
**Efficacy of Narrative Exposure Therapy in the
treatment of childhood trauma-related
Posttraumatic Stress Disorder:
a case series design**



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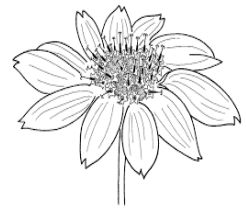
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Dedication

Thanks to my family and friends for all your support with my studies, and always.

To those whose traumas I was privileged to be able to hear as part of this research, thank you.



“If you want to know me, then you must know my story, for my story defines who I am. And if I want to know myself, to gain insight into the meaning of my own life, then I, too, must come to know my own story “Dan P. McAdams, 1993“...

Abstract

Narrative exposure therapy (NET) is considered effective for the treatment of simple PTSD (posttraumatic stress disorder) and that from multiple traumas. The efficacy of NET in the treatment of child abuse-related PTSD has, to our knowledge, has barely been determined and is the objective of this study. Quality of life ratings (QOL) of patients were also determined.

Using a single-case experimental design, two patients diagnosed with PTSD with the Clinician Administered PTSD Scale (CAPS) and having experienced child abuse received 16-20 sessions of NET. PTSD symptom scores and QOL ratings were obtained weekly following sessions using self-report questionnaires. These data and CAPS total symptom severity scores were also obtained at the end of treatment and at a 3-month follow-up for Patient 1. Although most self-reported data indicated non-significant reductions on total PTSD symptom scores and increases in QOL scores, significant reductions were observed for re-experiencing and avoidance symptoms for the data of one patient. Reliable change indices (RCIs) from CAPS scores indicate clinically significant changes in PTSD symptom scores and QOL ratings for both patients at the end of therapy and for the one patient in which these symptoms were determined at the 3-month follow-up. Although self-report and clinical results conflict somewhat, data from the clinical interview which is superior as a diagnostic tool, indicates promising preliminary findings. More research with greater numbers of patients is necessary to determine the efficacy of NET as a treatment for PTSD in this patient group.

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1. Introduction

Posttraumatic stress disorder (PTSD) commonly develops following traumatic events, such as the threat of or exposure to death, serious injury or sexual violence. Symptoms of this disorder include painful recurring memories and dreams of the traumatic event, avoidance of stimuli associated with the event and increased arousal. Another important symptom of PTSD is the development of adverse changes in mood and cognitions following the trauma (APA, 2014). PTSD is a chronic mental health disorder with a lifetime prevalence of 10.4% for women and 5.0% for men (Breslau et al., 1997). An overall prevalence of 1.1-2.9% was reported for PTSD in the EU in 2011 (Wittchen et al., 2011). Approximately 80% of those diagnosed with PTSD have a comorbid psychiatric diagnosis, the most frequent of which include depression, substance abuse, other anxiety disorders, personality disorders, and psychotic disorders (Van Minnen et al., 2015). PTSD sufferers also frequently experience problems with their physical health, work and social functioning (Wittchen et al., 2011).

Although the focus of this study is to treat PTSD arising from child abuse, many adults who experience abuse during childhood (also) develop a more complex form of PTSD, that of “complex PTSD” (Herman, 1992). A discussion of “complex PTSD” is thus warranted here.

1.1 “Complex PTSD”

The presentation of a more complex form of PTSD in the 1980’s, has led to the proposal of the theory of “complex PTSD” (Herman, 1992). “Complex PTSD”, also referred to as PTSD with associated features (APA, 2000), often occurs following exposure to complex traumatic experiences i.e. those which are prolonged or repeated in nature (Herman, 1992). Child abuse-related “complex PTSD” can develop from situations involving sexual, physical or emotional child abuse whereby victims are exposed for a longer period to repeated occurrences or to several forms of trauma. These situations are customarily of an interpersonal nature and under circumstances where the victim, the child, is unable to leave due to a variety of restraints, namely those of a physical, social, psychological or maturational nature (Herman, 1992 Cloitre et al., 2012). Abuse occurring in childhood is especially devastating since it occurs during those formative years in which the child develops his/her identity along with his/her ability to regulate emotions (Stovall-McClough & Cloitre, 2006). Experiencing child abuse has also been shown to have many adverse effects on a child’s mental health. Furthermore, the detrimental effects of child abuse on the attachment style of children have been well

established (Stovall-McClough & Cloitre, 2006). Having a history of childhood trauma continues to affect the developing brain of teenagers and young adults, particularly affecting right brain functions such as mood regulation and social adjustment (Straussner, & Calnan, 2014). Additionally, in an influential study of adverse childhood experiences, Felitti et al. (1998) reported a correlation between childhood abuse and various adult health, behaviour, and mental health related problems. A so-called “building block” effect exists with respect to PTSD, whereby a relationship exists between the amount of trauma experienced in childhood and the degree of pathology in adults (Weber et al., 2008). Individuals having experienced such abuse as children have mental health problems beyond those forming the criteria for a classic PTSD diagnosis. Indeed, the symptomology seems to be more complicated, more extensive and more persistent than simple PTSD (Herman, 1992). It is widely believed that individuals suffering from child abuse-related “complex PTSD” also have characterological difficulties in at least three domains, namely their (negative) self-concept, in the processing of emotions and in relationships (Herman, 1992; Cloitre et al., 2011; Ford, 2015). The far-reaching consequences of trauma for this group are thus indisputable.

Despite the severity of “complex PTSD”, this disorder is not a specific diagnosis in even the most recent version of the DSM, the DSM-5 (APA, 2014). Indeed, there is much deliberation over the symptoms of child abuse-related “complex PTSD”. The World Health Organization indicated that “complex PTSD” should be classified as separate from PTSD (Maercker et al., 2013) and in the most recent version of the International Classification of Diseases (*ICD-11*) “complex PTSD” is a separate diagnosis. A more detailed discussion of the specific symptoms of child abuse-related “complex PTSD” is outside the scope of this thesis but is given by Dorrepaal et al. (2012a) and ter Heide et al. (2014).

1.2 Treatment of PTSD in patients having experienced child abuse

This lack of a clear characterization of child abuse-related complex PTSD has probably also influenced the treatment of this disorder. Evidenced-based imaginary exposure treatments for the treatment of simple PTSD include therapies such as (prolonged) exposure, cognitive behaviour therapy (CBT) and eye movement desensitization and reprocessing (EMDR; Ehlers, 2010). These traditional (exposure-based) interventions for PTSD are also generally applied in the treatment of PTSD in adult survivors of child abuse (Ehring et al., 2014). However, there is much controversy regarding the efficacy of traditional PTSD treatments for

the treatment of PTSD in this patient group. Bradley et al. (2005) report that it is unknown if these traditional PTSD treatments are the most effective for patients that have histories of multiple trauma since the focus of the exposure may not be as clear and also the influence of personality is likely to be greater. Cloitre et al. (2009, 2011) also propose that child abuse-related PTSD may not respond in the best way to traditional PTSD treatments, taking into account the prolonged and repeated nature of the trauma. Keller et al. (2010) suggest that patients having a history of complex trauma, such as in the case of childhood sexual abuse, may be distrusting of others and may have negative assumptions about social relationships. This may obstruct the formation of the therapeutic alliance, which has been shown to be an important mediator in therapy (Doukas et al., 2014). Finally, Thomaes et al. (2015) suggest that traditional PTSD therapies should no longer be used for the treatment of PTSD in PTSD arising from child abuse patients, since scientific evidence for this generalisation is lacking.

In a meta-analysis of therapies for the treatment of PTSD in adults having earlier experienced child abuse, Ehring et al. (2014) reported that traditional interventions for PTSD are effective, having moderate to high effect sizes. These authors also reported that exposure-based therapies were more effective than those not involving exposure. Hedges's *g* effect sizes for active treatments versus waiting list controls for trauma-focused CBT and EMDR were 0.88 and 0.76, respectively, compared to that of 0.48 for the non-trauma-focused CBT.

One further topic of debate in the treatment of "complex PTSD" concerns the need for multi-phased, multi-component therapies. Some authors propose the necessity of a stabilisation phase of treatment prior to the processing of the trauma (Cloitre et al., 2002, 2010; Dorrepaal et al., 2012b; Ford et al., 2015), the aim of which is to increase the patient's ability to regulate emotions and also to help create a working alliance. In a randomized controlled trial (RCT) women with "complex PTSD" arising from child abuse, received skills training in affect and interpersonal regulation (STAIR) prior to exposure treatment or supportive counselling prior to exposure (Support/Exposure) or STAIR followed by supportive counselling (STAIR/Support; Cloitre et al., 2010). These authors reported that the STAIR/Exposure was more effective in achieving complete and long-term remission from PTSD symptoms than either of the other treatments. Furthermore, the greatest improvements in interpersonal relations and in regulation of emotions were achieved by the STAIR/ Exposure treatment. However, the methodology proposed in this study has been widely criticised. Cloitre (2015) compared the effect sizes from the studies included in the research of Ehring et al. (2014).

