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An investigation of trauma-centered inpatient treatment for adult survivors of abuse

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Abstract

Objective: The purpose of this study was to examine a comprehensive inpatient treatment program designed for adult survivors of childhood abuse with posttraumatic stress disorder (PTSD).

Method: One hundred and thirty-two formerly abused individuals completed clinician-administered and self-administered measures of PTSD symptomatology at admission and discharge. All participants experienced a range of physical, sexual, and/or emotional abuse as children prior to the age of 17. Approximately one-third of these individuals also completed measures at 3-months postdischarge and 1-year postdischarge. Data were collected using a clinician-administered PTSD measure and self-administered PTSD measure at admission and discharge. On admission, all participants met criteria for a diagnosis of PTSD.

Results: Analyses revealed that the program was effective in reducing symptoms from admission to discharge. Additionally, treatment gains were maintained at 1-year postdischarge.

Conclusion: The findings of this investigation suggest that the current intensive inpatient group treatment program appears to reduce PTSD symptoms effectively for a sample of adult survivors of abuse.

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Keywords: Posttraumatic stress disorder; Adult survivors; Inpatient treatment; Group therapy

Introduction

Prior research in the area of posttraumatic stress disorder (PTSD) has focused on treatment programs for combat veterans (Hutzell et al., 1997; Johnson, Rosenheck, & Fontana, 1997;

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[Spiro, Shalev, Solomon, & Kotler, 1989](#)). Most of these treatment programs are based on teaching coping skills to facilitate successful integration back into the family and community ([Hutzell et al., 1997](#)). Many programs emphasize group therapy and social support ([Johnson et al., 1997](#)), and incorporate the tasks of daily military life and training. Additionally, there are many programs that also utilize exposure therapy to help patients confront anxiety about their military experiences ([Spiro et al., 1989](#); [Hutzell et al., 1997](#)).

While there has been a plethora of research on combat veterans with PTSD, there is a lack of research on treatment programs designed for adult survivors of child abuse who have PTSD. Prior research has been useful in that it has brought attention to the existence of PTSD and treatment for combat veterans with this disorder; however, it is limited in its utility for the majority of people with PTSD. While combat veterans are a very important population, they are a relatively small percentage of the total population of people with PTSD. As many adult survivors of child abuse suffer from PTSD-related symptoms ([Herman, 1992](#)), it is important to target research specifically on this population.

Existing research on the treatment of adult survivors of abuse has been mainly anecdotal, and has focused on group therapy and support groups ([Goodman & Nowak-Scibelli, 1985](#); [Turner, 1993](#)). Anecdotal reports are able to provide an understanding of how members generally feel about the usefulness of their support groups. However, this type of research is limited in a number of ways. The limitations include the problem that anecdotal reports do not measure baseline scores, and do not use measures that examine change over time. Also, these reports have tended to use general satisfaction questionnaires rather than measures of specific symptomatology.

Although many studies on treatment of adult survivors of abuse have utilized primarily anecdotal reports, there have been several empirical outcome studies on this population as well ([Apolinsky & Wilcoxon, 1991](#); [Carver, Stalker, Stewart, & Abraham, 1989](#); [Roberts & Lie, 1989](#)). However, this research is problematic in that it does not address the treatment of posttraumatic stress disorder (PTSD), specifically. Instead, these studies have tended to examine overall psychopathology ([Carver et al., 1989](#)), as well as symptoms of depression and self-concept ([Apolinsky & Wilcoxon, 1991](#); [Carver et al., 1989](#); [Roberts & Lie, 1989](#)). Childhood abuse is known to be correlated with the later development of PTSD ([Herman, 1992](#); [Knight, 1993](#); [Widom, 1999](#)). As such, it is necessary to examine what types of treatment are most beneficial for adult survivors with PTSD specifically ([Zaidi, 1994](#); [Rowan & Foy, 1993](#)).

