



Brief Communication

Stabilizing group treatment for Complex Posttraumatic Stress Disorder related to childhood abuse based on psycho-education and cognitive behavioral therapy: A pilot study[☆]

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ABSTRACT

Objective: This study tests a Stabilizing Group Treatment protocol, designed for the management of the long-term sequelae of child abuse, that is, Complex Posttraumatic Stress Disorder (Complex PTSD). Evidence-based treatment for this subgroup of PTSD patients is largely lacking. This stabilizing treatment aims at improving Complex PTSD using psycho-education and cognitive behavioral interventions.

Method: Thirty-six patients with a history of childhood abuse, Complex PTSD and severe co-morbidity entered a 20-week treatment with pre-, post-, and follow-up-assessments.

Results: Improvement was found for PTSD and borderline symptoms. Post-treatment 64% and after 6 months 78% of patients no longer met criteria for Complex PTSD.

Conclusions: This open study indicates both the feasibility of investigating treatment outcome and the initial efficacy of stabilizing group treatment in severely ill patients with Complex PTSD related to childhood abuse.

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Introduction

A history of childhood abuse is highly prevalent among psychiatric patients. Childhood abuse—occurring in interpersonal dependency relationships, disrupting normal development—may result in Complex Posttraumatic Stress Disorder (Complex PTSD) (Herman, 1992). Besides PTSD symptoms such as intrusions, avoidance, and hyper-arousal, Complex PTSD also includes 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), somatisation, and systems of meaning (e.g., loss of faith, hopelessness) (Herman, 1992). This syndrome is also referred to as “Disorder of Extreme Stress” (Pelcovitz et al., 1997) or, in DSM-IV terminology, “PTSD with associated features.” Complex PTSD is associated with high co-morbidity on both DSM-IV Axis I and II, serious impairment (Breslau, 2001) and extensive use of health care. In simple PTSD, several treatments such as cognitive therapy and exposure are

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evidence-based (Bradley, Greene, Russ, Dutra, & Westen, 2005; Foa, Keane, & Friedman, 2000). Some evidence suggests that Complex PTSD predicts poor outcome (Ford & Kidd, 1998); severity of PTSD is associated with high drop-out rates during exposure treatment (McDonnagh et al., 2005); exposure in primarily angry patients is less effective (Foa et al., 2000); and EMDR is less effective after childhood trauma (van der Kolk et al., 2007). Complex PTSD is highly comorbid with personality disorders, which are likely to require more structured and less interactive treatments (Cloitre & Koenen, 2001; Lau & Kristensen, 2007). A meta-analysis (Bradley et al., 2005) identified evidence on PTSD treatment in cases of poly symptomatology related to child abuse and comorbid Axis II diagnosis, as a gap in the literature. Most studies exclude these patients and therefore have limited clinical utility and generalisability.

Despite the high morbidity associated with Complex PTSD, no treatment, to date, has been systematically tested to treat child abuse related Complex PTSD. PTSD treatment guidelines for severely dysfunctional patients recommend that treatment should primarily focus on the stabilization of patients, which is achieved by reducing symptoms and improving interpersonal functioning, self care and personal safety (Foa et al., 2000; Lubin, Loris, Burt, & Johnson, 1998). Exposure treatment is recommended only after sufficient tolerance of high affect has been achieved.

The purpose of this preliminary study is to investigate the feasibility and efficacy of a stabilizing group treatment for patients with Complex PTSD. We have adapted and extended an existing affect management group treatment protocol for women with posttraumatic stress disorder and childhood sexual abuse previously tested by Zlotnick et al. (1997) to seek to meet the needs of women with Complex PTSD.

Method

Subjects and procedure

Fifty-five female outpatients with a history of childhood abuse were referred by mental health clinicians. All participants signed a written informed consent, and the study was approved by the medical ethics board. Inclusion criteria were: PTSD according to the Structured Diagnostic Interview for DSM-IV Axis I disorder (First, Spitzer, Gibbon, & Williams, 1996), Complex PTSD according to the Structured Interview of Disorders of Extreme Stress (SIDES: Pelcovitz et al., 1997), and sexual and/or physical abuse before the age of 16 according to criteria of the Structured Trauma Interview (STI: Draijer, 1989; Draijer & Langeland, 1999). Sexual abuse was defined as repeated, forced sexual contact with a perpetrator in an intimate relationship; physical abuse as severely repeated maltreatment such as confinement, battering, or being pushed from the stairs.