From the 8 studies involving trauma-based CBT, they observed greater effect sizes in 3 of the 4 phased, multi-component treatments than for the 4 utilizing exclusively trauma methods. This indicates a superiority of the multi-component treatments treatment of PTSD in adults having earlier experienced child abuse. However, findings of Dorrepaal et al. (2012b) concerning stabilization treatment were equivocal. These authors carried out an RTC comparing a treatment as usual (TAU) not involving exposure or following a protocol but tailored for the specific needs of the patients to that utilizing TAU and a stabilizing group treatment (psychoeducation and CBT). Both treatments resulted in significant decreases in both PTSD and “complex PTSD” symptoms with medium and large effect sizes respectively, for the control and experimental treatments. However, the use of stabilizing group treatment did not lead to significantly greater improvements in either PTSD or “complex PTSD” outcomes than the control treatment. Rates of responders (those with a post therapy score on PTSD or “complex PTSD” symptoms of 1 standard deviation less than their pre-therapy score) were also determined for both groups. With respect to the PTSD symptoms, significantly greater rates of responders were observed for the experimental group. This was not observed for “complex PTSD” symptoms. Differences also exist with respect to continental recommendations for treatment. The International Society for Traumatic Stress Studies Complex Trauma Task Force in America proposes a phased treatment for “complex PTSD” (Cloitre et al., 2011). This should involve psychosocial stabilization phase followed by a phase wherein the traumatic experiences are processed and lastly a phase of psychosocial reintegration. However, Dutch guidelines for the treatment of PTSD advise the trauma-focused cognitive behavior therapy or EMDR with psychoeducation and exposure (Van Balkom et al., 2013). It is important to note, however, that the treatment proposed by the American task force was derived from expert opinions while that of the Dutch guidelines is evidence-based.

Because of the existence of rather opposing beliefs and findings as to the efficacy of traditional and multi-phased, multi-component PTSD therapies for the treatment of complex PTSD arising from child abuse, Ford (2015) proposed a need for the development of new treatments. Furthermore, recent PTSD theories suggest that habituation of emotions according to the emotional processing theory of PTSD, to which exposure therapy is associated, is only one method to reduce PTSD symptoms (Neuner et al., 2004). In their cognitive model of PTSD, Ehlers and Clark (2000) propose that disturbed functioning of the autobiographical memory as portrayed by inadequate elaboration and contextualisation together with good

associative memory and good perceptual priming, contributes to the persistence of the sense of threat associated with the trauma. The natural narrative processing of one's daily life experiences is thus believed to be disturbed in traumatized individuals. According to Wigren (1994), such incomplete narrative processing of the trauma memories results in PTSD symptoms. The reconstruction of the trauma memories and their integration into the individual's life story in the form of a narrative is thus required to reduce re-experiencing. Furthermore, the third of the recent models of PTSD, the dual representation model proposes that trauma memories are dissociated from the regular system of memory (Brewin, 2001) and that recovery requires their conversion to regular, narrative memories (Brewin & Holmes, 2003).

Thus, a treatment integrating both exposure and narrative therapy as in the case of narrative exposure therapy (Schaeur et al., 2005) appears suitable to treat PTSD symptoms since it seems to incorporate at least a part of, all 3 of the recent psychological theories of PTSD.

1.3 Narrative exposure therapy

Narrative exposure therapy (NET) is a recent variation of the traditional trauma-focused cognitive behaviour therapy (CBT) for the treatment of PTSD. NET involves both exposure to the traumatic events and the chronological organization of these memories into a personal narrative (Schauer et al., 2005). NET was developed by Schauer et al. (2005) with the intention of being a short-term, standardized treatment which could be effective irrespective of culture and which can be provided by local psychologists or even lay people. An important aim of NET is to increase encoding of explicit memories through activation of anxiety-evoking memories so that they can be stored. In this way, the time the event occurred is anchored, thereby allowing the present sense of threat to be diminished (Robjant & Fazel, 2010).

NET has already been shown to be effective for the treatment of patients of PTSD of diverse cultural backgrounds with multiple traumas namely refugees, soldier veterans and others suffering from trauma (Jongedijk, 2014). In a review of 9 studies concerning the efficacy of NET in the treatment of PTSD in refugees, asylum seeker and orphans, Robjant and Fazel (2010) reported that NET was more efficient than the other therapies (supportive counselling, psychoeducation or group interpersonal therapy) in the reduction of PTSD symptoms. Many

of the studies also showed that these positive outcomes were maintained at 6-12 months follow-up. However, some studies did not compare NET with the current standard treatment. Furthermore, the power of some studies to show the efficacy is limited since samples sizes varied from 6 to 111. In a meta-analysis of 7 quantitative studies, Gwozdziwycz and Mehl-Madrona (2013) found a medium effect size (0.63) for NET for refugees with trauma or PTSD. Furthermore, in a review comparing prolonged exposure therapy with NET, Mørkved et al. (2014) proposed that NET may be advantageous over prolonged exposure therapy in the treatment of victims of multiple traumas such as in the case of asylum seekers and refugees. This arises from the suggestion of Palic and Elklit (2011) that exposure treatments aimed for single traumas may not be suitable for the treatment of PTSD in patients having experienced multiple traumatic experiences, as may be the case in refugees. Furthermore, NET is designed particularly for patients that have experienced multiple traumas and takes the context of the trauma into account (Schauer et al., 2005). Jongedijk (2014) remarked that in a number of studies, the positive effects on PTSD symptoms from NET were still observed in the follow up measurements at least 6 months after the end of therapy. Furthermore, even greater reductions in PTSD symptoms could often be seen after the end of therapy. Besides being shown to be effective for the treatment of refugees with multiple traumas, NET also appears very suitable for the treatment of other patients suffering from multiple traumas (Jongedijk, 2014).

Preliminary results from two open studies using NET with patients of PTSD from childhood trauma also seem positive (Jongedijk, 2014). In one such study, Pabst et al. (2012) investigated the efficacy of NET for the treatment of 10 adult patients with borderline personality disorder (BPD) with a comorbid PTSD diagnosis, whose symptoms were deemed very severe. Large pre-treatment to 6 month post-treatment Hedges's g effect sizes of 0.92 and 0.85 were observed for PTSD symptoms and depression respectively. Large effect sizes, of ~ 0.85 for both BPD symptoms and dissociation symptoms were also observed (Pabst et al., 2012). A second open study using NET was carried out in Japan on five adults with child abuse-related complex PTSD (Dōmen et al., 2012, as cited in Jongedijk, 2014). Although there was no significant reduction in depressive symptoms, significant improvements were observed for PTSD symptoms, dissociation, feelings of guilt, relationships and functioning in society. The quality of this study is, however, difficult to determine since it was published in Japanese.

Although these initial results on the efficacy of NET on “complex PTSD” seem promising, they need to be confirmed in controlled studies with much greater numbers of patients. The present study therefore investigates the efficacy of NET in the treatment of PTSD symptoms arising from child abuse. In this study, a single-case experimental design was chosen to allow the efficacy of NET to be established while also providing the opportunity for elements of the mechanism of NET to be studied.

1.4 Single case experimental design

For more than a century, psychotherapy has been formally used for the treatment of psychological problems. Although much evidence exists for the efficacy of therapy, a lot remains to be learned, e.g., which treatments are the most effective for the particular disorders (Strauman et al., 2013). Also, evidence as to how even the most well-studied therapies work is greatly lacking (Kazdin, 2007). This is especially true for newer treatments such as NET.

RCTs are considered the golden standard in research for evaluating the effectiveness of therapies. By comparing the outcomes of an experimental therapy group with those from a control group, the effectiveness of the therapy can be determined. Unfortunately, however, RCTs provide little information as to why a particular therapy is effective (Versluis et al., 2014). Single-case experiments, or $N = 1$ experimental designs, are an alternative type of study design involve frequent measurement of therapy outcomes for individual patients over the course of the therapy. In these designs, each patient is his or her own control allowing a within-subject comparison (Smith, 2012). Single-case experiments date back to the beginning of the 20th century. Indeed, the infamous psychological studies of Watson (1925) and Skinner (1938) both involved single-case experiments (Smith, 2012). Although these study designs have been relatively little used in past decades, single-case experiments have regained popularity in recent years. This is probably at least partly due the great contributions which were made to our understanding of behaviour using these designs.

Single-case designs consist of at least two experimental phases, a baseline phase prior to therapy and therapy phase. Data concerning the therapy outcomes is collected during the baseline phase and is compared with data collected following the individual therapy sessions. Any reduction in symptoms over this period is deemed to be associated with the therapy. Indeed, the main aim of single-case experimental designs is to determine whether an

independent variable provided by the researcher (e.g., therapy) is associated with a change in the dependent variable (e.g., the symptoms of the disorder; Smith, 2012). An important advantage of single-case experimental designs is that through such frequent measurements, they provide more detailed information concerning the progress of the individual patients (Versluis et al., 2014). These designs also provide therapists and researchers the opportunity to report their observations and they thus allow the gathering of relevant information to be maximized and compared for different patients (Kazdin, 2008). This detailed information can help determine which particular techniques or components of the therapy make it effective, i.e., the mechanism. In the current study therefore, we employ a single-case experimental design.

We used an internet-based program as a means of collecting data in this study. With the internet being currently used globally for a huge variety of services in daily life, it is logically also becoming more popular as a research tool. Using an internet-based program to collect data in this study also has several advantages over the traditional use of paper questionnaires. Firstly, it provides more privacy and flexibility since the patient has the choice of where, when and how long he/she takes to answer the questions. Furthermore, it allows greater anonymity in the collection of data since patients receive emails from a software program. Both of these advantages may aid in the patient answering the questions more honestly, which is important for the reliability of the research findings.

