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General introduction

Based on:
‘Stabilization therapy as an answer on Complex posttraumatic stress disorder? Complex PTSD in women after childhood abuse: progress in diagnostics, treatment and research’ Ethy Dorrepaal, Kathleen Thomaes, Nel Draijer. Tijdschrift voor Psychiatrie, 2006, 48, 1-6
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Background

The question ‘what is the best treatment for patients with severe psychiatric symptoms related to a history of child abuse?’ was the start of this clinical and scientific endeavor. Many of these complex patients were suffering from a posttraumatic stress disorder (PTSD), but were frequently excluded from evidence based PTSD treatment, such as exposure, because these were not considered appropriate due to risk of destabilization. Moreover, patients admitted to these therapies regularly dropped out or did not reach sufficient results. Alternative treatment options were not easily found. However, these patients were obviously in need of treatment, since they did not only suffer from the customary PTSD symptoms such as intrusions, avoidance and hyperarousal, but also were hindered in their functioning by affect dysregulation, dissociation, problems with self-image, interpersonal relationships, somatization and with systems of meaning. Typically they experienced severe psychiatric symptoms, high comorbidity and social maladjustment (Breslau, 2001), with a tendency to become chronic in spite of considerable use of medical and psychiatric services (Höing, 2003). Thus, in clinical practice these patients frequently were underserved, or ‘neglected’.

Child abuse and (Complex) PTSD

Child sexual and physical abuse are widespread: in a general population study 10 % of Dutch women reported sexual abuse (Draijer, 1990). International studies indicated that 9 to 33% of women reported a history of child sexual abuse (Burnam et al., 1988; Finkelhor & Dzuiba-Leatherman, 1994). A history of childhood abuse is highly prevalent among psychiatric patients: an estimated 124,000–158,000 persons a year have a history of child abuse in Dutch outpatient mental health institutions, while adequate facilities were lacking (Höing, 2003). In psychiatric outpatients 17-19% had suffered sexual abuse and in clinical settings 23-31% (Höing, 2003).

A substantial body of literature has documented that childhood sexual abuse has profound and lasting effects (Browne & Finkelhor, 1986; Burnam et al., 1988). Compared to other psychotrauma’s, childhood physical abuse and rape are far more likely to result in PTSD, characterized by symptoms such as re-experiencing, numbing and hyper arousal: nearly 50% compared to 8–20% in other traumatized populations (Kessler et al., 1995).

Childhood trauma, or type II trauma, chronic and occurring in interpersonal relationships (Terr, 1991), is associated with a wide array of psychopathology, in addition to the ‘simple’ PTSD (according to DSM-IV) symptoms. Children in abusive environments are unlikely to acquire internal representations of safe caretakers and the concomitant ability to self-sooth in adaptive ways. This impairs a child’s ability to develop adaptive affect regulation skills and self-esteem, as well as the
ability to trust others. Thus, affect dysregulation, dissociation, self-harm behaviors, suicide attempts and problems in interpersonal functioning may develop (Draijer, 1990; Van der Kolk et al., 1996; Cloitre et al., 1997). The impact of repeated trauma in a child’s primary relationships and environment also affects her or his biology (Meewisse et al., 2007). Frequent co-occurring neglect, may play an important role as well (Draijer, 1988, 1990, 2003; Draijer en Langeland, 1999).

Thus, child abuse – occurring in interpersonal dependency relationships, disrupting normal development – may lead to additional problems in affect regulation (e.g. alteration between rage and affective emptiness, risky behavior), memory and attention (e.g. dissociation), self-perception (e.g. perceiving self as damaged, feelings of guilt and shame), interpersonal relations (e.g. inability to trust), somatization, and in systems of meaning (e.g. loss of faith, hopelessness), complicating the intrusions, avoidance and hyperarousal of ‘simple’ PTSD (Herman, 1992). This syndrome is presented under different headings, such as ‘PTSD with associated features’ (DSM-IV-TR), also known as PTSD with enduring personality change (ICD-10), Complex PTSD (Herman, 1992, Pelcovitz et al., 1997; Ford, 1999), and Disorders of Extreme Stress Not Otherwise Specified (DESNOS) (Jongedijk et al., 1996; Van der Kolk et al., 1992). The DSM-IV field trial tested this diagnosis as disorders of extreme stress not otherwise specified (DESNOS), a disorder closely related to Complex PTSD, but not necessary including simple PTSD. The findings of the field trial indicated that nearly everyone who met criteria for DESNOS also met criteria for simple PTSD (Roth et al., 1997). The committee listed symptoms of DESNOS as associated features of PTSD in the DSM-IV-TR, along with other comorbid symptoms. In this thesis we will use the term ‘Complex PTSD’ to refer to this syndrome.

