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Does dissociation moderate treatment outcomes of narrative exposure therapy for PTSD? A secondary analysis from a randomized controlled clinical trial

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ABSTRACT

Dissociative symptoms, especially depersonalisation and derealisation, are often perceived as a contraindication for exposure-based treatments of posttraumatic stress disorder (PTSD) despite limited empirical evidence. The present paper examines whether derealisation and depersonalisation influence the treatment outcomes of narrative exposure therapy (NET) and treatment as usual (TaU) among severely traumatised asylum seekers and refugees. We performed a secondary analysis of a recently published randomized controlled multicentre trial comparing NET and TaU for the treatment of PTSD in asylum seekers and refugees. In order to investigate whether depersonalisation and derealisation moderate treatment outcomes, a number of moderated multiple, blockwise regression analyses were conducted. Missing data were handled with multiple imputation. The main finding from intention-to-treat analyses is that derealisation and depersonalisation overall do not moderate the treatment outcomes of either NET or TaU. The treatment condition was the most stable predictor of residual gain scores across outcome measures, with NET being associated with lower residual gain scores indicating better treatment outcomes. The present study substantiates and extends previous research indicating that dissociative symptoms such as derealisation and depersonalisation do not moderate the treatment outcome of exposure-based treatments for PTSD.
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Narrative exposure therapy (NET), a recently developed standardised, short-term treatment for posttraumatic stress disorder (PTSD) in survivors of armed conflict, political violence and torture (Schauer, Neuner, & Elbert, 2005), is based on the principles of prolonged exposure therapy (Foa, Hembree, & Rothbaum, 2007) and testimony therapy (Cienfuegos & Monelli, 1983). Specifically, NET has two distinctive features: It uses the chronicity of testimony therapy and, instead of identifying the worst traumatic event as a target in therapy, the survivor constructs a narrative of his or her whole life, and is exposed to all the traumatic experiences in his or her life through imaginal reliving. Imaginal exposure for traumatic experiences is performed as in prolonged exposure therapy, however, there is no explicit focus on in-vivo exposure. Thus, the focus of NET is twofold. As with prolonged exposure therapy, one aim is to reduce the posttraumatic symptomatology by confronting the memories of the traumatic events. The second aim is to reconstruct the autobiographical memory of the traumatic events and create a consistent narrative or testimony as in testimony therapy. In line with the fact that exposure-based psychological treatments have the most and the methodological strongest evidence for its efficacy in the treatment of PTSD (Bisson et al., 2007; Institute of Medicine, 2008), NET has been found to be effective in treating both PTSD and comorbid disorders in a number of randomized controlled trials in a variety of refugee and asylum-seeking samples (see Robjant & Fazel, 2010 for a recent review) and is probably the treatment modality with the most empirical support to date for this specific patient group (Crumlish & O'Rourke, 2010).

Although exposure therapy is a highly effective treatment for PTSD (Powers, Halpern, Ferenschak, Gillihan, & Foa, 2010), a substantial minority of patients either drop-out of treatment, present substantial residual symptoms after treatment or do not respond to

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treatment at all (Bradley, Greene, Russ, Dutra, & Westen, 2005; Schottenbauer, Glass, Arnkoff, Tendick, & Gray, 2008). The same reservations are in place for NET. As evident from Stenmark, Catani, Neuner, Elbert, and Holen (2013), there are large variations in treatment responses to NET: Over 50% still satisfied the diagnostic criteria for PTSD at 6 months follow-up, while 36% did not achieve clinically significant symptom remission. Therefore, it is important to identify potential moderators of treatment outcomes (Kraemer, Frank, & Kupfer, 2006; Kraemer, Wilson, Fairburn, & Agras, 2002) in an effort to personalise treatments (Simon & Perlis, 2010) for PTSD.

Dissociation has been suggested by a number of researchers and trauma therapists as an important moderator of treatment outcomes for PTSD. Despite controversy, the recently published DSM-5 (American Psychiatric Association, 2013) includes a dissociative subtype of PTSD marked by prominent depersonalisation (i.e., feeling as if oneself is not real) and derealisation (i.e., feeling as if the world is not real) symptoms. Whereas Friedman, Resick, Bryant, and Brewin (2011) concluded that sufficient evidence for a dissociative subtype of PTSD is lacking, others have argued that current research points toward the existence of such a subtype (Dalenberg & Carlson, 2012; Lanius, Brand, Vermetten, Frewen, & Spiegel, 2012). Recent research in both civilian (Steuwe, Lanius, & Frewen, 2012) and military samples (Wolf, Lunney, et al., 2012; Wolf, Miller, et al., 2012) indicates that derealisation and depersonalisation are salient features of PTSD in a subset of individuals with the disorder. The same pattern has also been found in a recent cross-cultural epidemiologic survey (Stein et al., 2013). The inclusion of such a subtype of PTSD rests partly on demonstrating that these dissociative symptoms moderate treatment outcomes of already existing efficacious treatments for PTSD (Bryant, 2012; Resick, Bovin, et al., 2012). Several authors emphasise that this dissociative subtype of PTSD might be associated with treatment outcomes (Feeny & Danielson, 2004; Ginzburg & Neria, 2011; Lanius et al., 2010; Lanius et al., 2012; Steuwe et al., 2012; Wolf, Lunney, et al., 2012; Wolf, Miller, et al., 2012), notably with a poor response to ordinary cognitive behavioural treatment. In line with this, a survey among more than 200 practicing psychologists indicated that a majority experienced symptoms of dissociation as a significant contraindication to use exposure therapy for PTSD (Becker, Zayfert, & Anderson, 2004).