Another problem with the current state of research on the treatment of adult survivors of abuse is that there are very few studies of comprehensive trauma treatment delivered on an inpatient basis. One study by [Zaidi \(1994\)](#) did provide a special treatment group for male inpatients for whom childhood abuse was suspected to play a role in patients' overall pathology. However, the inpatient unit described was a general ward for treating combat veterans, not a specific abuse-related trauma program. The author reported positive responses from patients regarding their needs being met on an inpatient basis; the overall program, however, was not designed solely for the purposes of treating adult survivors of abuse-related trauma. There is a need to evaluate comprehensive inpatient programs for abuse survivors. It is posited that inpatient treatment can provide a safe and supervised environment for patients to deal with the broad range of issues that result from the trauma. This may be important since psychological trauma is known to have broad effects on adaptive functioning ([Arnsworth & Holaday, 1993](#);

van der Kolk, McFarlane, & Weisaeth, 1996), and intensive treatment of psychological trauma may be destabilizing (Saporta & Gans, 1995).

Yet another problem with the empirical research on treatment of adult survivors of abuse is that long-term 1-year follow-ups are lacking. Typically the existing studies have tended to use pre-post methods (Carver et al., 1989). A few studies have looked at 3-month (Najavits, Weiss, Shaw, & Muenz, 1998) and 6-month follow-up (Lubin, Loris, Burt, & Johnson, 1998; Roberts & Lie, 1989). However, longer-term follow-up of at least 1-year posttreatment is necessary because it is important to know that treatment has had lasting effects once people return to their regular daily routines.

The purpose of this study is to examine a comprehensive inpatient treatment program designed for adult survivors of abuse with PTSD. More specifically, this study addresses the limitations of prior research and the methodological deficits in the existing literature. First, the current study addresses the issue that previous research on group treatment for adult survivors of abuse has been mainly anecdotal in nature. This study is an empirical investigation that quantitatively examines change in symptoms following treatment occurring in a group therapy modality.

Second, while there has been some empirical research conducted on treatment of adult survivors of abuse, these outcome studies have tended to examine general psychopathology and general well-being rather than specifically investigating symptoms of PTSD. The research that has in fact focused on PTSD symptoms has been limited to combat survivor populations. The current study addresses these issues by examining PTSD symptoms in the abuse survivor population.

Another facet of group treatment for adult survivors, namely, comprehensive inpatient group treatment, has been neglected in the literature. The existing studies tend to focus on outpatient groups, long-term treatment, or support group therapy. The current study attempts to answer the question of whether a brief, inpatient group program is effective in reducing PTSD symptoms in adult survivors of abuse.

The current study extends methodology of the existing outcome research for studies of group treatment in adult survivors of abuse by examining 1-year posttreatment symptoms. Previous research has been limited to 3- or 6-month follow-up research, which is problematic because it does not fully address the issue of long-term maintenance of treatment gains.

The Program for Traumatic Stress Recovery (PTSR) is a 28-bed, 6-week inpatient treatment program that merges the concepts of the trauma model (Bloom, 1997) with that of the therapeutic community (Jones, 1956). Trauma theory suggests that the lives of survivors can become organized around the traumatic experiences, affecting human thoughts, feelings, and behaviors (Bloom, 1997). Based on research by Herman (1992), the current treatment program was designed with trauma theory in mind, with the main goals of promoting empowerment in the survivor and fostering the development of new community ties and connections. The treatment takes place within the context of interpersonal relationships where survivors can recreate the psychological faculties that were disrupted or damaged by trauma. These psychological faculties include the basic human capacities of trust, autonomy, initiative, competence, identity, and intimacy. The path to recovery is designed to occur in three stages: the establishment of safety, remembrance and mourning, and reconnection with ordinary life (Herman, 1992).

The philosophy of the therapeutic community is that the therapeutic environment provides a milieu in and of itself that is an instrumental part of healing. Key principles of the therapeutic community include self-responsibility, joint decision-making, and open communication as well as a belief that all community members, staff and patients alike, are active agents in healing.

The program is administered by a multidisciplinary treatment team, and in order to enhance the experience of community, the primary mode of delivery is group therapy. This program was expected to be effective for a sample of adult survivors of child abuse with PTSD because of the group format. Group therapy is considered to build a strong sense of community and in so doing facilitates the development of social support (Reichert, 1994). Group therapy provides individuals with the chance to meet other people with whom they can identify and who have had similar experiences. Hence, they come to believe that they are not alone in their pain.

We hypothesized that the current treatment program would reduce PTSD symptoms as reported both by patients and by clinicians. We proposed that this reduction would hold true for both frequency and intensity of PTSD symptoms. The second hypothesis was that treatment gains at discharge would be maintained over a 1-year period following completion of the program. The hypotheses described above were examined within the context of an inpatient Program for Traumatic Stress Recovery designed to reduce symptoms of PTSD in adult abuse survivors.