Complex PTSD is associated with high comorbidity (or symptom overlap) on both DSM-IV Axis I (e.g. depressive disorder) and II (e.g. borderline personality disorder), serious impairment (Breslau, 2001) and extensive use of health care (Höing, 2003). Empirical studies (Ford, 1999; Van der Kolk et al., 2005; Zlotnick et al., 1996) have supported the concept of Complex PTSD and have reported a prevalence of 1% (Ford et al., 2006) in a student population.

Phase based treatment for Complex PTSD patients

The central question in this thesis is: ‘How to treat these Complex PTSD patients?’. In the regular, ‘simple’ PTSD, trauma focused cognitive behavioral therapy (TF CBT) such as exposure, Eye Movement and Desensitization Reprocessing (EMDR) or cognitive therapy has been proven effective although dropout rates and post treatment symptom scores are considerable (e.g. Bradley et al., 2005; Foa et al., 2000).

However, a subgroup of patients – probably the early and chronically traumatized – did not get better or even worsened, with high dropout rates and
compliance problems (Scott & Strandler, 1997; Tarrier et al., 1999; Cloitre, 2009).
Some studies suggested that common characteristics of this population, such as
Complex PTSD (Ford & Kidd, 1998), anger (Foa 1995; Pitman, 1991; Taylor, 2001) and
child abuse (Foa et al., 2000, Hembree, 2004b; Van der Kolk et al., 2007) predicted
poor outcome, but other studies did not confirm this (van Minnen, 2002; Cahill
2004; Resick, 2003). Severity of PTSD and comorbid borderline personality disorder
(BPD), have been associated with higher dropout rates during exposure treatment
(McDonagh et al., 2005; Cloitre 2001), while borderline characteristics only did
not give higher dropout rates (van Minnen, 2002; Feeny, 2002), but predicted less
favorable post treatment outcomes. The difficulties of child abuse related Complex
PTSD patients in tolerating and/or benefiting from exposure-based therapy,
potentially leading to exacerbation of distress, retraumatization or psychiatric
decompensation, have been attributed to deficits in coping skills (Ehlers et al.,
1998; Herman, 1992; Tarrier, et al., 1999; Van der Kolk et al., 1996; Wolfsdorf &
Zlotnick 2001). Exclusion criteria for PTSD treatment, such as exposure or EMDR,
according to the International Society for Traumatic Stress Studies (ISTSS) (Foa,
2000) are: suicidality, self harm, substance dependence and severe dissociation are
in line with these observations.

This confronts the clinician with the dilemma: which treatment to choose for these
severely traumatized patients in the absence of randomized clinical trials leading
the way?
The ISTSS PTSD treatment guidelines (Foa et al., 2000) recommend for severely
dysfunctioning patients with an inability to tolerate strong affects that therapy
should initially focus on the stabilization of patients, which is so-called phase-based
treatment. Exposure treatment is recommended only after sufficient tolerance of
high affect has been achieved (Chu, 1991, 1998; Courtois, 2004; Foa et al., 2000;
Herman, 1992; Lubin et al., 1998; Nicolai, 1991; Van der Kolk, 1996; Wolfsdorf &
Zlotnick, 2001).

