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Research paper

A systematic review and meta-analysis of group treatments for adults with symptoms associated with complex post-traumatic stress disorder

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ABSTRACT

Background: No previous meta-analyses have specifically investigated the effectiveness of psychological group therapy for symptoms associated with complex interpersonal trauma, including whether trauma memory processing (TMP) therapies are superior to psychoeducational approaches alone.
Methods: A systematic review identified 36 randomised control trials (RCTs) which were included in the meta-analysis.
Results: Large significant effect sizes were evident for TMP interventions when compared to usual care for three outcome domains including: PTSD (k = 6, g = -0.98, 95% CI -1.53, -0.43), Depression (k = 7, g = -1.12, 95% CI -2.01, -0.23) and Psychological Distress (k = 6, g = -0.98, 95% CI 1.66, -0.40). When TMP and psychoeducation interventions were directly compared, results indicated a small non-significant effect in favour of the former for PTSD symptoms, (k = 4, g = -0.34, 95% CI -1.05, 0.36) and small non-significant effect sizes in favour of the latter for Depression (k = 3, g = 0.29, 95% CI -0.83, 1.4) and Psychological Distress (k = 6, g = 0.19, 95% CI -0.34, 0.71).
Limitations: Heterogeneity and a limited number of high quality RCTs, particularly in the Substance Misuse and Dissociation domains, resulted in uncertainty regarding meta-analytical estimates and subsequent conclusions.
Conclusions: Results suggest that TMP interventions are useful for traumatic stress whereas non-TMP interventions can be useful for symptoms of general distress (e.g. anxiety and depression). Thus, both TMP and psychoeducation can be useful for the treatment of complex interpersonal trauma symptoms and further research should unravel appropriate sequencing and dose of these interventions.

1. Introduction

1.1. Post-traumatic stress disorder and complex post-traumatic stress disorder

Interpersonal violence refers to the traumatic events associated with emotional, sexual and physical abuse, neglect as well as other forms of intimate partner violence, and the atrocities committed in war, torture and exploitation. Emerging evidence has indicated that exposure to interpersonal violence, particularly during key developmental stages as well as repeated victimisation, frequently results in psychological distress that can have profound consequences throughout an individual's life (Courtois & Ford, 2016; Enlow et al., 2013; Mauritz et al., 2013). Indeed, the more frequent and numerous, the more complex and potentially disabling such experiences can be for an individual's social, psychological and interpersonal functioning (Felitti et al., 1998; Herman, 1992; Karatzias et al., 2016; Wolff et al., 2011).

Across various clinical populations, histories of interpersonal violence and its negative psychological sequelae have long been recognised as having a profound impact on survivor's lives (Loewenstein and Brand, 2014; Herman, 1992; van der Kolk and van der Hart, 1989). The development of maladaptive coping strategies for these difficulties often includes a range of destructive behaviours such as substance misuse, self-harm and risk taking such as unsafe sexual practices and involvement in abusive relationships (e.g. Howard et al., 2017; Saxena et al., 2015). As such, not only do such behaviours prevent the appropriate processing of traumatic experiences through avoidance and numbing but they also lead to potential further traumatisation and an exacerbation of such difficulties (Courtois & Ford, 2016).

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The recently published ICD-11 has formally recognised 'complex post-traumatic stress disorder' (CPTSD) as a disorder that can arise from chronic and often inescapable interpersonal violence (Cloitre et al., 2011; Karatzias et al., 2016). In this respect, CPTSD has been conceptualised as the core symptoms of PTSD plus 'disturbances in self-organisation', involving affect dysregulation, negative self-concept and disturbances in relationships (Maercker et al., 2013). The evidence suggests CPTSD may involve a distinct symptom profile, including symptom clusters associated with PTSD along with high levels of depression, psychological distress, dissociation and substance misuse (Loewenstein and Brand, 2014; Mauritz et al., 2013). It is therefore important to clearly evaluate the efficacy of PTSD interventions that have been offered to clinical populations where there is high prevalence of CPTSD symptoms (Dorrepaal et al., 2014).

1.2. Phase based vs. non-phase based interventions

A number of authors have advocated that trauma-focused treatments should be phase based in their application for CPTSD symptoms (Courtois and Ford, 2016; Cloitre et al., 2002; Bohus et al., 2013; Herman, 1992). Efforts have been made to avoid symptom exacerbation through trauma memory exposure and instead psychoeducational interventions have been offered at the beginning of therapy (i.e. phase 1) and often focus on safety planning, coping, anxiety management or interpersonal difficulties (Dorrepaal et al., 2010; Zlotnick et al., 1997; Krupnick et al., 2008). Such interventions are inherently present focused, however, they can vary in terms of the focus that they bring towards managing or ameliorating symptoms (Dorrepaal et al., 2012; Karatzias et al., 2012) or specific clusters of symptoms (Falsetti et al., 2008; Krakow et al., 2001). In general, group based stabilisation interventions have tended to been brief and psychoeducational in their approach (Pelekis and Dahl, 2005). Indeed, such interventions have tended to be much briefer than the 6 month generally regarded as reasonable for this phase (Cloitre et al., 2012).