Method

Participants

One hundred and thirty-two individuals admitted to a PTSD inpatient treatment program for adult survivors of childhood trauma consented to participate in this study. Data were collected on individuals who were inpatients between May of 1995 and May of 1996, and the program has continued to run consecutively since that time. For the purposes of the present study, childhood trauma includes all experiences up to and including age 16. All patients who were admitted to the program during the data collection points completed the study as a routine part of the program. Mean age was 40 years ($M = 39.6$, $SD = 8.37$) ranging from 20 to 56 years. By gender, there were 19 men (14%), mean age of 41.5 ($SD = 7.74$), and 113 women (86%), mean age of 39.24 ($SD = 8.46$). Socio-economic status was assessed using the Hollingshead Four-Factor Index of Social Status (Gottfried, 1985), using education and occupation levels. The median class category endorsed by 30% of participants was “medium business, minor professional, and technical workers” (class two). Fifty-five percent were married. The percentages of individuals reporting physical abuse, sexual abuse, domestic violence (witnessed as children), and rape respectively were 74.8, 74.1, 11, and 12.6%. Reports of type and extent of abuse experiences were gathered by chart review. Physical abuse included all acts involving physical violence directed by an individual over the age of 16, and experienced by the child prior to age 17. Sexual abuse included direct contact to the child’s genitals, as well as direct exposure to adult genitals, directed by any individual older than the child, and experienced by the child prior to age 17. Emotional abuse involved extreme and chronic yelling, threats, excessive teasing, and put-downs. All participants reported experiencing at least one type of abuse, with 58% reporting at least two forms of abuse. The adult survivors in the study were

admitted to the program based on their symptoms of PTSD. However, the patients also presented with other comorbid symptoms and disorders, including depression or mood disorders (87%), personality disorders (89%), hopelessness (59%), and internalized/externalized anger. In cases where patients entered the program taking prescribed medication, their medication was continued and monitored by psychiatrists involved with the treatment program.

Program

The Program for Traumatic Stress Recovery (PTSR) is a 28-bed, 6-week voluntary inpatient treatment program that merges the concepts of the trauma model (Bloom, 1997) with that of the therapeutic community (Jones, 1956). The current program utilizes a multidisciplinary treatment team approach for both treatment and assessment. The team consists of psychiatrists, psychologists, nurses, occupational therapists, social workers, pastoral staff, and therapists who provide recreation, creative arts, horticulture and dance therapies. This is a voluntary treatment program designed specifically for treating PTSD symptoms. For this reason, individuals are excluded from participation in the program if they are markedly unstable due to an addiction, eating disorder, or psychotic condition, due to the impact these disorders have on the patients' ability to engage in the treatment process. Individuals in acute crisis such as active suicidality are also not admitted.

Assessment

The first week in the program consists of a 1-week assessment phase during which patients are introduced to the program's core concepts. Individuals participate in small interactive psycho-educational and community-based groups, and are evaluated according to their ability to engage in group process, their level of safety, and their capacity to tolerate interventions from others. Patients are asked to establish specific personal goals, along with corresponding action steps, achievable within the 6-week program parameters. The establishment of goals helps inform the treatment plan by facilitating selection of group options. Little or no change is made to medications during treatment other than monitoring the course of drug treatment that individuals had coming into the program. (For a complete review of this program, please see Wright & Woo, 2000).

Treatment

During the treatment phase, participants actively work on established goals and receive feedback from others regarding unhealthy behavior patterns. Participants in this phase of the program attend daily psycho-educational groups, as well as daily process groups. The treatment focus is based largely on safety, as the program has taken the stance that before exploratory or reconstructive work about the specific traumatic experiences can be undertaken, the individual must demonstrate an ability to establish and maintain safety in the here and now. Using the concept of traumatic reenactment (van der Kolk, 1989), participants are asked to look at repetitive problematic behavior patterns that are employed in dealing with stress in the present. These behaviors are linked with past traumatic experiences.