The treatment’s three phases are: 1. Stabilization and symptom reduction. 2. Exposure. 3. Integration and rehabilitation with the following objectives:
Phase 1. treatment goals are: understanding the relation between symptoms and
problems in daily life and social functioning; improving self care, stability in daily
life, acquiring personal safety; gaining control over self destructive symptoms like
automutilation, suicidality, binge-eating, dissociation and flash backs; diminishing
of isolation, guilt and shame; obtaining skills in affect and impulse regulation and
interpersonal functioning.
Phase 2. treatment aims at processing trauma related emotions and injury caused
by the trauma. Effective treatments are exposure, EMDR, cognitive (processing)
therapy (CT) with and without exposure.
Phase 3. treatment aims are directed to integrating the trauma in the life story and
building up a better social, working and family life: so called rehabilitation.
The treatment of choice for the severe traumatized patients seems to focus first on stabilization: so called phase 1 treatment. Before exposing patients to their traumatic memories- phase 2, patients need to be able to maintain structure and stability in daily life, manage intense emotions without getting suicidal, conducting self-harm, become severely dissociated or start excessive alcohol or drug abuse.

As this model diverges from evidence based practice in PTSD treatment, the important question in the field is the extent to which treatment should focus on the trauma itself (i.e., exposure-based or trauma-focused), or to start a focus on current symptoms and stabilization (‘trauma informed’, affect management).

This topic relates to two different perspectives on coping with stress, probably concurring with different subtypes of PTSD. “Phase 2” exposure-based models for the treatment of PTSD are consistent with a fear based orientation that advocates approaching and dealing directly with stress. This orientation allows for acquisition of information and understanding, and an opportunity for emotional expression (Roth & Newman, 1991; Cloitre, 2009). Likewise, exposure-based treatments include desensitization to the traumatic event and related situations, and integration of the traumatic memory into a new, adaptive meaning system. However, complex patient difficulties in tolerating and/or benefitting from an early focus on traumatic experiences may exacerbate distress.

In contrast, “phase 1” treatments for the treatment of PTSD are more consistent with an orientation that advocates avoiding and containing overwhelming stress. This orientation creates some distance between the individual and the traumatic situation and, at least in the short-term, reduces distress. Unfortunately, avoiding exposure may prevent important information from being processed, may constrict life both emotionally and interpersonally, and may exacerbate emotional distress in the long-term (e.g., Herman, 1992; van der Kolk et al., 1996).

This initial focus on affect management skills in patients with Complex PTSD may be particularly useful because deficits in this area may interfere with both daily functioning as well as the therapeutic process (Zlotnick et al., 1997). In this way, a phase based perspective may integrate the long-term strengths of exposure-based models with the more immediate benefits of affect management models (cf Cloitre, 2009; Linehan, 1993; Roth et al., 1997; Van Der Kolk et al., 1996). This indicates the need for suitable stabilizing treatments (Chard et al., 2005; Cloitre, 2009; Foa et al., 2000; Van Der Kolk et al., 2007), to address sequelae like affect dysregulation (Lubin et al., 1998; Zlotnick et al., 1997).

**Evidence based treatments for child abuse related Complex PTSD**

Literature on treatment of child abuse (CA) related PTSD was found in two scientific fields: 1) the child abuse field and 2) the PTSD field. The child abuse centered treatments aim at reducing problems like low self esteem, interpersonal problems (e.g. mistrust), and isolation. As far as tested for efficacy, these are mainly group
treatments. The PTSD perspective is aimed at achieving goals like PTSD symptom reduction by exposure, and is mainly given in an individual format.

The studies found in the international literature around the turn of the century pointed towards beneficial effects of group treatment (Draijer, 2003; Dorrepaal et al., 2006; Kessler et al., 2003). Some studies tested cognitive therapy in part aiming at trauma processing or exposure (Echebura et al., 1997), others were feminist based aiming at improvement of relational functioning or self-esteem in women (Stalker et al., 1997; Westbury et al., 1999; Morgan et al., 1999). Some treatments focused on interaction (Alexander et al., 1989), others on coping (Zlotnick et al., 1997).