1.5 Research question and hypotheses

The research question for this study involves establishing if narrative exposure therapy (NET) can provide a reduction of PTSD symptoms and an increase in quality of life (QOL) ratings of patients with child abuse-related PTSD.

The hypotheses for this study are:

1. There is a correlation between the amounts of NET a patient receives and the reduction PTSD symptom scores in patients (hypothesis 1a). A correlation also exists between the amount of NET received and an increase in QOL ratings (hypothesis 1b).
2. PTSD symptom scores are significantly less at the end of the treatment phase as compared to at the baseline phase (hypothesis 2a). QOL ratings are significantly greater at the end of treatment relative to at the baseline (hypothesis 2b).

3. The effects of NET on the reduction of PTSD symptom scores in patients are clinically significant (hypothesis 3a). The effects of NET on the increase in QOL ratings are also clinically significant (hypothesis 3b)

In the case of NET, improvements in symptoms often continue to occur several months following the end of therapy. To avoid having too large a number of hypotheses, however it was decided to base hypotheses in this thesis only on the period between the start and the end of therapy. Improvements at the 3-month follow up will also be discussed though since they are obviously relevant for the treatment outcomes.

2. Methods

2.1 Participants

Patients (N=2) diagnosed with PTSD arising from child abuse were recruited from the waiting list for PTSD treatment at PsyQ Den Haag Noord. These patients were further assessed for their suitability to take part in this study using the following inclusion criteria, 1) being traumatized before 16 years of age, 2) being able to speak Dutch and 3) being considered suitable for exposure treatment by the clinics' intake staff. Exclusion criteria for this study included having current psychoses or serious depression with suicidality or alcohol or drug misuse or dependence. Furthermore, medication use had to be stable in the month prior to the therapy and patients should not have auto-mutilated for which medical treatment was necessary within 2 months, as determined by the Mini-International Neuropsychiatric Interview Plus 5.0 (MINI; Sheehan et al., 1998).

2.2 Measures

2.2.1 Mini-International Neuropsychiatric Interview Plus 5.0

The Mini-International Neuropsychiatric Interview Plus version 5.0 (MINI) is a structured interview used in the initial baseline assessment of patients for psychiatric disorders. It allows a concise screening for the most important disorders of Axis 1 of the DSM-IV including addictions. With respect to the validity, sensitivities and specificities have been calculated. For all diagnoses except for those of generalized anxiety disorder, bulimia and agoraphobia these measures are either good or very good (Lecrubier et al., 1997). Also for all diagnoses the inter-rater reliability is very good with kappa coefficients of 0.88-1.0 for 42 patients

(Lecrubier et al., 1997). Test-retest reliability for 23 diagnoses with the MINI is also very good with kappa values for 19 of the diagnoses ranging between 0.65 and 1.0 and with only 1 being below 0.40 (Sheehan et al., 1998).

2.2.2 Clinician Administered PTSD Scale

PTSD was diagnosed using the Dutch version of the Clinician Administered PTSD Scale version IV (CAPS; Blake et al., 1990 and the Dutch translation, Hovens et al., 2005) which is a standard measure for the assessment of PTSD internationally. The CAPS is a semi-structured clinical interview consisting of 30 items corresponding to the criteria for PTSD according to the DSM-IV (APA, 2014). It measures the 17 symptoms of PTSD and incorporates an ordinal scale comprising of 5 points to measure the intensity and frequency of each symptom. In a review of the first 10 years of research using the CAPS, Weathers et al. (2001) reports of the excellent psychometric properties that the CAPS possesses in a variety of trauma populations. This instrument has excellent inter-rater reliability with reliability coefficients (r) of 0.92-0.99, being obtained for frequency and intensity scores across the 3 main clusters of symptoms. Also, the internal consistency is high across these three clusters of symptoms with alpha coefficients of 0.73-0.85 (Weathers et al., 2001). There is also great evidence of validity with correlations for convergent validity with several self-report instruments for measuring PTSD (Impact of Event Scale, The PTSD Checklist, The Mississippi Scale for Combat-Related PTSD, The Davidson Trauma Scale and The Keane PTSD Scale) ranging from 0.70-0.90. In this study the CAPS was used for two purposes; 1) as a diagnostic tool to determine if patients met the criteria for PTSD and 2) as a measure of the total PTSD symptoms severity scores for patient prior to and following their treatment. For the purpose of diagnosis, symptoms for which a frequency score of 0 or 1 was obtained were not included while they were included for the total symptom severity scores.

2.2.3 PTSD Symptom Scale-Self-Report

The Dutch version of the PTSD Symptom Scale-Self-Report (PSS-SR; Foa et al., 1993 and Dutch translation, Arntz, 1993) as shown in Appendix 2, was used to determine the PTSD symptom scores and to establish the degree of disruption of the patient's life due to these symptoms. This questionnaire was administered prior to therapy (baseline), as an outcome measure following the weekly therapy sessions and at the 3-month follow up. The PSS-SR is a self-report measure with 17 items and higher scores indicate a greater number of PTSD

symptoms. It has a satisfactory internal consistency with a Cronbach's alpha for the total score of the PSS-SR of 0.91 (Foa et al., 1993). For the subscales of re-experiencing, avoidance and arousal, alpha coefficients of between 0.78-0.82 were observed. The one-month test-retest reliability of the total score of the PSS-SR was high with a Pearson's correlation of 0.74. The concurrent validity is also good with Pearson correlation coefficients relating PSS-SR total scores to other measures of psychopathology all being significant at $p < 0.5$. Furthermore, the convergent validity of the PSS-SR as determined by comparing diagnoses of PTSD with those from SCID interviews was good with a kappa of 0.68 (Foa et al., 1993). The psychometric properties of the Dutch translation of the PSS-SR are also considered good (Engelhard et al., 2007).

2.2.4 Manchester verkorte Kwaliteit van Leven meting

The Manchester verkorte Kwaliteit van Leven meting (MANSA VN-12; Van Nieuwenhuizen et al., 2015), as shown in Appendix 3, was used to determine the satisfaction of life prior to the study (baseline), following treatment sessions and at the 3-month follow up. The question concerning the sex life of the patient was omitted since it was considered too confronting for the patients by an experienced researcher in this area. The MANSA VN-12 is a self-report inventory whereby higher scores represent a greater QOL. The MANSA VN-12 has satisfactory psychometric properties including correlation coefficients between satisfaction scores of > 0.83 and a Cronbach's alpha for QOL ratings of 0.74 (Priebe et al., 1999).

2.2.5 Childhood Trauma Questionnaire–Short Form

The Dutch version of the Childhood Trauma Questionnaire–Short Form (CTQ–SF; Bernstein et al., 2003), as shown in Appendix 4, was used to gather background information on the type of trauma that patients experienced during childhood. It is a retrospective self-report measure consisting of 28 items, of which 25 are clinical and 3 are validity items. The CTQ–SF covers five domains of maltreatment; emotional, physical and sexual abuse and emotional and physical neglect. (Scher et al., 2001). Five items cover each sort of maltreatment providing sufficient reliability and covering the content. Each item is scored on a Likert-type scale whereby responses can vary from 1, for never true, to 5, for very often true. Satisfactory psychometric properties for the CTQ–SF have been demonstrated including test–retest reliability (Bernstein & Fink, 1998) and the internal consistency of the Dutch version of this questionnaire (Thombs et al., 2009). These authors reported Cronbach's alpha's for physical,

emotional and sexual abuse and for emotional neglect of 0.91-0.95 along with 0.63 for physical neglect. Furthermore, the convergent validity between scores from Dutch patients and responses on the ITEC, an interview for traumatic events in childhood on all 5 CTQ-SF scales were good. (Lobbestael et al., 2009).

2.2.6 Exit questionnaire

A questionnaire developed at PsyQ (see Appendix 5) was developed to get the opinion of the patients on their expectations of narrative exposure therapy, the effect of the therapy on their symptoms and their views on the therapy. Patients filled in this questionnaire at the end of the therapy.

2.3 Procedure

2.3.1 Design, recruitment of participants and data collection prior to the start of therapy

A single-case experimental AB, design (Barlow & Hersen, 1973) was utilized in this study. In addition to having a diagnosis of PTSD due to childhood trauma, patients had to satisfy the inclusion and exclusion criteria. Patients deemed suitable were contacted by telephone by their proposed therapists to explain the research and to invite them to participate. Patients expressing interest were then sent detailed information about NET and those agreeing to participate were subsequently telephoned to arrange appointments for the baseline measurements. During this appointment, the MINI and CAPS interviews were carried out by a trained psychologist to definitely ascertain suitability of the patient for the study regarding DSM-IV diagnoses generally, and the specific diagnosis of PTSD. This psychologist was not involved in the research in any other way. At this time, patients also gave demographic data and filled in de PSS-SR and the MANSA VN-12 to provide baseline data. Following the proposal of Blake et al. (1990) that a total PTSD symptom severity score of ≥ 65 on the CAPS indicates a diagnosis of severe PTSD, only participants having this initial score were included in this research. Included Patients also filled in the CTQ-SF questionnaire to provide background data for the nature of the childhood trauma. Furthermore, patients provided written consent to participate in the research. NET sessions began within a week. Five measures of baseline data were gathered, whereby patients completed the PSS-SR and MANSA VN-12 questionnaires over a period of approximately 2 weeks. Vacation periods of the therapist or other natural breaks in the therapy were used as additional baseline phases in which patients also completed the PSS-SR and MANSA VN-12 questionnaires. Follow-up

measurements at 3 months after the end of therapy were taken for Patient 1, but due to the time scale for this thesis, will only be taken at a later stage for Patient 2. Follow-up data for Patient 2 are therefore not included in this thesis.