Groups

There are several groups offered in the program; some are mandatory, some are referral groups, and some are optional. One of the main mandatory groups is the “Process” group, where participants are invited to bring up anything they wish to discuss, including a past issue surrounding the trauma, or a present day issue such as a relationship problem. They are then asked to discuss how the issue is impacting their present lives and to explore how their specific traumatic reenactments may be impacting life in the present. Through this process, participants are able to choose new ways of responding to their present environments, thus placing the focus on creating a new present rather than continually dealing with traumatic events of the past. Participants who have an extreme level of dissociation or are severely self-harming and are not at a stage where they can engage in the process group, are required to take the “Self Care” group. The focus in this latter group is on how to take care of one’s body and how to maintain a feeling of safety. The “Education” group involves a teaching component, providing participants with information on topics such as “what is PTSD,” the “stages of healing,” and the “victim triangle.” The “Skills” group focuses on teaching strategies that can be helpful in the healing process, for example, how to identify and manage feelings, managing flashbacks and nightmares, and how to build and maintain hope. The “Community Meetings” take place twice a week and focus on daily living issues and community announcements. The “Expressions” group takes place at the end of each week and provides a time for the community to bring closure to the week. Participants are encouraged to express themselves in any way that they choose, including singing a song, reciting a poem, or simply talking about the events and feelings that have been experienced that week.

The referral groups are not mandatory to everyone, but participants may be referred to them by the treatment team on the basis of their individual needs or on the basis of the patient’s personal goals for treatment. These groups include: “Coping with Anger,” “Loss,” “Art Therapy,” and “Leisure Connections.”

Finally, there are optional groups that may be attended on a drop-in basis. These groups include: “Play Shop,” which is an experiential group providing opportunities to challenge barriers to play and recreation; “Finding your Emotional Voice,” a group directed toward those who are alexythemic and are unable to use words to describe their emotional experiences; and “Getting Centered,” where breathing and body focused exercises are used to help people gain greater awareness of their bodies in the present and decrease dissociation.

Groups run in cycles, and participants must sign up for specific slots. Decisions regarding the appropriateness of particular groups for each participant (other than the mandatory groups) are made based on consultation with their primary nurse, their individual treatment goals, and in discussions at multidisciplinary team meetings. Attendance is taken at all group sessions and recurrent absence results in the participant being asked to leave the program.

Measures

1. Clinician Administered Posttraumatic Stress Disorder Scale (CAPS; [Blake et al., 1990](#)) is a clinician-administered interview that assesses PTSD symptoms and consists of two forms. Each form examines both frequency and intensity of symptoms, based on a 5-point

Likert rating. For frequency items, scores range from 0 (never) to 4 (daily). For intensity items, scores range from 0 (none) to 4 (extreme). CAPS-1 measures current DSM-III-R diagnosis of PTSD. If current PTSD criteria are not met based on the month immediately preceding the interview, the entire set of questions is asked again in regard to an earlier “worst-ever” month since the trauma to establish life-time diagnosis. CAPS-2 assesses current symptom status rated over a 1-week, rather than a 1-month period. It is used to monitor symptom change over a brief period. This form has been found to be valuable in evaluating treatment outcome over relatively short assessment intervals (Nagy, Morgan, Southwick, & Charney, 1993). Cronbach alphas range from .85 to .87 for the three PTSD symptom clusters of re-experiencing, avoidance, and arousal on CAPS-1 (Blake et al., 1995).

2. Symptom Checklist-90-Revised (SCL-90-R; Derogatis & Melisaratos, 1983) is a 90-item self-report measure of psychopathology, consisting of nine subscales. Each item is rated on a 5-point Likert scale, ranging from 0 (not at all) to 4 (extremely). Subjects are asked to indicate their level of distress based on the past 7 days. A 28-item PTSD scale using items from the SCL-90 has been developed (Saunders, Arata, & Kilpatrick, 1990); demographics of the current sample and the sample on which this subscale was developed originally are very similar. The majority of participants in the current sample were women, and all participants in the Saunders et al. study were women. Also, two-thirds of sexual assault crime victims in the Saunders et al. study were victims of childhood abuse (Saunders, personal communication, 1999), comparable to the participants in the current study. Cronbach alpha was reported as .93. Discriminant analyses indicated that the SCL-PTSD scale correctly classified 89.3% of respondents with positive PTSD symptomatology. Cronbach alpha for the current study was .90.