Research populations were hardly described: sometimes only the traumatic history was established (Alexander et al., 1989), unfortunately psychiatric diagnoses failed and only occasionally (Complex) PTSD symptoms (Zlotnick et al., 1997) and psychiatric comorbidity (Cloitre et al., 2002) was measured in a standardized way. Moreover, severe psychiatric comorbidity was sometimes excluded (Echebura et al., 1997; Cloitre et al., 2002), but not in other cases (Lubin et al., 1998). Outcomes varied from improvement in guilt, shame and isolation (Herman & Swartzow, 1984) to PTSD symptoms (Lubin et al., 1998; Zlotnick et al., 1997), complicating systematic comparison.

In short, studies were very heterogeneous, thus precluding general conclusions beyond improvement on a diversity of measures after varying treatments in different CA populations. In line with our findings, a meta-analysis (Bradley et al., 2005) identified evidence on PTSD treatment in cases of polysymptomatology related to CA and comorbid Axis II diagnosis, as a gap in the literature. Such patients (the focus of the current thesis) were frequently excluded from PTSD studies, and these studies therefore have limited clinical utility and generalizability.

Thus, treatments need to be developed that explicitly address these difficulties, and study designs should include the measurement and evaluation of these problems in addition to the standard measures of PTSD.

Of the identified studies, one study was prominent with a broad inclusion of well assessed CA related PTSD patients. In this population, patients with comorbid psychiatric disorders were not excluded and PTSD symptom changes were measured. Moreover, the stabilizing content of that treatment protocol fitted within the clinical consensus of phase 1 treatment (Zlotnick et al., 1997).
Study aim and design

We decided to try and replicate this RCT (Zlotnick et al., 1997) on the effectiveness of affect management in the Netherlands by randomly assigning 71 well diagnosed Complex PTSD patients to treatment as usual (TAU) or to a combination of TAU and a stabilizing group treatment, which we named “Vroeger en verder” (“Past and beyond”), based on psycho-education and cognitive behavioral therapy. We measured outcome in terms of both PTSD as well as Complex PTSD symptoms, and explored if severity of dissociation or personality disturbance predicted treatment effect and compliance. In addition to the psychological outcome measures, part of the patients of the RCT (those willing and able to be included on the basis of additional fMRI inclusion criteria N = 33) participated in the ‘twin’ neuro imaging study (by Kathleen Thomaes, VUmc, 2012), in which we investigated how participants were scarred on the level of the brain, and investigated whether psychological recovery was accompanied by normalization of these brain ‘abnormalities’.

Study population: Complex PTSD patients

We specifically searched for patients with Complex PTSD as referred by their therapist for stabilizing treatment. To optimize generalizability we limited our exclusion criteria as much as possible. Participants were only excluded if they met the criteria for antisocial personality disorder (to protect group members), current psychotic episode or dissociative identity disorder (because of insufficient consciousness and attention to be able to learn from our intervention) or severe, predominant alcohol or drug dependence or abuse (likely to interfere with compliance) as assessed by Structured Clinical Interviews for DSM-IV Axes I and II disorders (First et al., 1995; Pelcovitz et al., 1997; Pfohl et al., 1997). The subjects that were currently in exposure treatment or seeking such treatment, were also excluded because stabilization was considered unnecessary in those cases, and at odds with the treatment rationale. Patients using medication (including antipsychotics), suffering psychosocial difficulties or personality disorders were not excluded.

We used the Structured Trauma Interview to assess child sexual and/or physical abuse (STI; Draijer, 1989). Child abuse was defined as occurring before the age of 16. Patients who had suffered moderate or severe child abuse were included, classified as (a) only physical abuse, (b) only sexual abuse, or (c) both physical and sexual abuse.