To assess the presence of comorbid disorders the integral Structured Clinical Interviews for DSM-IV Axis I and II Disorders (First et al., 1996; Pfohl, Blum, & Zimmerman, 1997) and SCID-D (amnesia part; Steinberg, Rounsaville, & Cicchetti, 1990) were completed in all respondents.

Exclusion criteria were: antisocial personality disorder, primary substance abuse likely to interfere with treatment, a current psychotic episode or Dissociative Identity Disorder as determined by these interviews.

Of the 55 patients, 19 were excluded, 7 did not meet criteria for CPTSD, 2 were diagnosed with comorbid DID, 1 was abused at age 17 but not before 16, 3 had severe psychosis, 3 were concurrently in day treatment, 1 applied for treatment for the second time, and 2 withdrew because they were unable to meet the necessary time schedule requirements.

Measurements

The Davidson Trauma Scale (DTS: Davidson, Tharwani, & Connor, 2002) was used to measure PTSD symptoms; the Borderline Personality Disorder Severity Inventory (BPDSI: Arntz et al., 2003) to measure borderline symptoms; and the Dissociative Experiences Scale (Bernstein & Putnam, 1986) to measure dissociative symptoms. Severity of general psychopathology was assessed using the Symptom Checklist (SCL-90: Derogatis, Lipman, & Covi, 1973) and severity of depression using the Beck Depression Inventory (BDI: Beck, Steer, & Garbin, 1998). At pre-treatment, post-treatment and 6 months follow-up, presence or absence of (Complex) PTSD was assessed using SCID-I and SIDES. Interviews were administered by trained and supervised raters.

Intervention

The stabilizing group treatment employed in the present study was focused on decreasing the core symptoms of Complex PTSD. Psycho-education aimed at attaining a sense of cognitive mastery by explaining symptoms as adaptations once necessary to emotional survival in a context of child abuse. A cognitive behavioral skills training was used to acquire increased self-regulation, adaptive beliefs, and relationships to enhance stability. The focus of the treatment was towards the here-and-now, on positive reinforcement and empowerment. The group format aimed at inducing hope and reframing patients' symptoms as normal responses to trauma, thereby reducing shame, guilt and isolation.

The treatment was highly structured, which seems appropriate for patients with severe symptoms and personality problems (Cloitre & Koenen, 2001; Lau & Kristensen, 2007). Interaction between group members was limited since we aimed to create a safe place to learn. Sharing individual trauma histories, which might affect other group members, was explicitly discouraged.

Table 1

Stabilizing Group Treatment for Complex PTSD related to childhood abuse based on psycho-education and cognitive behavioral therapy: topics per session.

Session number	Session topic
1	Complex PTSD psychology and biology (Me, A)
2	'Safe' sleep (M)
3	Dissociation, re-experiencing (Me, A)
4, 5	Correct recognition of emotions and introduction cognitive model (M, L)
6–9	Skills building: affect regulation, self care/soothing, relaxation, self esteem (L)
10	Crisis management
11, 12	Cognitive techniques (false beliefs, thinking errors) (Mc)
13	Anger management (Mc, Me)
14, 16, 18	Assertiveness, bodily experiences and sexuality (L, K, B, A)
15	Distrust (B)
17	Guilt and shame (B)
19, 20	Saying goodbye and future (A).

The manual is based on the work of Zlotnick et al. (1995). In parenthesis the most contributing sources are indicated: Linehan (1993: L), Matsakis (1994, 1996: M), McKay and Fanning, 1987; McKay (1987, 2003: Mc), Meichenbaum (1994: Me), Korsten (2004: K), Bouma (1999: B) and Authors (A).

The treatment manual consisted of a structured, detailed session-by-session script (psycho-educational presentations on a weekly topic, connected skills training, assignments and homework pages). The material in the stabilizing group treatment consisted of a tested manual by Zlotnick et al. (1997), Wolfsdorf and Zlotnick (2001), and Zlotnick, Simpson, Begin, and Costello (1995). Three of the authors (Dorrepaal, Thomaes, & Draijer, 2008) extended this protocol by inserting additional sessions (14–19) to cover all symptom domains of Complex PTSD. Also, some adaptations were made to the existing sessions of Zlotnick's manual (Table 1).

The groups consisted of 8–12 participants and two therapists. The group leaders received on-site training and adherence supervision. Moreover, therapists used a checklist concerning treatment adherence after every session, confirming therapists' competence and revealing no major protocol violations.