Procedure

The current study was reviewed and approved for completion by the Ethics Review Board of the Homewood Health Centre. Inpatients were approached about the current study during intake to the program. During the routine psychological assessment at intake, all patients were administered CAPS-1. The 95% of all patients who met DSM-III-R criteria (as determined by the CAPS) were invited to participate in the study. Informed consent was obtained and CAPS-2 was then administered to all study participants. The SCL-90-R was also completed. Two days prior to discharge, the CAPS-2 and SCL-90-R were readministered. Three months postdischarge, the SCL-90-R was mailed to participants, and one follow-up letter was sent to those individuals who did not return the questionnaire. Finally, at 1-year postdischarge, the SCL-90-R was again mailed out to participants. One follow-up letter was sent to remind those participants who had not yet returned their packages.

Analyses

Several analyses were used in the current study. Initial analyses were conducted to determine whether there were any significant gender differences. In order to examine admission and discharge data paired *t*-tests were run on the CAPS-2 data to examine both the frequency

and intensity of PTSD symptom clusters. These multiple *t*-tests were run using Bonferroni corrections with adjusted probability to meet the a priori .05 experiment-wise Type I error rate. A repeated-measures ANOVA was run on the SCL-PTSD data.

To examine maintenance of treatment gains over time several repeated-measures ANOVAs and pairwise comparisons were conducted, using the Bonferroni correction factor to adjust for multiple comparisons. The independent variable for each ANOVA was time (admission, discharge, 3-months postdischarge, and 1-year postdischarge). The dependent variable was PTSD scores using the SCL-PTSD data. An ANOVA was run to compare those participants who completed admission, discharge, and 3-months postdischarge data. A separate ANOVA was run to compare those participants who completed admission, discharge, 3-months postdischarge, and 1-year postdischarge data. Finally, an ANOVA was run to compare those participants who completed admission, discharge, and 1-year postdischarge data.

Results

There were 113 women and 19 men. A multivariate analysis of variance (MANOVA) was conducted with each of the PTSD measures serving as the dependent variable, and gender as the independent variable to determine whether there were any significant gender differences. Results indicated that there were no significant differences between women and men, $F(3, 118) = .612, p = .58$. As a result, the remainder of the analyses were conducted on the sample as a whole, pooling women and men together.

Hypothesis 1: evaluation of PTSD symptomatology data at admission and discharge

Analyses of the CAPS-2 data were conducted for both the frequency and intensity of the three PTSD symptom clusters (re-experiencing, avoidance/numbing, and increased arousal) as well as on the overall PTSD symptoms. As shown in Table 1, all paired *t*-tests with Bonferroni corrections were statistically significant at $p < .01$.

Table 1
CAPS-2 *t*-test scores at admission and discharge ($n = 127$)

Subscale	Admission <i>M</i> (<i>SD</i>)	Discharge <i>M</i> (<i>SD</i>)	<i>t</i>
Re-experiencing Frequency	1.80 (1.11)	1.27 (.96)	5.14
Re-experiencing Intensity	1.84 (1.01)	1.24 (.87)	5.79
Avoidance/Numbing Frequency	2.41 (.83)	1.28 (.91)	13.61
Avoidance/Numbing Intensity	2.07 (.71)	1.21 (.78)	11.72
Increased Arousal Frequency	2.11 (.80)	1.58 (.83)	6.82
Increased Arousal Intensity	1.86 (.69)	1.24 (.66)	9.30
Overall Frequency	2.16 (.70)	1.40 (.79)	11.22
Overall Intensity	1.95 (.62)	1.23 (.66)	11.12

Note. For all *t*-tests listed, $p < .01$.

Computed test statistics (*ts*) exceeded the critical value of *t* associated with a probability adjusted so as to meet a priori .05 experiment-wise Type I error rate. Reported *t* values are therefore Bonferroni corrected.

A repeated-measures ANOVA was conducted on the SCL-PTSD scale. The independent variable was time (admission vs. discharge). Results were significant [$F(1, 126) = 70.63$, $p < .001$, $\eta^2 = .64$], which indicated that discharge scores were significantly lower than admission scores. Findings from the t -tests and ANOVA indicated significant decreases among all PTSD subscales (clinician-administered and self-administered) from admission to discharge.