We choose to use concept of Complex PTSD, referring to both simple PTSD as well as associated features captured as DESNOS, for several reasons. First, PTSD fits within the DSM-IV diagnostic system, thereby allowing comparison with other research. Second, in the study of Zlotnick (1997) which we partly replicated, all patients met criteria for simple PTSD as well as DESNOS and PTSD outcome was measured. Third,
in the Structured Interview for Disorders of Extreme Stress (SIDES) (Pelcovitz et al., 1997) a PTSD diagnosis is warranted, strengthening the relation between trauma and symptoms more explicitly as compared to the DESNOS diagnosis only. Fourth, some validation research on the SIDES was available (Zlotnick & Pearlstein, 1997; Pelcovitz et al., 1997; Ford & Kidd, 1998). Zlotnick and Pearlstein (1997) reported that the various subscales were moderately correlated with the borderline subscale of the Personality Diagnostic Questionnaire-Revised (PDQ-R; Hyler et al., 1990), the avoidant and hypervigilance subscales of the Clinician Administered PTSD Scale (CAPS; Weathers et al., 2001), the Self-Injury Inventory (Zlotnick et al., 1996), and the hostile and somatization subscales of the Symptom Checklist-90-R (SCL-90-R; Derogatis, 1977). Internal consistency alphas of .81-90 for total score and .42- .96 for subscales were reported. Ford and Kidd (1998) reworded items to clarify item anchors, while retaining the content and intent of items and scoring procedures, to construct the SIDES-R. They reported acceptable interrater reliability ($\alpha = .74-.93$) in a treatment-seeking sample of 75 combat veterans, and subscale alphas ranging from .74-.93. Concurrent validity was supported by findings that higher SIDES-R scores were associated with more severe intrusive reexperiencing symptoms, childhood abuse, severe combat exposure, and witnessing and/or participation in war-zone atrocities (Ford, 1999). Note however, that to date, no measure exists that captures both PTSD as well as associated features.

Thus, the diagnosis of Complex PTSD, comprising both PTSD as well as associated Complex PTSD features, was captured by two measures:

1. PTSD was established initially in the pilot study with the Structured Diagnostic Interview for DSM-IV axis I disorders (First et al., 1996). Later on (RCT) the presence of PTSD was assessed using the Dutch version of the Clinician-Administered PTSD Scale (Hovens et al., 1994), a structured diagnostic interview that has robust psychometric properties ($\alpha = .83$). The severity of PTSD was established using the Davidson Trauma Scale (DTS; Davidson, et al., 2002), a well-validated 17-item measure assessing DSM-IV diagnostic criteria on a 5-point Likert scale (range 0–68; Cronbach’s $\alpha = .88$), also tested in in a sample of survivors of childhood sexual abuse (Zlotnick et al., 1996a).

2. The original 48-item SIDES, Dutch version was used to assess Complex PTSD diagnosis with domains: affect regulation, memory and attention, self-perception, perception of perpetrator, interpersonal relations, somatization, and systems of meaning (Pelcovitz et al., 1997). Following personal consultation with its author (J. Ford), the revised 37-item 4-point scale version scoring format (Ford, 1999) was used to assess severity, except for the perception of perpetrator and somatization items mainly due to difficulties with the lacking sensitivity for change of the somatization items and the balance between number of items per domain. (range= 0–111; Cronbach’s $\alpha = .77$).
**Intervention: development, content and preliminary evaluation**

The intervention we tested is called ‘Vroeger en verder’ (‘Past and beyond’, Dorrepaal et al., 2008). It can be labeled as a stabilizing, phase one treatment. We consider our treatment as ‘trauma informed’, meaning that trauma is assessed at the start, but direct exposure to traumatic details is postponed. At the same time, the trauma is constantly referred to as origin of symptoms. These are explained as once necessary adaptations for emotional survival in a context of child abuse, but now interfering with daily functioning.

The intervention was based on the affect management manual of Caron Zlotnick (Wolfsdorf & Zlotnick, 2001). Sources included work by Matsakis (1994), Linehan (1993), McKay et al. (2003) and Meichenbaum (1994). This manual included sessions addressing psycho-education and skills training about Complex PTSD symptoms, improvement of sleep, dissociation, skills to recognize emotions and manage intense affects, mainly using dialectical behavioral treatment techniques, and introduces cognitive therapy as well. We (Dorrepaal et al., 2008) extended this protocol by inserting additional sessions, with psycho-education and cognitive restructuring to address additional domains of Complex PTSD, such as assertiveness, guilt and shame, distrust, bodily experiences and sexuality, and extended the topic saying goodbye, based on own work as well as on other resources (Bouma, 1999; Korsten 2004). In the additional sessions 14-19 skills are extended, and already acquired skills and cognitive techniques are consequently administered and rehearsed. Also, authors made some adaptations to the existing sessions of Zlotnick’s manual (table 1).