This research was approved by the Research Committee of PsyQ Den Haag Noord.

2.3.2 Narrative exposure therapy

NET was carried out in individual sessions in Dutch by two psychotherapists trained to work with this form of therapy. NET was performed according to the method of Schauer et al. (2005). Briefly, NET initially involved creating the lifeline of the patient using a small rope, flowers and stones. The stones and flowers were used to represent traumatic events and positive events, respectively. The traumatic and positive events of the lifeline were then discussed in chronological order. Both traumatic and positive events, but particularly traumatic events, were worked through using exposure therapy. This involved the simultaneous activation of the anxiety network associated with the trauma and the context information of the traumatic event. A report of the content represented by particularly the traumatic events, but also of the positive events as discussed in each session, was prepared. This report was read aloud to the patient at the beginning of the following session. Finally, at the end of the treatment, the patient received a shortened version of the combined session reports, as proposed by Schauer et al. (2005). An assistant researcher was present during the sessions to write the therapy report. The assistant was in no other way involved in the therapy. Sessions lasted approximately 90 minutes and were carried out weekly to treat all traumatic experiences for a maximum of 20 sessions.

2.3.3 Data collection between therapy sessions, at the end of therapy and at the 3-month follow-up

The PSS-SR and MANSA VN-12 questionnaires were put together to comprise a survey using the Qualtrics Research Suite 2015 software (Qualtrics Labs Inc., Provo, UT, USA). Four days after each therapy session and before the following therapy session, links to the survey were e-mailed via the Qualtrics program to participants. If the survey was not filled in 1 day after receiving the questionnaire, patients were sent a first reminder. If the survey was still not filled in 2 days after receiving the questionnaire, a second reminder was sent. If the survey was still not filled in after 2 reminders, no further action was taken and data were considered missing for that time point. At the end of therapy patients underwent a second

CAPS interview as well as completing the exit questionnaire. Three months following the end of therapy patients filled in the PSS-SR and the MANSA VN-12 questionnaires via Qualtrics and Patient 1 underwent a third CAPS interview. The same psychologist performed all CAPS interviews as well as giving assistance with the completion of the exit questionnaire.

2.3.4 Data analysis

Demographic data and case descriptions

Demographic data obtained from patients, diagnoses made with the MINI and the CAPS at the screening appointment prior to starting therapy and background information obtained from the patient database at the institution were put together to comprise case descriptions.

Visual inspection of plots of PTSD symptom scores and QOL ratings

Graphs showing PTSD symptom scores and ratings for the QOL for the individual clients prior to and following weekly treatment were prepared and visually examined as a way of determining the efficacy of NET. These graphs were used to determine if there was a correlation between the amount of NET received and the reduction in PTSD symptom scores in patients (hypothesis 1a). Also, the existence of a relationship between the amount of NET and an increase in QOL ratings was established (hypothesis 1b).

SPSS mixed models analysis

Although data of single subjects can be analysed by statistical techniques using either parametric or non-parametric methods, these methods are difficult to apply (Maric et al. 2015). In this research, the SPSS method of Maric et al. (2015) developed to analyse univariate data was therefore used to determine the significance with respect to changes in symptoms with NET. This method is illustrated in the following video: <http://youtu.be/sYGOynx-J8M>. With this mixed models analysis, we established if PTSD symptom scores were significantly less at the end of the treatment phase as compared to at the baseline phase (hypothesis 2a). Similarly, the significance of the increases in QOL ratings at the end of treatment relative to at the baseline were determined (hypothesis 2b).

Reliable change index

The clinical meaningfulness of any effects of NET observed in this research was determined using the reliable change index (RCI) described by Jacobson and Truax (1991). This was carried out by comparing PTSD symptom scores measured at the baseline with those at the end of the therapy and establishing if any reductions in symptoms were clinically significant (hypothesis 3a). RCIs with respect to changes in PTSD symptom scores were measured with data from both the PSS-SR and the CAPS, the latter in the form of CAPS total severity scores. The RCI analysis was applied to determine the clinical significance of increases in QOL ratings at the end of therapy relative to at the baseline (hypothesis 3b). For this analysis data from the MANSA VN-12 was used.

3. Results

3.1. Demographic data and case descriptions of patients

Demographic data, the type of child abuse experienced and diagnoses according to the MINI and CAPS PTSD diagnoses of the two patients involved in this study are given in Table 1. This data is further discussed in the case descriptions below.

Patient 1 was a 44 year-old married Argentinian mother of 5 children. She went to Germany with a friend in her early twenties, where she was forced to work as a prostitute before escaping to the Netherlands in 1997. She currently lives with her present husband, their two children, age 4 and 12, and her sick mother-in-law. She is educated to university level. She has been unemployed for almost a year, since losing her job because of her psychological and health problems. As a child, she suffered extreme emotional abuse and emotional neglect, as well as severe to extreme physical abuse and physical neglect. Her parents separated at age 5 and her and her two brothers were brought up by her grandparents and father. At age 19, she began to experience depressive symptoms and has since had 10 depressive episodes, including the current episode. She also has a current diagnosis of dysthymia. Prior to the age of 30, she has had many somatic symptoms, including head, stomach and back pain. She also suffers from fibromyalgia and thyroid problems. These problems have lasted for many years and have had an important effect on her functioning in important areas of her life, including her work. An organic cause has not been ruled out. She has made 2 suicide attempts. In the month prior to the PTSD therapy, she was considered a moderate suicide risk. She has had treatment for depression prior to being included in this study. In the past, she has been

dependant on Valium and sleeping pills, but she is not currently dependant on these medicines. Prior to the therapy she was diagnosed with PTSD.

Table 1. Demographic data of patients, type of child abuse experienced by patients, Mini-International Neuropsychiatric Interview Plus 5.0 (MINI) diagnoses and PTSD diagnoses before and after therapy as determined by the Clinician Administered PTSD Scale (CAPS).

	Patient 1	Patient 2
Demographic data		
Age (years)	44	35
Gender	Female	Female
Highest education level	University	Higher professional education
Marital status	Married	Single
Ethnicity	Argentinian	Dutch
Type of child abuse		
Emotional abuse	Severe to extreme	Severe to extreme
Emotional neglect	Severe to extreme	Severe to extreme
Physical abuse	Severe to extreme	Low to moderate
Physical neglect	Severe to extreme	Severe to extreme
Sexual abuse	None to minimal	Severe to extreme
Diagnoses (MINI)		
PTSD diagnosis	Yes	Yes
Number of additional diagnoses		
-lifetime	4	2
-current	3	2
PTSD Diagnoses (CAPS)		
PTSD before therapy	Severe	Severe
PTSD after therapy	Moderate	Severe
PTSD 3 mo follow-up	Moderate	NA*

*Data not yet available

Patient 2 was a 35 year-old single Dutch woman who lives alone. She is educated to HBO level and works fulltime in rehabilitation. As a child, she suffered severe to extreme emotional abuse and emotional neglect. She also experienced low to moderate physical abuse, physical neglect and severe to extreme sexual abuse involving her father. She was an only child. Her family moved from Amsterdam to Haarlem when she was 8. Her parents had an unhappy marriage and divorced when she was 24. Her father died 2 years later. She had problems in intimate relationships and is currently single. In 2015, she experienced a short psychotic episode. Stress and possibly cannabis use are believed to be contributing factors in

this episode. At the pre-screening stage of this research, she was diagnosed with depression (current episode) and considered a low suicide risk. She was also diagnosed with PTSD.

3.2. Plots of PTSD symptom scores and QOL ratings

Visual plots of PTSD symptom scores and QOL ratings following therapy sessions are shown in Figure 1 and Figure 2 for Patient 1 and Patient 2, respectively. Initial baseline PTSD symptoms scores of 36 to 41 were observed for Patient 1, which decreased to 34 after the first therapy session. Following the 5th NET session, the lowest PTSD symptom score, 31, was observed for this patient. Following this session, scores generally increased to a maximum of 50, with a score of 40 after the last therapy session. At the 3-month follow-up measurement PTSD symptom scores had decreased to 33. There appeared to be little reduction in PTSD symptom scores at the end of treatment compared to that prior to treatment. Therefore a correlation between the amount of NET which Patient 1 received and a reduction in PTSD symptom scores is unlikely. Thus, hypothesis 1a appears to be false for Patient 1. The PTSD symptom score at the 3-month follow-up (33), however, was one of the lowest scores observed. Baseline QOL ratings ranged from 29-33 for Patient 1 and remained around this value for the rest of the therapy apart from one very low value of 19 following the therapy session in week 10. Increases in QOL ratings were usually observed with decreases in PTSD symptom scores and vice-versa. A QOL rating of 33 was observed at the 3-month follow-up. With an average baseline value of 31 prior to therapy and a value of 29 at the end of treatment, there appeared to be no improvement in the QOL ratings of Patient 1 at the end of the treatment compared to that at the beginning. There is therefore also probably no correlation between the amount of NET Patient 1 had and an increase in her QOL ratings. Hypothesis 1b is therefore also false for Patient 1.