Hypothesis 2: evaluation of treatment gains maintained over time

The SCL-PTSD scale was administered at four points in time: admission, discharge, 3-month postdischarge, and 1-year postdischarge. Maintenance of treatment gains over time was examined using this scale. Several repeated measures ANOVAs and pairwise comparisons were conducted, all using the Bonferroni correction factor.

Three separate ANOVAs were calculated, using different subgroups. First, a repeated-measures ANOVA was conducted on those subjects who completed admission, discharge and 3-month measures ($n = 45$). To ensure that this subsample was not significantly different than those who did not complete 3-month testing, t -tests were conducted on the admission and discharge SCL-PTSD scores comparing these two groups. Results were non-significant for admission data ($t = .22$, $p > .80$), nor for discharge ($t = .04$, $p > .90$), suggesting that those who completed the 3-month tests were not a significantly different sample.

Results on the overall F -test for the sample who completed admission, discharge and 3-month tests were significant [$F(2, 88) = 14.99$, $p < .001$, $\eta^2 = .50$]. Pairwise comparisons showed significant differences between admission and discharge scores. The mean difference (MD , where MD represents the differences between means of average item scores) between the scores was significant ($MD = .61$, $p < .001$). Admission and 3-month scores also differed significantly ($MD = .33$, $p < .01$). Discharge and 3-month scores were also significantly different for this sample ($MD = .28$, $p < .05$) (see [Figure 1a](#)).

A subsample of $n = 20$ subjects completed the SCL-PTSD tests at admission, discharge, 3-months postdischarge, and 1-year postdischarge. Again, t -tests were conducted to ensure that this group was not significantly different than those who did not complete the 1-year measures. Results were nonsignificant for admission ($t = .06$, $p > .90$), discharge ($t = 1.22$, $p > .20$), and 3-month ($t = .14$, $p > .80$) suggesting that the participants who completed the 1-year measure were not significantly different from those who did not complete the 1-year measure. Results of the repeated-measures ANOVA conducted using the four time periods indicated a significant time effect [$F(3, 57) = 5.8$, $p < .01$, $\eta^2 = .48$] (see [Figure 1b](#)). Pairwise comparisons showed that admission and discharge scores differed significantly ($MD = .64$, $p < .001$), as did admission and 1-year scores ($MD = .49$, $p < .01$). The other comparisons were not significantly different.

A subsample of $n = 42$ subjects completed the SCL-PTSD tests at admission, discharge, and 1-year data points. A repeated-measures ANOVA indicated a significant effect [$F(2, 82) = 18.76$, $p < .001$, $\eta^2 = .56$] (see [Figure 1c](#)). Pairwise comparisons showed that admission and discharge scores were significantly different ($MD = .72$, $p < .001$), and admission and 1-year scores were significantly different ($MD = .53$, $p < .001$).