The group treatment consisted of 20 weekly 2-hour meetings in addition to individual treatment as usual (TAU). The typical patient was seen in TAU by a psychotherapist, psychiatric nurse or psychiatrist, including medication bi- or three-weekly for supportive counseling sessions, tailored to the individual needs of the patients. In TAU no formal "uncovering" trauma-focused therapy was used.

Statistics

Two-tailed paired *t*-tests were used to compare subjects' symptoms before and after treatment and after 6 months follow-up. In ITT we applied a conservative Last Observation Carried Forward method in which the available pretest-score was used to account for the subsequent missing posttest-score. Cohen's effect size *d* was calculated by the formula: (Mean pre-treatment – Mean post-treatment)/SD pre-treatment. The within effect sizes were interpreted as follows: <0.50: weak or no effect; 0.50–0.80: moderate effect; >0.80: large clinically meaningful effect (Cohen, 1992).

Results

Of the 36 women who entered treatment, the mean age was 34.1 years (SD = 8.3), 61% were single or divorced, and 22% were married or cohabiting. No significant age difference between included and excluded patients was observed.

All participants had suffered childhood abuse: 72% physical abuse by a (step/foster-)parent, 69% sexual abuse, and 44% both. Physical abuse was chronic in a majority of subjects (83%), with a mean age at the start of 6 years and a mean duration of 11 years. Sexual abuse was characterized as 57% intrafamilial; 60% with penetration; 70% chronic; 50% more than one perpetrator; mean age at the start, 7 years; mean duration, 7 years. In addition, 75% of participants had also suffered abuse during adulthood: 64% physical abuse; 61% sexual abuse; and 50% both.

Mean scores on the DTS, BPDSI, DES, BDI, and SCL (Table 2) indicated severe psychopathology. Seventy percent met criteria for co-morbid Major Depressive Disorder, and the mean number of current co-morbid Axis I diagnoses was 3 (SD 1.6). On Axis II 44% met criteria for borderline personality disorder. The mean number of Axis II (personality disorder) diagnoses was 1.6 (SD 1.7).

There were no significant differences between treatment completers (24) and drop-outs (12) on demographic or baseline clinical status variables, except for the level of education (completers scored higher: 11 years versus 9 years). The level of education did not correlate with pre-treatment severity or treatment effect on the DTS.

As shown in Table 2, patients improved with regard to posttraumatic stress (DTS) and borderline symptoms (BPDSI), with large effect sizes in the completers' analysis on DTS and BPDSI (above 0.80). Patients improved on all PTSD symptom clusters in pre- versus post-comparisons, that is, re-experiencing ($t = 4.05$; $df = 20$; $p = 0.001$), avoidance ($t = 3.42$; $df = 19$; $p = 0.003$) and hyperarousal ($t = 6.43$; $df = 21$; $p = 0.000$). Patients improved pre- versus post-treatment mostly on the following subscales of the BPDSI: anger ($t = 4.09$; $df = 19$; $p = 0.001$), identity ($t = 3.52$; $df = 19$; $p = 0.002$) and emptiness ($t = 3.44$; $df = 19$; $p = 0.003$).

Table 2

Clinical ratings before treatment (Pre), after 20 weeks of stabilizing group therapy (Post), and at 6 months follow-up (FU) in 36 patients with Complex Posttraumatic Stress Disorder related to childhood abuse.

	Score						Comparison					
	Pre		Post		FU		Pre-Post			Pre-FU		
	Mean	SD	Mean	SD	Mean	SD	Cohen's <i>d</i> ^a	<i>t</i> ^b	<i>p</i> ^b	Cohen's <i>d</i> ^a	<i>t</i> ^b	<i>p</i> ^b
DTS												
Completers, <i>n</i> = 20 ^c	89	22	62	29	61	34	1.06	5.865	0.000	1.00	4.612	0.000
ITT, <i>n</i> = 35 ^d	86	24	70	29	69	31	0.60	4.598	0.000	0.62	3.177	0.003
BPDSI												
Completers, <i>n</i> = 16 ^c	25	7	17	8	18	8	1.07	3.404	0.004	0.93	3.101	0.007
ITT, <i>n</i> = 34 ^c	27	9	23	12	23	11	0.38	3.550	0.001	0.38	3.900	0.000
DES												
Completers, <i>n</i> = 16 ^c	33	21	29	21	24	23	0.19	1.043	0.314	0.40	1.512	0.151
ITT, <i>n</i> = 33 ^d	33	18	31	19	28	20	0.11	0.833	0.411	0.26	1.589	0.120
BDI												
Completers, <i>n</i> = 11 ^c	34	10	22	12	27	12	1.25	3.957	0.003	0.71	1.684	0.123
ITT, <i>n</i> = 34 ^d	32	10	24	12	26	12	0.72	4.287	0.000	0.60	3.288	0.002
SCL												
Completers, <i>n</i> = 15 ^c	283	58	234	68	230	65	0.83	5.979	0.000	0.91	4.178	0.001
ITT, <i>n</i> = 33 ^d	274	59	245	65	241	66	0.49	4.237	0.000	0.52	0.523	0.001