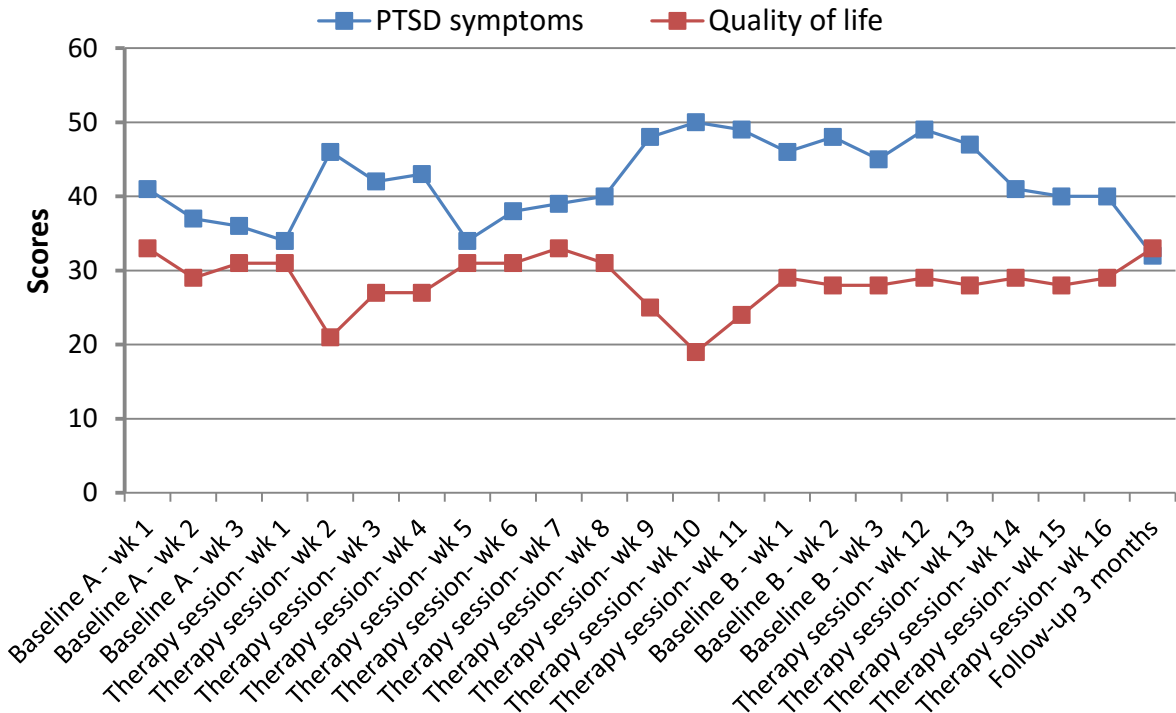


Figure 1. Visual plots of PTSD symptom scores and quality of life (QOL) ratings for Patient 1 prior to and following weekly narrative exposure therapy (NET) sessions.

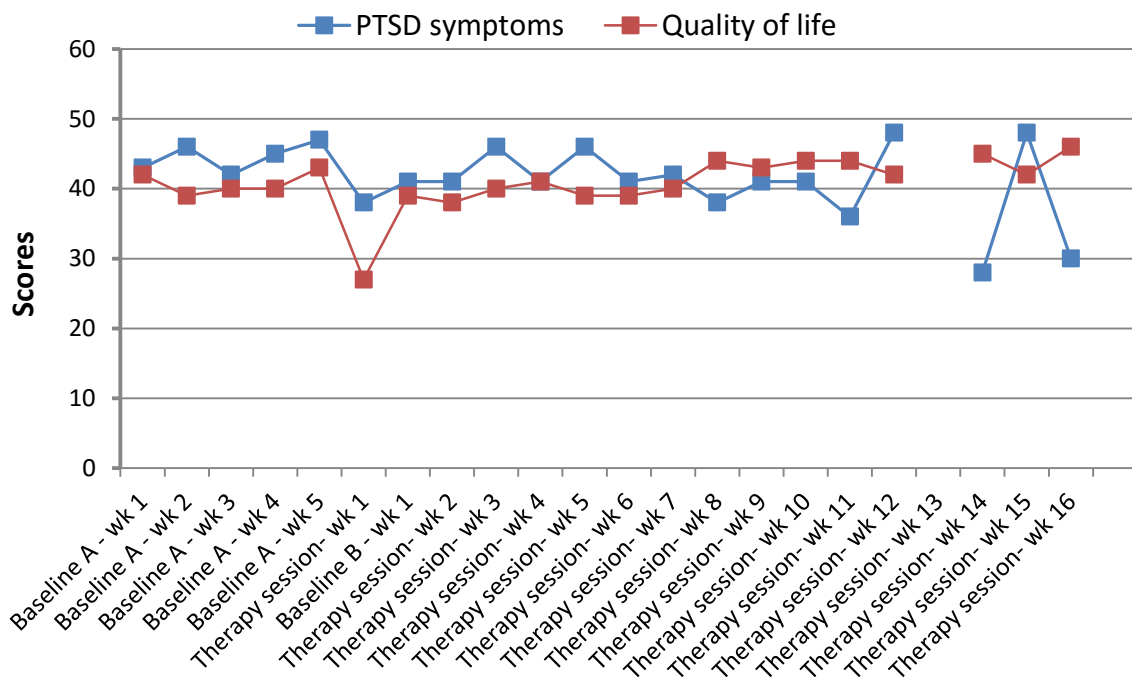


Figure 2. Visual plots of PTSD symptom scores and quality of life ratings (QOL) for Patient 2 prior to and following weekly narrative exposure therapy (NET) sessions.

Patient 2 had initial baseline PTSD symptom scores ranging between 42 and 47 (Figure 2), which remained rather constant up to the therapy session of week 12. The patient did not fill in any data following the therapy session of week 13 and therefore there are no data included for this session. From week 14 onwards, scores fluctuated from between 28 and 48 to a final score of 30 at the end of therapy. There appears to be only a very slight reduction in PTSD symptom scores at the end of treatment compared to that prior to treatment. From the data presented in Figure 2, it therefore seems unlikely that there is a correlation between the amount of NET which Patient 2 received and a reduction in her PTSD symptom scores. Hypothesis 1a therefore seems also false for Patient 2. The baseline QOL ratings for patient 2 ranged from 39 to 43. Apart from a dramatic drop to 27 after the 1st therapy session, values remained fairly constant throughout the treatment period, with a final value of 46 at the end of treatment. There does not appear to be a correlation between the amount of NET received and an increase in QOL ratings. Hypothesis 1b therefore appears to be also false for Patient 2.

3.3 SPSS mixed models analyses

Treatment efficacy results from analysis with SPSS mixed models are outlined in Table 2 and Figures 3-6. Analysis of the data of Patient 1 could not be carried out since only 3 baseline A measurements were taken for Patient 1 and 5 are needed for this analysis.

The parameter b_0 (Table 2) represents the baseline score for the groups of symptoms re-experiencing, arousal and avoidance and QOL factors. Parameter b_1 is the difference in these symptoms and factors between the end of the baseline and the end of treatment. A negative value of b_1 indicates a decrease in symptoms. In this study, a negative value for b_1 was obtained with respect to re-experiencing, arousal and avoidance symptoms (Table 2). A positive value for b_1 was obtained for QOL ratings, which indicates an increase in QOL at the end of the therapy. There was a significant phase difference between baseline and treatment phases for re-experiencing and avoidance symptoms with $p < 0.10$ for b_1 for both. Hypothesis 2a, which proposes that PTSD symptom scores are significantly less at the end of the treatment phase as compared to at the baseline phase, is thus true for both these symptom groups for Patient 2. There were no significant differences, however, with respect to arousal symptoms or QOL ratings with $p > 0.10$ for b_1 in both cases. Hypothesis 2a is therefore false for Patient 2 for arousal symptoms. Hypothesis 2b, that QOL ratings are significantly greater at the end of treatment relative to at the baseline is also false for Patient 2.

Table 2. Treatment efficacy results at the end of treatment for Patient 2 from SPSS mixed models analysis.