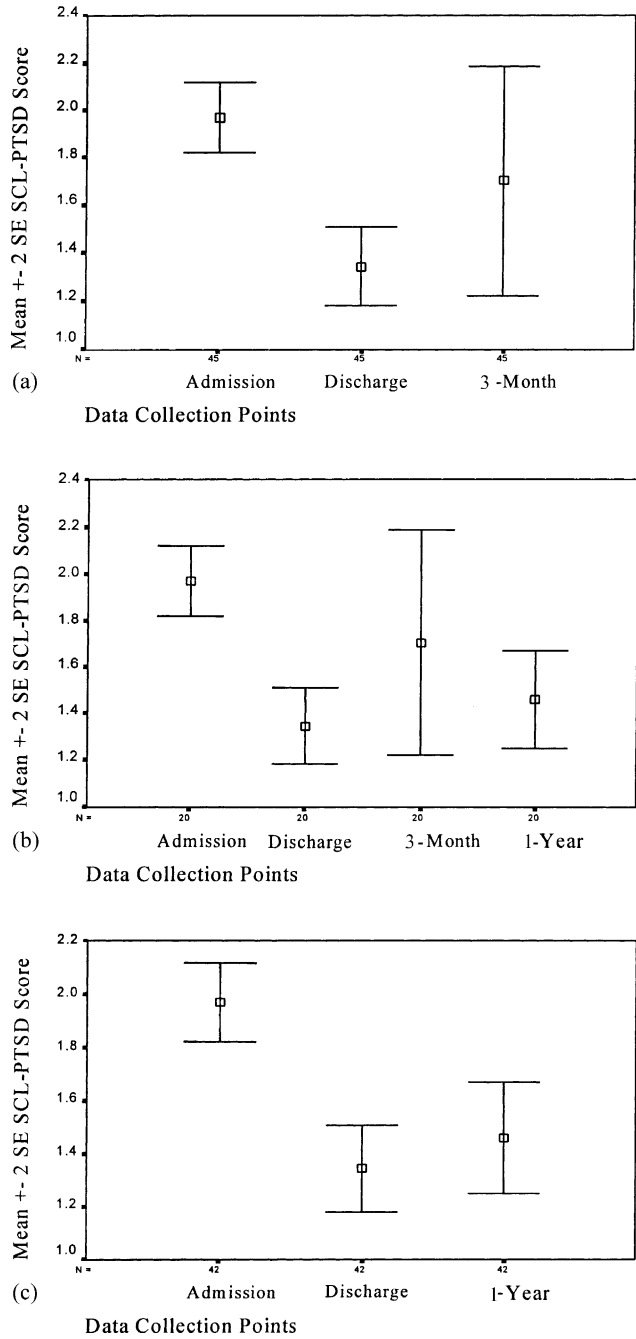


Figure 1. Means for SCL-PTSD data reported at ± 2 standard errors around the mean. (a) SCL-PTSD scores at admission, discharge, and 3-month ($n = 45$), (b) SCL-PTSD scores for all data points ($n = 20$), (c) SCL-PTSD scores at admission, discharge, and 1-year ($n = 42$).

Discussion

This study examined whether a 6-week comprehensive inpatient treatment program can reduce PTSD symptoms among adult survivors of child abuse. Treatment gains were examined over a 1-year follow-up period to determine whether symptom reduction was maintained over time. Both clinician-administered and self-report measures indicate that PTSD symptoms were significantly reduced at discharge when compared to admission scores. Results of the clinician ratings indicate that both the frequency and intensity of these PTSD symptoms were reduced. Examination of the results from the self-report measure indicate that mean PTSD symptom scores at 3-months and at 1-year postdischarge were still significantly below admission levels for those individuals who completed the data at all four time periods.

The current treatment program, which uses group therapy, appears to reduce PTSD symptoms effectively. This finding is consistent with previous research showing the benefits of group therapy for both abuse survivors generally (Apolinsky & Wilcoxon, 1991; Carver, Stalker, Stewart, & Abraham, 1989; Roberts & Lie, 1989) and war veterans specifically diagnosed with PTSD (Hutzell et al., 1997; Spiro et al., 1989). The literature in this area has shown the benefits of utilizing both social support and a community milieu approach (Goodman & Nowak-Scibelli, 1985; Turner, 1993).

One unexpected finding was that overall PTSD symptoms began to increase at 3-months postdischarge, although symptom gains were fully reestablished at 1-year postdischarge. In addition, there was some increase in symptom variability at 3-months postdischarge. Upon closer examination, it became clear that this increased variability was due to the scores of 10 individuals. Research is currently being conducted to determine what leads to this variability among some individuals within the first few months after treatment. It is possible that once individuals complete treatment, some experience significant adjustment issues, which may lead to decreases in treatment gains. It would be important to examine what stressful life events are occurring at this phase postdischarge that may be responsible for set-backs.

The program has recently incorporated a discharge-planning phase to facilitate the transition back into daily living outside the hospital. This discharge-planning phase is being evaluated as well.

While these results are encouraging, it is important to note that there are some limitations. First, there was no control group. This limitation raises the possibility that symptoms decreased as a result of factors other than the treatment program. Several alternative arguments could be postulated for the decrease in symptoms. First, there is the possibility that symptoms decreased simply as a result of the passage of time (Kessler, Sonnega, Bromet, Hughes, & Nelson, 1995). However, it is unlikely that the passage of time was solely responsible for the treatment outcome. The adult survivors in this sample were individuals who had been living with severe PTSD and various other symptoms and disorders for many years. More than half of the participants had attempted suicide multiple times in the past. Additionally, many of these people were individuals who had been, or were currently, in individual therapy, and did not show a substantial decrease in symptoms until after completing the current program. A second argument could be made that simply coming to the hospital for 6 weeks and leaving past lives behind for a brief period of time contributed to the decrease in symptoms. However, these individuals returned to their previous lives and routines after the brief inpatient stay.