In a recent review, de Jongh et al. (1996) argued that the evidence for a special stabilization phase is weak. Therefore, there has been some scepticism as to whether phase 1 interventions achieve greater levels of symptom and behavioural stabilisation as opposed to phase 2 interventions that are more orientated towards trauma memory processing (TMP). Despite this, recent head-to-head trials have also questioned whether TMP treatments are necessarily more efficacious that phase 1 or 'non-trauma focused' interventions (Foa et al., 2018). As such, questions still exist as to whether a phased based approach or a general compassionate and therapeutic response might help survivors make more substantive progress in addressing symptoms and disorders resulting from interpersonal violence (Hoge and Chard, 2018).

1.3. Group versus individual treatment modalities

There is also considerable ambivalence and indeed disagreement about the benefits and treatment efficacy that might be derived from group based interventions for complex trauma. Several meta-analyses have reported that the largest reductions in PTSD symptoms is achieved through individual trauma-focused treatments (Ehring et al., 2014; Taylor and Harvey, 2010; Watts et al., 2013).Historically, those advocating for the benefits of group based treatments have relied on clinical experience and theory (Fritch and Lynch, 2008; Herman, 1992; p. 214). It is thought that group approaches help to normalise symptoms, counteract isolation, provide peer support and observational learning, and ameliorate important shame based cognitions (Burlingame et al., 2003; Dorrepaal et al., 2010; Herman, 1992; Mendelsohn et al., 2011; Mendelsohn et al., 2007; McCrone et al., 2005; Shea et al., 2009; Zlotnick et al., 1997).

Short-term group psychotherapy has been a major treatment modality offered to people suffering from the psychopathology associated with complex interpersonal trauma such as child sexual abuse (Pelekis and Dahl, 2005). The potential of group based trauma-focused treatments to be an effective response to potentially large populations of survivors is an important consideration (Wolff et al., 2015). However, along with these potential benefits come the challenges of implementing processes that maintain treatment replicability and fidelity (Najavitis 2002). The aim of this review is therefore to produce a synthesis of the current evidence relating to the efficacy of group interventions, as a distinct treatment modality, for survivors of interpersonal trauma. Synthesising treatment outcomes according to a phase based approach may also help to develop a more nuanced understand of this modality's effectiveness across a range of symptoms.

1.4. Previous meta-analysis

To date a number of meta-analyses and systematic reviews have investigated the efficacy of PTSD treatments in general (Barrera et al., 2013; Bisson and Andrew, 2007, 2005; Bisson et al., 2007; Bisson et al., 2013; Callahan et al., 2004; de Jong and Gorey, 1996; Ehring et al., 2014; Pelekis and Dahl, 2005; Lenz et al., 2017; Roberts et al., 2015; Sloan et al., 2013; Taylor and Harvey, 2009; Taylor and Harvey 2010; Watts et al., 2013). In Bisson et al. (2013) extensive review of psychological therapies for 'chronic' PTSD, 70 RCT studies were identified; this included 10 group based studies of which only one study was categorised as having a group non-Trauma Focused Cognitive Behavioural Therapy (non-TFCBT) arm. Bisson et al. (2013) concluded that group TFCBT was superior to waitlist/usual care control conditions but that this was not the case for group non-TFCBT. Other meta-analyses have also highlighted that survivors with CPTSD symptoms, may present specific challenges to PTSD treatments (Dorrepaal et al., 2014; Greger et al., 2014), however, Torchalla et al. (2012) also demonstrated that individuals with concurrent substance misuse disorder and PTSD responded equally well to both integrated and non-integrated treatments.

Sloan et al. (2013) and Barrera et al. (2013) are currently the only meta-analytic reviews that have focused exclusively on the efficacy of group treatments for PTSD. However, Barrera et al. (2013) was specifically limited to CBT group treatments ($n = 12$). Given the preponderance of CBT studies within the PTSD treatment literature, there are of course similarities between this review and Sloan et al. (2013) who identified 16 studies. Both reviews concluded that group treatments lead to large and significant pre-post treatment reduction in PTSD symptoms. However, Sloan et al. (2013) concluded that there was no relative superiority for group treatments when compared to active treatment controls ($d = 0.09$, 95% CI [−0.03, 0.22]). Nevertheless, group treatments were better than waiting list (WL) control comparisons ($d = 0.56$, 95% CI [.31, 0.82]). Barrera et al. (2013) did not undertake an analysis according to the type of control used and reported that there were no significant differences in effect sizes between group treatments that included both in-group exposure and those that did not. Recent, meta-analyses have computed large effect sizes when individual trauma-focused (i.e. TMP) treatments are compared against minimal or no treatment arms. However, small or marginal effect sizes have been obtained when compared to other, non-trauma-focused active interventions, which has led to the efficacy of TMP treatments being questioned (Erford et al., 2016; Lenz et al., 2017). Such comparisons have never been made in group therapies.

Although there is considerable evidence for the treatment of PTSD there has been no meta-analysis of the efficacy of the group based interventions for complex interpersonal trauma symptoms in the outcome domains of PTSD, Depression, Psychological Distress, Substance Misuse and Dissociation. Symptoms associated with these conditions are commonly reported in people with interpersonal trauma. Furthermore, no previous meta-analyses of interventions for complex interpersonal trauma have considered whether phase 1 interventions (i.e. psychoeducational approaches), as characterised by high levels of psychoeducation and stabilisation, are more effective than phase 2 approaches, which include TMP protocols.