(a) Estimates of fixed effects with re-experiencing as the dependent variable.					
	<i>Estimate</i>	<i>SE</i>	<i>p</i>	90% Confidence Interval	
				Lower bound	Upper bound
Intercept (b_0)	12.82	0.79	0.000	11.40	14.25
Phase (b_1)	-1.74	0.89	0.080	-3.35	0.12
Time in phase (b_2)	0.30	0.35	0.398	-0.32	0.93
Time in phase*phase (b_3)	-0.21	0.35	0.555	-0.83	0.41

(b) Estimates of fixed effects with avoidance as the dependent variable.					
	<i>Estimate</i>	<i>SE</i>	<i>p</i>	90% Confidence Interval	
				Lower bound	Upper bound
Intercept (b_0)	16.74	0.92	0.000	15.08	18.40
Phase (b_1)	-3.09	1.04	0.014	-4.96	-1.21
Time in phase (b_2)	-0.25	0.40	0.541	-0.97	0.47
Time in phase*phase (b_3)	0.41	0.40	0.334	-0.32	1.13

(c) Estimates of fixed effects with arousal as the dependent variable.					
	<i>Estimate</i>	<i>SE</i>	<i>p</i>	90% Confidence Interval	
				Lower bound	Upper bound
Intercept (b_0)	15.37	1.07	0.000	13.31	17.43
Phase (b_1)	-2.03	1.26	0.167	-4.55	0.50
Time in phase (b_2)	-0.38	0.44	0.412	-1.20	0.44
Time in phase*phase (b_3)	0.50	0.45	0.302	-0.35	1.34

(d) Estimates of fixed effects with quality of life (QOL) as the dependent variable.					
	<i>Estimate</i>	<i>SE</i>	<i>p</i>	90% Confidence Interval	
				Lower bound	Upper bound
Intercept (b_0)	39.08	47.25	0.974	-8858765.96	8858835.11
Phase (b_1)	7.00	12.51	0.588	-15.64	29.64
Time in phase (b_2)	0.75	1.63	0.661	-2.43	3.93
Time in phase*phase (b_3)	-2.11	1.85	0.307	-5.86	1.64

Parameter b_2 is interpreted as the rate of change in the baseline phase and as such values should be negligible. Values observed in this study were small with a maximum for QOL ratings at 0.75. Parameter b_3 is the difference in rates of change with respect to the symptoms and ratings between the baseline phase and the NET phase and b_3 must be interpreted with b_2 . When b_2 is negative and b_3 is positive, as is the case for all 3 of the main groups of PTSD symptom scores in this study, this indicates a greater decrease in symptom scores during the NET phase as compared to the baseline phase. For the QOL ratings, the reverse was seen; i.e., b_2 was positive and b_3 was negative which is indicative of a greater increase in QOL

following NET as compared to in the baseline phase. However, neither the decreases in the groups of PTSD symptom scores or the increases in QOL ratings were significant with ($p > 0.10$) for b_2 and b_3 in all cases. An α of 0.10 was used for significance in this analysis (Maric, 2016).

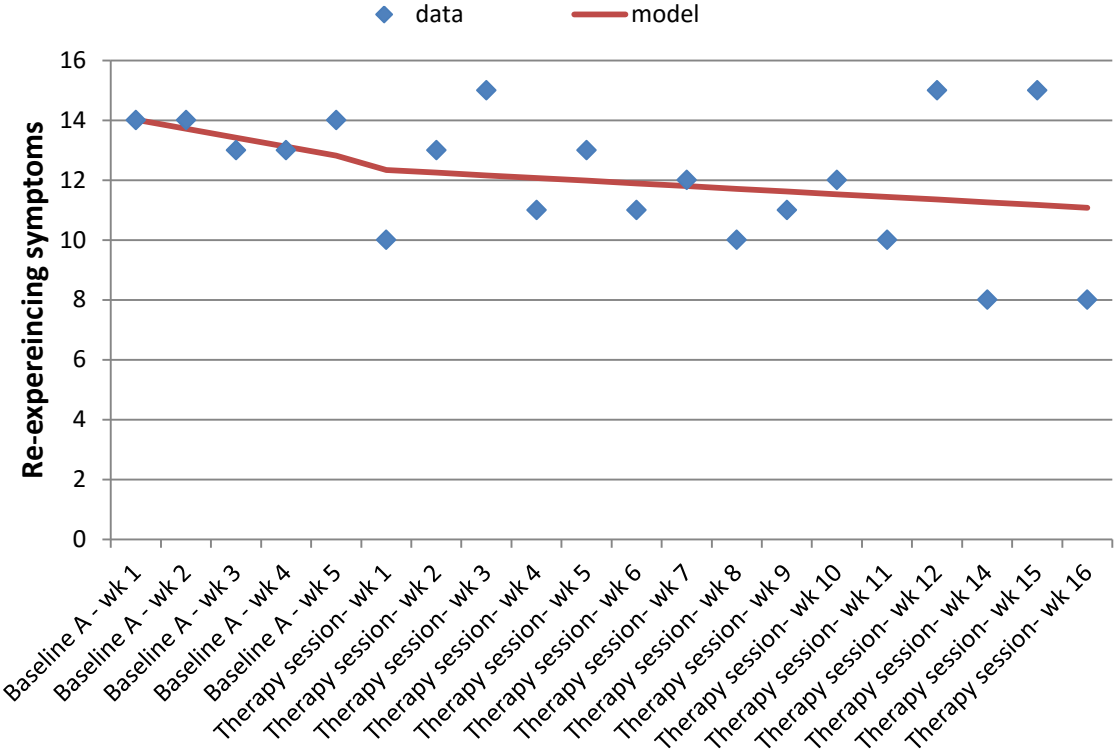


Figure 3. Visual representation of the models of the differences between the baseline and narrative exposure therapy (NET) phases on re-experiencing symptoms for Patient 2.

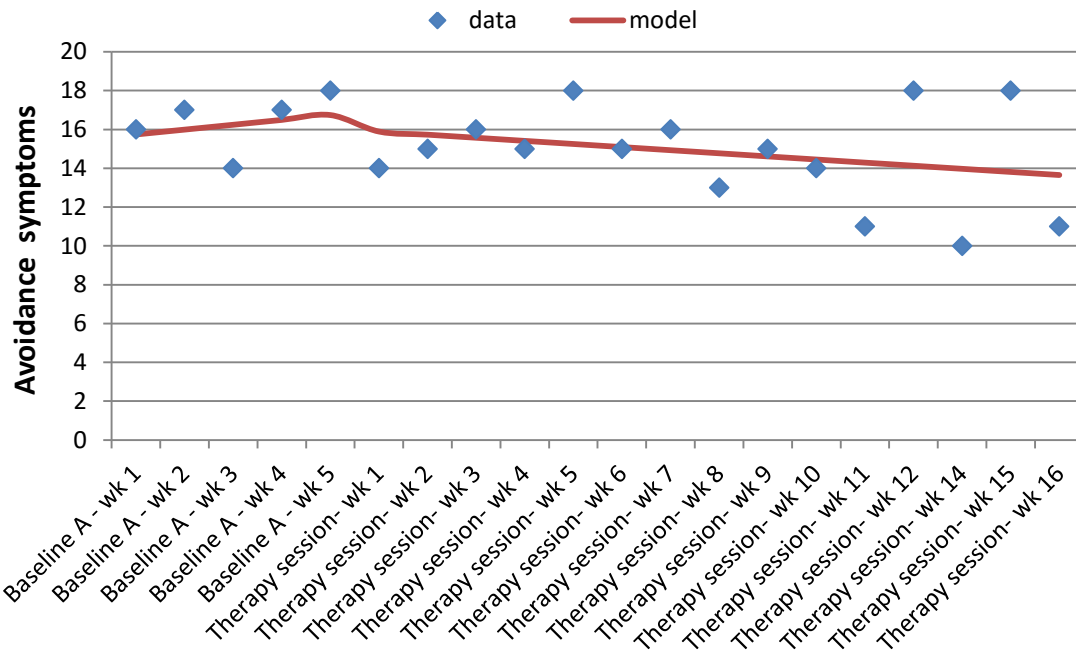


Figure 4. Visual representation of the models of the differences between the baseline and narrative exposure therapy (NET) phases on avoidance symptoms at the end of therapy for Patient 2.

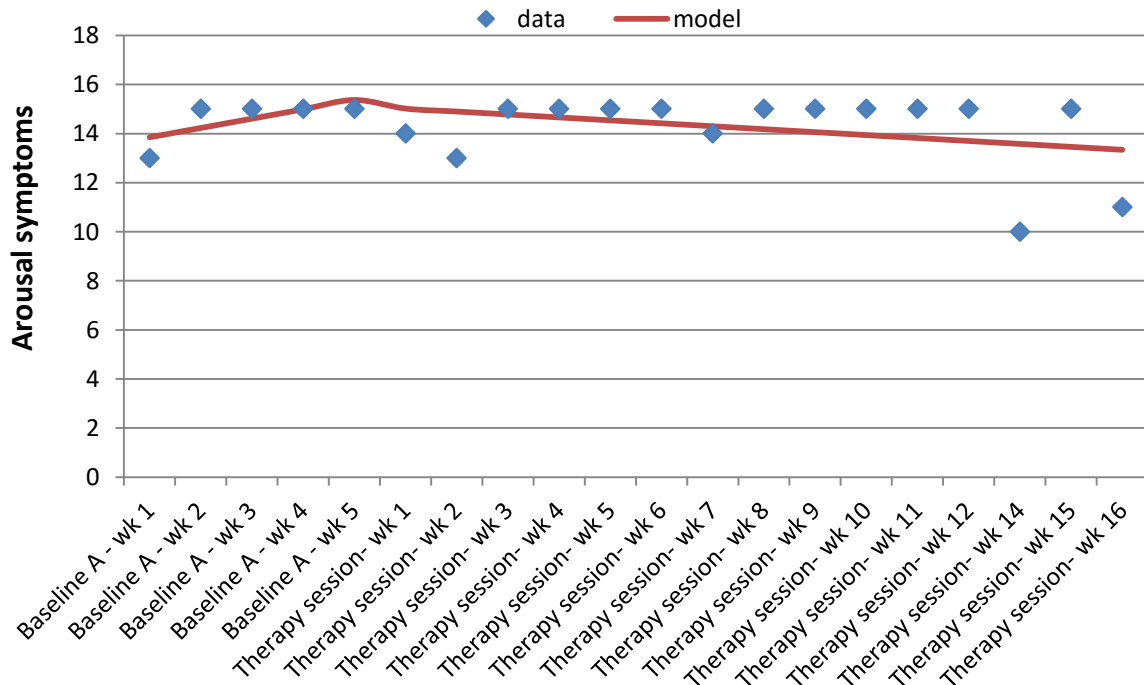


Figure 5. Visual representation of the models of the differences between the baseline and narrative exposure therapy (NET) phases on arousal symptoms for Patient 2.