They faced the same people and problems they faced prior to entering treatment, and yet at 1-year posttreatment, the treatment gains were maintained.

Another limitation is the fact that there was no formal measure of type or extent of abuse experiences. Reports of abuse were collected informally by reading patients' intake and assessment information as documented on their hospital charts. The present study was designed specifically to examine PTSD symptoms over time in the sample as a whole. In future studies it would be interesting to have formal data collected on abuse experiences to determine whether there is a correlation between type and/or extent of abuse experiences and response to treatment both immediately postdischarge, as well as on follow-up.

A third limitation is that there was substantial attrition during follow-up. While the present study demonstrated that those individuals who dropped out during follow-up do not appear to be significantly different from those who completed the study, it would be valuable to have a larger sample to complete the four data points. It may be the case that those individuals who did complete all follow-up measures were functioning better than those who did not complete follow-up measures, and they may have been more eager to report their improved symptomatology. Conversely, those individuals who did not complete follow-up measures may have deteriorated in their overall functioning. A more rigorous follow-up method would be important in future work to rule out this possibility.

Fourth, there are always potential problems of response bias when using self-report questionnaires. An improved methodology for follow-up research may include using clinician-ratings as well as subject self-ratings across all data points.

While there are some limitations to this study, many of which are inherent when working with a clinical sample, the results of this investigation are valuable. The findings derived from both the patients' own reports and clinicians' reports suggest that the brief intensive group treatment offered in the Program for Traumatic Stress Recovery is effective in reducing symptoms of PTSD in adult survivors of abuse. Further, the longitudinal design of the study extends past research to show maintenance of treatment gains at 1-year post treatment. Finally, results indicate that there is a small group of patients that show a rise in symptoms in the period following discharge from the program; the importance of investigating what makes these patients more susceptible to an increase in symptoms immediately after leaving treatment is important for future research.

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Résumé

Objectif: Le but de cette étude fut d'examiner un programme complet de traitement dans un service interne, conçu pour traiter des adultes qui ont été victimes de mauvais traitements en enfance et qui souffrent du désordre du stress posttraumatique.

Méthode: Au moment de l'admission et du congé, on a fait passer des tests à 132 patients jadis abusés, pour mesurer leurs symptômes du désordre en question. Certains tests étaient administrés par des cliniciens tandis que d'autres étaient auto-administrés. Les patients avaient vécu des mauvais traitements physiques, sexuels et émotionnels durant leur enfance, avant l'âge de 17 ans. Environ un tiers des patients ont aussi complété des tests 3 mois après le congé, puis un an après. Au moment de l'admission, et selon les critères établis pour ce diagnostic, tous les participants souffraient du syndrome en question.

Résultats: Une analyse révèle que le programme a su réduire les symptômes durant la période de l'hospitalisation. De plus, les bienfaits du traitement continuaient à se faire sentir un an suivant le congé.

Conclusions: Les constats de cette enquête portent à croire que le programme de traitement en groupe intensif dans un service interne, réussit à réduire les symptômes du désordre du stress posttraumatique dans un échantillon de personnes adultes maltraitées durant leur enfance.

Resumen

Objetivo: El objetivo de este estudio fue examinar un programa de tratamiento diseñado para adultos que habían sido víctimas de maltrato infantil con trastorno por estrés postraumático (PTSD).

Método: Un total de 132 individuos víctimas de maltrato completaron en el momento de admisión y de salida una serie de medidas de sintomatología de PTSD autoadministradas y administradas por los clínicos. Todos los participantes experimentaron siendo niños una serie de situaciones de maltrato físico, emocional y/o sexual antes de cumplir los 17 años. Aproximadamente un tercio de esos individuos también completaron medidas tres meses y 1 año después de ser dados de alta. En el momento de la admisión, todos los participantes cumplieron los criterios de diagnóstico de PTSD.

Resultados: Los análisis revelaron que el programa fue eficaz en la reducción de los síntomas entre la admisión y el alta. Además, las ganancias del tratamiento se mantienen 1 año después del alta.

Conclusiones: Los hallazgos de esta investigación sugieren que el programa de tratamiento grupal e intensivo parece reducir efectivamente los síntomas de PTSD en una muestra de adultos víctimas de maltrato infantil.