Thus, the stabilizing group treatment, based on psycho-education and cognitive behavioral treatment, employed in the present study focusses on decreasing ‘simple’ PTSD symptoms as well as Complex PTSD features.

Psycho-education is aimed at attaining a sense of cognitive mastery by explaining symptoms as adaptations that were once necessary for emotional survival in a context of child abuse. Registering homework helps to recognize possible triggers. Then deliberate avoidance of triggering situations is stimulated, leading to more sense of control. Subsequently, affect management skills are taught to increase the ability to tolerate feelings instead of avoidance or destructive behaviors that arise from disrupted affect regulation (e.g., self-mutilation, dissociation), an ability that may never have developed in the first place in the face of child abuse.
This approach teaches patients how to cope with potentially triggering situations before they occur without using maladaptive attempts at affect regulation, thus leading to less need for coping by avoidance in daily life, thereby improving life both emotionally and interpersonally. A wide variety of affect management strategies are presented to patients, including skills such as mindfulness, distraction, self-soothing, crisis planning, relaxation, time-out.

In the second half of the treatment, when group members experience more stability and safety within and outside the group enabling review of topics such as anger, assertiveness, bodily experiences, shame, guilt and distrust, topic that interfere with good self esteem and interpersonal relationships, cognitive restructuring is scheduled. This contents restructuring of distorted thinking about current difficulties and trauma-related affect such as all-or-nothing thinking (thinking in polarized, absolute terms), emotional reasoning (relying too heavily on emotions to interpret reality and guide behavior), and overgeneralization (extrapolating overarching rules from single facts or events; Zlotnick et al., 1995). Challenging these thinking errors as well as core beliefs such as “I am not worth being loved, nobody can be trusted, I am not able to achieve anything, I will be left” (partly derived from Schema Focused therapy; Young, 1999).

In sum, CBT principles are used with the aim to tolerate feelings and withstand avoidance in the end. After chronic trauma patients are afraid of feelings, because of the associations with extreme painful conditions. This aim is reached gradually, first psycho-education and registering helps to recognize possible triggers. Then deliberate avoidance of triggering situations is stimulated, leading to more sense
of control. Subsequently, new skills are taught to increase the ability to tolerate feelings instead of avoidance. Sessions 10–20 contain cognitive restructuring, by discovering and correcting thinking errors and false beliefs. Subsequent rehearsal of cognitive restructuring and skills are conducted on new topics. Together with psycho-education and recognition in the group they reduce desolation and improve social relationships. Finally, attention is paid to the appreciation of relationships and to the relevance of properly parting and saying goodbye.

The treatment manual consists of a structured, detailed session-by-session script (psycho-educational presentations on the weekly topic, connected skills training and cognitive restructuring, and homework pages). These topics are presented with PowerPoint presentations, and interactive teaching. Patients are increasingly encouraged to present examples of their own experiences and ask questions. In discussing the homework, patients become more and more involved in advising each other.

The focus of the treatment is towards the here-and-now, on positive reinforcement and empowerment. The group format aims at inducing hope and reframing patients’ symptoms as understandable responses to trauma, thereby reducing shame, guilt and isolation. The interaction between group members is limited outside the direct content of the course in order to create a safe place to learn. During the early stages of recovery, highly structured groups can facilitate feelings of safety and predictability, and may be particularly useful and well-received by patients (Wolfsdorff & Zlotnick, 2001; Lau, 2007).

The rationale for a primary focus on current affect and problems, rather than a focus on traumatic material itself, is explicitly discussed with patients. The therapists validate the importance of traumatic experiences as origin for distorted beliefs, but highlight the current focus on skills. In addition, the group leaders emphasize the importance of not triggering other group members with detailed descriptions of traumatic events.