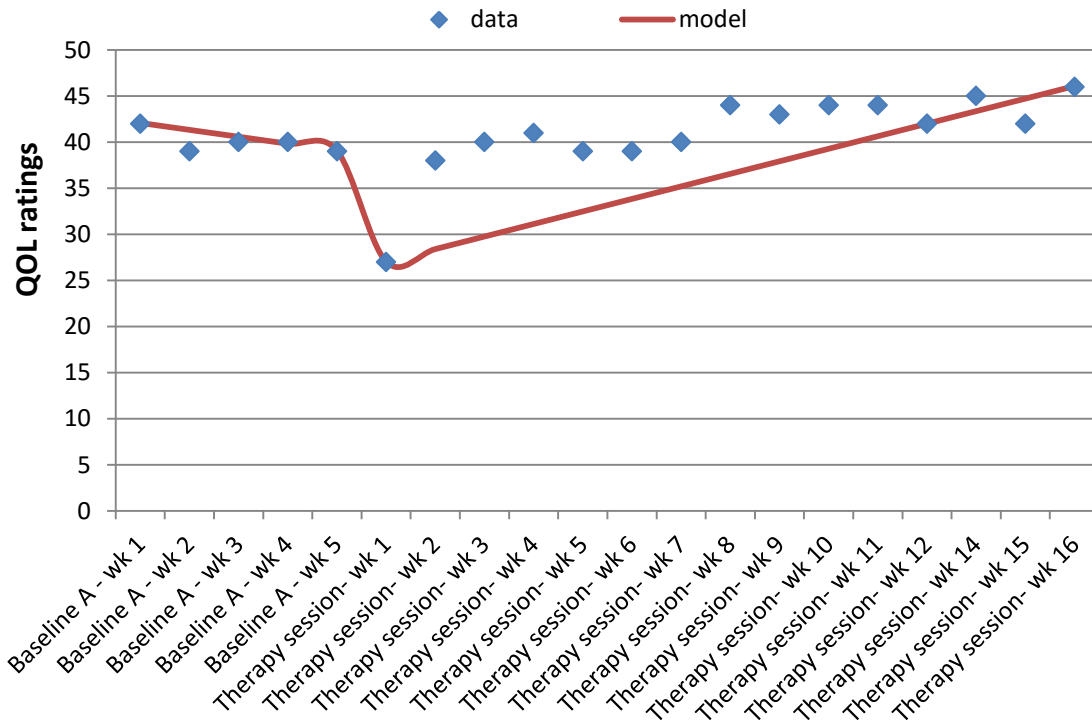


Figure 6. Visual representation of the models of the differences between the baseline and narrative exposure therapy (NET) phases on quality of life (QOL) ratings for Patient 2.

3.4 Reliable change index

The reliable change index (RCI) was used to determine clinical significance of the changes in PTSD symptom scores and QOL ratings from prior to therapy to after therapy and from prior to the therapy to the 3-month follow-up. RCIs for PTSD symptom scores, calculated from data from both the PSS-SR and the CAPS, and QOL ratings are given in Table 3. The RCI for the PTSD symptom scores (PSS-SR) for Patient 1 following NET were 0.28 and -0.84 respectively for at the end of therapy and at the 3-month follow up (see Appendix 1 for calculations). These changes are deemed non-significant however, since according to Jacobson and Truax (1991) the RCI must have an absolute value of at least 1.96 for a change to be clinically significant. Hypothesis 3a, i.e., that effects of NET on the reduction of PTSD symptom scores in patients are clinically significant, is therefore not true with respect to the PSS-SR either at the end of treatment or at the 3-month follow-up for Patient 1. The RCI for PTSD symptom scores using the PSS-SR for Patient 2 at the end of therapy was at an absolute value of 2.0, clinically significant. Hypothesis 3a is therefore true for Patient 2.

With the large range of standard deviations available for the CAPS total symptom scores, and the great influence this has on the RCI value, care must be taken in selecting a representative

value to calculate the RCI. The average of two standard deviations, i.e., that of 14.2 (Morath et al., 2014; n=19) and 16.2 (Van den Berg et al. 2015; n=155) was therefore employed in these calculations. RCI values for Patient 1 for the changes in PTSD symptom scores as determined by the CAPS at the end of therapy and at the 3-month follow-up were -2.07 and -3.14 respectively. Since both absolute values are greater than 1.96, changes in the CAPS total severity scores for Patient 1 during both periods are considered clinically significant. The RCI for Patient 2 for the decrease in PTSD symptoms between prior to therapy and at the end of therapy at -2.68 also indicates a clinically significant change. Hypothesis 3a is therefore true for CAPS values for Patient 1 and Patient 2 at the end of therapy and for Patient 1 at the 3-month follow-up. Changes in the QOL ratings appear not to be of clinical significance however. Patient 1 had CAPS, RCI absolute values of 0.52 for both the changes in PTSD symptom scores between prior to therapy and at the end of treatment and between prior to therapy and the at the 3-month follow-up. For Patient 2 the RCI for between prior to therapy and at the end of treatment was 1.37. Hypothesis 3b, i.e. the effects of NET on the increase in QOL ratings are clinically significant, is not true for Patient 1 at either time-point or for Patient 2 at the end of therapy.

Table 3. *Reliable change indices (RCI) for PTSD symptom scores, quality of life (QOL) ratings and CAPS total severity scores of patients at the end of therapy and at the 3-month follow-up.*

	PSS-SR	CAPS	QOL
Patient 1			
-End of therapy	+0.28	-2.07	-0.52
-3 mo follow-up	-0.84	-3.14	+0.52
Patient 2			
-End of therapy	-2.0	-2.68	+1.37
-3 mo follow-up	NA*	NA*	NA*

*Data not yet available

3.5 CAPS total severity scores

The CAPS scores per PTSD symptom group and total symptom severity scores prior to and following NET of patients are given in Table 4. The CAPS total severity score of Patient 1 decreased considerably from 90 initially to 63 following therapy. This involved large decreases, from 31 to 14 and from 33 to 18 for the symptom groups of re-experiencing and of increased arousal, respectively for this patient, during this period. Slight increases in avoidance symptoms were observed following therapy when compared to scores prior to treatment. However, avoidance scores decreased greatly, from 31 to 17, between the end of

therapy and the 3-month follow-up. Also the final total PTSD severity score for Patient 1 reduced greatly between the end of treatment and the 3-month follow-up measurement, to a score of 49. The CAPS total severity score for Patient 2 had also decreased greatly from 105 prior to therapy to 70 at the end of treatment (Table 4). This decrease incorporated a particularly large reduction in avoidance symptoms scores with a reduction from 41 to 18. Only a slight decrease, from 32 to 25, was observed for re-experiencing symptoms and no change was seen in increased arousal symptoms. Data for the 3-month follow-up are not yet available for Patient 2.

Table 4. CAPS scores per PTSD symptom group and total severity scores prior to and following narrative exposure therapy (NET).

	Patient 1			Patient 2		
	Before NET	After NET	3 mo follow-up	Before NET	After NET	3 mo follow-up
Re-experiencing	31	14	13	32	25	NA*
Avoidance	26	31	17	41	18	NA*
Increased arousal	33	18	19	32	32	NA*
Total severity score	90	63	49	105	70	NA*

*Data not yet available

3.6 Exit questionnaire

Patient 1 reported that she sleeps better (longer) following the therapy. She said that she also has her angry outbursts more under control and feels less guilty. She feels milder towards herself and others and her emotional regulation is better. She had little expectation of the therapy and found the exposure part of the therapy good. She was also very positive about the therapist. She found her really nice and understanding. She found the therapy too short since she had a lot of difficult life experiences and would like to have more NET and couples therapy.

Patient 2 found that the therapy had an effect on her symptoms later in treatment. She felt recognised in being able to see how her life was and feels for a great part healed. She was

open and hopeful that the therapy would reduce her symptoms. She found the therapist good and the visual form of the therapy matched well with how she learns. She would like to have follow-up therapy sessions with the same therapist on how to deal with similar situations. She would also like to have 3 or 4 more sessions possibly on how to deal with the death of her boyfriend.

4. Discussion

The efficacy of NET in the reduction of PTSD symptom scores and the increasing of QOL ratings in patients with PTSD arising from child abuse was investigated in this study. Overall, the results revealed somewhat conflicting findings. Much self-reported data of patients (used for visual plots, SPSS analysis and some of the reliable change index calculations) imply that little improvement in PTSD symptom scores and QOL ratings was obtained through NET. In contrast, RCIs from CAPS total severity symptoms scores suggest clinically significant reductions in PTSD symptom scores.