Indeed, dissociative symptoms are associated with poorer treatment outcomes for in-patient dialectical behaviour therapy for borderline personality disorder (Kleindienst et al., 2011), cognitive behavioural treatment for panic disorder with agoraphobia (Michelson, June, Vives, Testa, & Marchione, 1998) and obsessive–compulsive disorder (Rufer et al., 2006), as well as for in-patient brief psychodynamic psychotherapy for affective, anxiety and somatoform disorders (Spitzer, Barnow, Freyberger, & Grabe, 2007). However, although the above mentioned theoretical assumptions and empirical studies indicate that dissociation is generally related to poorer treatment outcomes, the existing research on the influence of dissociation on treatment outcomes for PTSD is not as clear.

Several clinical trials have examined whether dissociation is a predictor or a moderator of treatment outcomes of exposure-based treatments for PTSD. Overall, dissociation does not seem to be a predictor of treatment outcomes (Hagenaars, van Minnen, & Hoogduin, 2010; Jaycox, Foa, & Morral, 1998; Speckens, Ehlers, Hackmann, & Clark, 2006; Taylor, 2003).

Secondary data analyses from two dismantling randomized controlled trials have investigated whether dissociation moderate treatment outcomes. In the first trial, Cloitre, Petkova, Wang, and Lu (2012) found that severity of dissociative symptoms at pre-treatment did not moderate the treatment outcomes of skills training in affective and interpersonal regulation followed by narrative storytelling (STAIR–NST) and the constituent parts of the manual.

In the second trial, comparing the different elements of cognitive processing therapy (i.e., the full manual, cognitive therapy only and written trauma account only) in the treatment of PTSD, severity of dissociative symptoms at pre-treatment did not influence treatment outcomes when averaged across treatment conditions (Resick, Suvak, Johnides, Mitchell, & Iverson, 2012). However, patients with more severe dissociative symptoms, especially depersonalisation symptoms, had better outcomes if they received the full manual as compared to cognitive therapy only, whereas patients with less severe dissociative symptoms had better treatment responses to cognitive therapy only compared to the full manual. Thus, these results indicate that therapeutic tasks with elements of exposure therapy might be especially indicated in patients with severe dissociative symptoms.

Of note, both Hagenaars et al. (2010) and Cloitre et al. (2012) found that higher levels of dissociation at baseline was associated with more severe PTSD-symptoms at both pre- and post-treatment.

The comorbidity between depression and depersonalisation and derealisation is high (Hunter, Sierra, & David, 2004) and the dissociative subtype of PTSD has higher comorbidity with depression as compared to “classical” PTSD (Steuwe et al., 2012). As such, it is important to examine whether dissociative symptoms influence treatment outcomes for comorbid depressive symptoms.

Moreover, as pinpointed by Hagenaars et al. (2010) treatment efficacy concerns both improvement and drop-out. Dissociation has been found to predict drop-out from CBT treatment for OCD (Rufer et al., 2006). However, whereas Hagenaars et al. found that baseline dissociation was not related to drop-out from exposure therapy for PTSD, Cloitre et al. (2012) found that patients with high as compared to low dissociation were less likely to drop-out of treatment. Thus, it is also important to investigate whether dissociation predicts drop-out.

Dissociation is a multidimensional phenomenon (Briere, Weathers, & Runtz, 2005) and as such Bryant (2007) underlined that research on dissociative phenomena should be based on specific symptoms rather than the global construct of dissociation. Furthermore, according to Wolf (2013), derealisation and depersonalisation “reflect more pathological forms of dissociative phenomena that are distinct from other types of dissociation” (p. 2). Thus, the present paper set out to examine whether derealisation and depersonalisation moderate treatment outcomes of NET and treatment as usual (TaU) among severely traumatised asylum seekers and refugees.

The present exploratory analysis aims to extend previous research in several ways. First, to our knowledge, this is the first paper to examine whether dissociative symptoms moderate treatment outcomes of both NET and TaU. Furthermore, no other studies have investigated the role of dissociation in treatment outcomes in this specific patient population, i.e. severely traumatised asylum seekers and refugees. In addition, whereas most other studies have used global constructs of dissociation, we set out to examine whether specific symptoms of dissociation, i.e. derealisation and depersonalisation, moderate treatment outcomes independently.

Method

The present paper is based on exploratory secondary analyses from a recently published randomized controlled multicentre trial comparing NET and TaU for the treatment of PTSD in asylum seekers and refugees (Stenmark et al., 2013), and the details will only be briefly reviewed herein. The main finding of the trial was