Fitting with the course-like design of treatment, the attitude of the therapists, although necessarily skilled in cognitive behavioral therapy and group treatment, as well as treating this complex population, is teacher-like. Participants are informed that symptoms will not directly decrease, because the pattern of ignoring problems is changed. Responsibility for improvement lies with the participants, and positive learning atmosphere is created by positive reinforcement of contributions. The focus is at participants own successful efforts, and efforts of other participants. Of course the boundaries for behavior in the group are set in some rules to create a safe place to learn. Therapists show understanding for the big effort hat is asked from patients; they underline that everyone has her own pace that will be respected, and that topics are repeated in the course. This is very important because many patients have harmed self esteem by negative experiences in school. The aim of
the treatment is symptom reduction, and – probably even more important – less interference of symptoms on daily functioning.

The first group treatment was conducted by one of the researchers and an additional therapist, with two others observing and supervising. Interfering behavior and attitude are important aspects in supervision. The results of this first group are described below in sum (Dorrepaal et al., 2006). Subsequently, the therapists of all four participating mental health institutes, scattered over the west of Holland (GGZ Dijk en Duin, Altrecht, GGZ Noord-Holland-Noord and GGZinGeest) participated in the study and conducted the pilot groups. They were additionally trained and supervised on site. Nowadays, a structured 3 day training program is developed, to train new therapists.

**Preliminary results of the first group**

Preparing for the subsequent studies, we investigated the feasibility of including patients, implementing assessments, and conducting the extended and adapted treatment manual in a first group treatment (Dorrepaal et al., 2006). The assessments as well as the treatment manual were accurate and clear and tolerable for the patients. The majority of patients (7 of 11) attended at least 15 out of 20 sessions. Of the 7 completers 5 did not meet criteria of Complex PTSD at post treatment, and 6 no longer met criteria at 6 month follow up. The mean score on the PTSD frequency and severity rating (Davidson Trauma Scale; Davidson et al., 1997) decreased from 71 (range 28–103) to 49 (range 14–98). At follow up, the score decreased further to 40 (range 10–68). This decrease equals the decrease Zlotnick reported (67 to 46) and is considered clinical relevant. We concluded this group treatment protocol was well possible in our more severely symptomatic population. The group seemed to decrease shame, guilt and distrust, and improve social functioning. These very preliminary results, underlined the usefulness of our clinical and scientific endeavor.
Personal evaluations by group participants
Apart from scores and numbers, personal evaluations can illustrate what an intervention may mean for the participants. These quotes are from participants after conducting this group treatment. They are included in the manual to encourage others:

“I learned a lot in the course. Unconsciously I apply exercises in my daily life. Unknowingly. I feel more control in what I do or don’t. I recognize my emotions better. At last, I am no longer as angry at my boyfriend. Actually, I can see he tries very hard. Since the session about anger – in which I really cried of recognition – something changed. I know better now when I am really angry and at whom.”

“I found it very special to experience that the women in the course actually were very nice. I expected that you could see from the outside what they had been through. But they were not crazy at all! I was afraid the course would go too far into depths, but that turned out better, because the rule was not to share details of the traumatic experiences. You needed little words. Nobody judged another, there was understanding. Without being glanced at. In the outside world that’s usually different. It is nice to experience. I feel less shame and I am less hard towards the outside world and myself. Though it is confronting, in the past I could hide, you have to dare and change yourself.”

“For me the most important element of the course was that I met fellow-sufferers with the same problems such as I have. Recognition is important because I feel I am no longer the only one. It relieved me, you don’t feel so isolated any more. Although there is much interest for abuse nowadays, but I did not know these complaints could be related. I thought it was my failure. I feel less isolated now and I no longer think these problems are my own fault. I participate more in life now.”

“I have walked around with my problems for years – always in a detached way. I did not know what was wrong and what to do about it, and I thought it was my own fault. During the course I found out; it’s not all my fault, but an effect of the past. It shocked me. But with the aid of the training I have more understanding and I am less nervous, because I understand the cause. When I have an anger attack, I use the clenched fist exercise, or I start counting en that helps. I don’t let go any more.”

