced long-term or multiple trauma experiences. Having the stages of therapy articulated into six discrete stages facilitated therapy greatly and provided a sound basis from which to undertake client work. The treatment guidelines also allowed for an individualised focus and each participant's program was different (in terms of the symptoms that were included for treatment and the order in which symptoms were treated). The guidelines thus allowed for flexibility in approach, without losing sight of the main objectives.

Implementation of the program also highlighted the complex and challenging presentations of individuals who have experienced long-term or multiple trauma experiences. Many such individuals are highly emotionally responsive people who may have strong emotional responses to events. These individuals therefore require sensitive and skilled intervention. Supervision is thus often recommended (especially for less experienced therapists) when working with these clients.

Conclusion

A guideline-based treatment program, based on the HEALTH model, used in the treatment of CP in ten clients, led to marked improvements in both core PTSD and CP symptoms for eight of the ten individuals. While the evaluation of the HEALTH model was limited by the small number of clients participating in the study, the results are promising for guideline-based programs. However, further randomised, controlled studies are needed to establish the relative efficacy of this approach.

Although it was not possible within the current study to draw conclusions 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 would likely extend our knowledge in this area. Such a comparison study would allow further

conclusions to be reached regarding the importance of placing specific emphasis on areas of safety, functioning and core PTSD symptoms, as well as CP-specific symptoms.

The effectiveness of the treatment model has been documented fully by Connor (2005). This is the only documented study to implement and evaluate a guideline-based program for the treatment of CP symptoms over an extensive period and, as such, it has been a valuable contribution to the literature in this area. The effectiveness of the model has also been demonstrated in a detailed case study (Connor & Higgins, 2008). A detailed literature review outlining the usefulness of the CP construct has also been undertaken (see Connor & Higgins, forthcoming).

Notes on contributors

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

Note

1. A sample of the type of client information that could be distributed to clients is available on request from the first author (pam.connor@bigpond.com).

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