DTS, Davidson Trauma Scale; BPDSI, Borderline Personality Disorder Severity Index; DES, Dissociative Experiences Scale; BDI, Beck depression inventory; SCL, Symptom Checklist; ITT, Intention to treat sample.

^a Within-group effect size by Cohen's *d*.

^b From paired *t*-tests.

^c *N* varies due to missing data/measurements.

^d *N* varies due to missing pre-treatment measurements; only subjects included who completed pre-measurements.

Although attrition was considerable (33%), severity of both PTSD and borderline symptoms—but not dissociative symptoms measured with the DES—showed a statistically significant decrease even in the intention-to-treat analysis between pre- and post-treatment, and these effects were sustained during follow-up.

At post-treatment 22% and at follow-up 35% of our patients no longer met criteria for “simple” PTSD.

In addition, at post-treatment 64% and after 6 month 78% of our patients no longer met criteria for Complex PTSD. Whereas all patients met criteria for all 6 symptom domains for Complex PTSD at pre-test, at post-test this was reduced to an average of 3 symptom domains. Specifically, at post-test only 28% still met criteria for the domain affect dysregulation; 39% for memory and attention problems; 56% for the domain self-perception; 72% for the domain interpersonal relationships; 39% for somatisation; and 67% for the domain systems of meaning.

Discussion

The present study indicates both the feasibility and efficacy of stabilizing treatment in Complex PTSD related to childhood abuse as an adjunct to routine individual treatment. The completers' effect sizes on DTS and BPDSI are large in this Complex PTSD population and comparable to effect sizes achieved in “simple” PTSD populations (Davidson et al., 2002; Foa et al., 2000). We consider the results on PTSD and borderline symptoms are not only statistically significant, but also clinically meaningful, and improvement was found to be stable throughout follow-up. A similar pattern was observed in the intention-to-treat analysis.

While dissociative symptoms did improve according to the criteria of SIDES—61% no longer met criteria for the dissociative feature (memory/attention)—this improvement was not reflected in the DES data, possibly due to the lack of a specific (recent) time frame in the DES questionnaire (Dubester & Braun, 1995).

Our study population was early and severely poly-victimized in childhood as well as frequently re-victimized in adulthood (see Finkelhor, Ormrod, & Turner, 2007a; Finkelhor, Ormrod, & Turner, 2007b), and suffered from severe co-morbidity on DSM-IV Axis I and II. Although our study population suffered from an even higher level of psychopathology compared to other severely ill traumatized populations (Lubin et al., 1998; Zlotnick et al., 1997), PTSD symptom levels decreased to a similar extent, thus replicating Zlotnick's results.

The present study did not include a control group. In addition, we did not control for ongoing individual treatment or medication, which may have contributed to patients' improvement. However, significant improvement was shown between pre- and post-treatment only, which implies that individual TAU in the follow-up period did not result in further improvement. As with earlier reports (Lubin et al., 1998; Zlotnick et al., 1997) drop-out rate in our study was high, but unrelated to symptom severity. Reducing drop-out, especially among women with less education, is therefore an important future concern. Although the present study provides preliminary evidence for the efficacy of this stabilizing group treatment for PTSD, full recovery was not achieved and further treatment options should be considered. For some patients repeating this

20-week treatment protocol might be useful. Considering that problems in the domains of relationships and self perceptions tend to persist despite treatment, a more extensive focus on these theme's is also warranted. For other patients, treatment of prominent co-morbid disorders may be important, while some may be able to profit from exposure after stabilization.

In summary, whereas our findings are clearly in need of replication in a randomized clinical trial, the present study indicates the feasibility and initial efficacy of a structured stabilizing group intervention in women with Complex PTSD and childhood abuse, a subgroup of PTSD patients that is severely ill and understudied.

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