“I have been thinking a very long time that I needed thrills in my life. After the abuse I went for kicks such as drugs and very fast and dangerous driving. Now, I call someone for support and plan nice things for myself. Moreover, I enjoy nature now. I learned to handle aggression. And above all: I learned I am worth being loved.”
Outline

In chapter 2 a pilot study testing a stabilizing group treatment protocol is described, designed for the management of the long-term sequelae of child abuse, that is, Complex posttraumatic stress disorder (Complex PTSD) aiming to improve Complex PTSD using psychoeducation and cognitive behavioral interventions. We investigated the effectiveness of this protocol in addition to treatment as usual and we expected patients would improve substantial. Included were thirty-six patients with a history of childhood abuse, Complex PTSD and severe comorbidity. These patients participated in a 20-week treatment with pre-, post-, and follow-up-assessments in three mental health institutions.

In chapter 3 this pilot study was followed by a randomized controlled trial in which we aimed to test the efficacy of psychoeducational and cognitive behavioral stabilizing group treatment in terms of both PTSD and Complex PTSD symptom severity. Seventy-one patients with Complex PTSD and severe comorbidity (e.g. 74% axis II comorbidity) were randomly assigned to either a 20-week group treatment (EXP) in addition to treatment as usual (TAU) or to TAU only. Primary outcome measures were the Davidson Trauma Scale (DTS) for PTSD and the Structured Interview for Disorders of Extreme Stress (SIDES) for Complex PTSD symptoms. We hypothesized that only patients with additional group treatment would improve. Moreover we expected patients with a comorbid borderline personality disorder – associated with difficulties in staying in relationships – would predict drop-out. And we expected highly dissociative symptoms – interfering with attention – would be associated with poor outcome. A subpopulation of this study was additionally included in a neuroimaging study before and after treatment.

In chapter 4 we investigated if we could identify personality based subtypes of Complex PTSD. Although Complex PTSD seems to be a useful concept, the disorder shows high inter-subject variability in terms of comorbidity. Moreover, core symptoms of Complex PTSD concern personality disturbances, that pose major treatment challenges (Allen, Coyne, & Huntoon, 1998), predict a poor outcome in regular PTSD treatment (Ford & Kidd, 1998), and imply the need to tailor treatments (Breslau, 2001; Cloitre, 2009; Cloitre & Koenen, 2001; Cloitre et al., 2002; Wolfsdorf & Zlotnick, 2001; Zlotnick et al., 1997). In the literature it has been conceptualized that some features of Complex PTSD co-vary with internalizing personality characteristics (e.g., feelings of shame, despair, and social withdrawal), whereas others are associated primarily with externalizing personality characteristics (self-destructive and impulsive behavior, hostility; Allen et al., 1998; Miller & Resick, 2007). We expected to find subtypes differentiated by introversion and disinhibition. Because both dimensions are included in the concept of Complex PTSD, symptom severity was hypothesized to be correlated with both introversion and disinhibition. Furthermore, we aimed to explore whether the severity of
simple PTSD, dissociation, depression, and borderline characteristics as well as trauma history and parental bonding differed between these subtypes. To his aim we conducted a cluster analysis.

To investigate whether the presence of such subtypes could explain difficulties in engaging some patients in treatment (Allen et al., 1998) as well as differential treatment needs and results (Follette et al., 1997), we conducted a prediction study (chapter 5) to investigate if these subtypes would predict treatment compliance and effectiveness in our population.

In chapter 6 we present a quantitative review of the literature on child abuse related (Complex) PTSD studies to investigate whether treatment for this population should differ from ‘simple’ PTSD guidelines in general. This study sought to determine what evidence is currently available to guide choice of treatment for this population. We performed a quantitative review of literature from 1989 to 2012 with populations addressing treatment for combined PTSD as well as child abused populations, based on variables such as inclusion and exclusion criteria, effect size, recovery and improvement rates, pre and post scores in both completers as well as intention-to-treat analysis.

The dissertation ends with a general discussion (chapter 7). Main results will be summarized and discussed. Implications of the presented studies and suggestions for future research will be addressed.