4.1. Self-report data

Although findings from self-reported data showed generally little change in PTSD symptom scores and QOL ratings, some significant changes from this data were also observed. The significant reduction in re-experiencing symptoms observed from SPSS analysis of PSS-SR data for Patient 2 was not supported by the CAPS scores. The significant reduction in avoidance symptoms for Patient 2 was observed from the SPSS analysis however, is greatly supported by the reduction of 23 observed for this PTSD criterion in the CAPS results at the end of therapy. Interestingly, with Patient 1 there was no decrease in avoidance symptoms from the baseline to at the end of the therapy; indeed a slight increase was observed. At the 3-month follow-up, however, a large decrease in avoidance symptoms was also observed for Patient 1. The differences between patients in the PTSD symptoms groups where they experienced most improvement may be due to slight differences in focus of therapy by the therapists. The change in PTSD symptom scores observed using the PSS-SR for Patient 2 from prior to therapy to after the therapy was deemed clinically significant from the RCIs observed. However, since the PTSD symptom scores for this patient fluctuated greatly in the last few weeks of therapy, from 30 to 48, it is unlikely that this result is actually of clinical significance.

There are several possible explanations for the limited improvements observed for the rest of the self-reported data (PSS-SR scores and MANSA VN-12 data used for visual plots, SPSS mixed models analysis and the RCI calculations). Firstly, since these scores were filled in by patients themselves, they could, for several reasons (unintentionally or intentionally), have filled in scores indicating that they experienced less improvement in symptoms than they actually did. Some of these reasons include patients being negatively biased with respect to how they see themselves and their improvement. Indeed, both patients were also diagnosed with depressive episodes with the MINI during the baseline measurement phase of this research. The cognitive model of depression proposes that the thinking of those suffering from depression is characterised by an emphasis on negative expectations and interpretations of one's self, one's future and the world (Beck, 2005). Furthermore, depressive thinking generally involves distortion and selection of negative interpretations, although positive explanations are equally likely. These errors in information processing occur automatically and spontaneously, outside the patient's awareness (Hammen & Watkins, 2008) and could have played a role in the results obtained by self-report in this study.

Patients may also have not wanted to appear better, so that the therapy could continue since both patients were positive about the therapy and their therapists and came loyally to their therapy sessions. In the exit questionnaire completed at the end of the treatment, both patients also indicated that they would like to have had more therapy. Besides, patients could have quickly and also inaccurately filled in the questionnaires since their usually requiring reminders to fill them in suggested some difficulty/confrontation with their PTSD symptoms in doing so. A second reason for the absence of significant results from self-reported questionnaires may be due to the questionnaires used having a low sensitivity to changes due to treatment. Maric et. al (2015) proposed the need to use instruments specifically designed for the regular assessment of clinical symptoms or whose psychometric properties with respect to sensitivity to therapeutic change are sufficient. These authors report that non-significant changes can be incorrectly concluded from questionnaires not meeting these standards. However, in a study assessing the influence of a brief psychotherapeutic intervention on factors concerning QOL, Petrakis and Joubert (2013) reported significant improvements using the MANSA questionnaire. Also the PSS-SR is frequently used as an instrument to measure PTSD symptom scores in therapy research. E.g., van den Berg (2015) found large decreases in PTSD symptoms from 30 to 16 with the PSS-SR in an RCT comparing the efficacy of prolonged exposure, EMDR and remaining on a waiting list for the

treatment of patients with PTSD and a psychotic disorder. Thus, it seems unlikely that a low sensitivity to changes due to treatment of the questionnaires employed in this study is a plausible explanation for the non-significance of some of the self-reported results.

4.2 Clinical interview data

The decrease in the CAPS total severity score for Patient 1 from 90 prior to treatment to 63 following treatment implies, according to Hovens et al. (2005), that the PTSD diagnosis of Patient 1 changed from severe PTSD to moderate PTSD. This finding is supported by the clinically significant absolute RCI values obtained for Patient 1 for the changes in PTSD symptom scores during this period. Also, importantly the large further reduction to 49 for the CAPS score at the 3-month follow-up is just a few scores above a classification of mild or no PTSD, which according to Hovens et al. (2005) ranges from 45-65. These reductions in CAPS total severity score are also supported by the apparent clinical significance of these scores as determined by the RCI values. The reduction in the CAPS total severity score of 35 points to 70 for Patient 2 was similar to that observed for Patient 1 following therapy. The decrease seen for Patient 2 however, did not allow the diagnosis of severe PTSD for this patient to be reduced to one of lower severity although it was deemed clinically significant by the RCI values. The clinical significance of our CAPS reductions of 27 and 41 for Patient 1 after therapy and at the 3-month follow-up, respectively, and of 35 for Patient 2 after the therapy is agreement with findings of other authors. Weathers et al. (2001) and Erbes et al. (2014) proposed that reductions in CAPS total severity score of 10-12 or 15 points, respectively, are clinically significant. The clinically significant reduction in CAPS scores for both patients appear to be supported by the responses to the questions in the exit questionnaire. Patient 1 reported that she slept better, has greater regulation of her anger, feels less guilty and feels milder towards herself. Patient 2 reported that she felt “for a great part healed”. Furthermore, both patients were positive about their therapists. It is widely accepted that positive therapeutic alliances are associated with better therapeutic outcomes (Martin et al., 2000).

Reductions in CAPS results observed for NET in this study were also found by previous authors. In a study of refugees with PTSD arising from experiencing war and torture, Morath et al. (2014) also reported clinically significant decreases in CAPS scores after 12 sessions of NET. An average CAPS score of 92 prior to therapy was reduced to 55 at the 4-month follow-up and further to 43 at the 1-year follow-up. Also, in an RCT comparing the efficacy of NET

and interpersonal psychotherapy for the treatment of PTSD in Rwandan genocide orphans, Schaal et al. (2009) reported moderate decreases in CAPS scores from 67 prior to therapy to 50 the end of therapy with NET. Furthermore, in a systematic review and meta-analysis on the psychological treatments for severe PTSD in adults, Cusack et al. (2016) reported moderate evidence for NET in the reduction of PTSD symptoms. The evidence for NET regarding the loss of a diagnosis of PTSD however was low in this study. The extent of the reduction in CAPS scores observed in this study may have been attributable to the likelihood that NET encompasses all three recent psychological theories of PTSD as discussed earlier in this thesis.

4.3 Comparison of the findings from the clinical interview and the self-report data

Several explanations exist for the discrepancy in the reduction in the PTSD symptom scores seen with the CAPS and the PSS-SR observed in this study. Firstly, since the CAPS involves a much more detailed assessment of the individual PTSD symptom scores than the PSS-SR, involving the judgement of the frequency and intensity of the symptoms as well as requiring examples, it is likely that more accurate results are achieved with the CAPS. Even the authors of the PSS-SR (Foa et al., 1993) propose that although the PSS-SR can be used as a measure of PTSD symptom severity, that this instrument should be “an adjunct to a clinical interview with traumatized individuals”. Hereby, they acknowledge the superiority of the clinical interview over the PSS-SR for the diagnosis of PTSD. Also, in an RCT treating patients with PTSD and psychotic disorders, Van den Berg et al. (2015) used the CAPS total symptom severity score as the primary outcome measure of PTSD symptoms and scores from the PSS-SR as a secondary measure.

Also, it is likely that therapists view therapy outcomes more favourably than patients themselves since, as outlined previously, patients may have a negative view of their functioning. For example, it can be that as some symptoms decreased, patients became more aware of other symptoms. A psychologist may correctly see such a change as an improvement in functioning, whereas patients themselves may not see it as progress, but as just another difficulty arising. However, in contrast to our findings, in their RCT treating patients with PTSD and psychotic disorders, Van den Berg et al. (2015) reported that self-reported PTSD symptoms observed with the PSS-SR showed similar reductions in PTSD symptoms as the CAPS results. In the present study, the psychologist may also have been somewhat biased in his rating during the

CAPS interview since he was also aware that the patients were taking part in a research study. Experimenter expectancy effects, defined by Kazdin (2010) as beliefs and desires of the experimenter about the performance of the patients and about the outcomes may thus have played a role in the results and particularly the CAPS results in this study. It is important therefore to measure the inter rater-reliability for this clinical interview.

4.4 Improvements in symptoms during the 3-month follow-up

The further large reduction in the CAPS scores as well as the slight reduction in PSS-SR scores and the increase in the MANSA VN-12 scores for Patient 1 between the end of therapy and the 3-month follow-up is frequently observed with NET. According to Jongedijk (2014), the full effects of NET are not evident directly after the end of therapy, and may only be seen at least 6 months afterwards. These improvements after the end of therapy refer not only to reductions in PTSD symptoms, but also to other symptoms such as those of depression. Furthermore, several other authors have reported decreases in PTSD symptoms between the end of NET and follow-up measurements after 3-6 months. Firstly in a study on the comparison of the efficacy of NET to that of other forms of counselling in the treatment of traumatised African refugees Neuner et al. (2004) reported further decreases in PTSD symptoms up to 1 year. Also, in a pilot randomised controlled feasibility study of NET for the treatment of PTSD in Chinese earthquake survivors, Zang et al. (2014) found that reductions observed in PTSD symptoms continued during the 3-month follow-up.

One possible reason for this further decrease in PTSD symptom scores frequently experienced by NET patients may be as follows. Since NET deals with all patients major life events in a relatively short period, it may take more time for patients to really process these events and the usually great impact they have on their lives.

4.5 The importance of the results of this study

Although the efficacy of NET for the treatment of PTSD in refugees and veterans and orphans, who have experience multiple traumas, has been determined, this is to the author's knowledge, one of the first studies to investigate the efficacy of NET in patients with PTSD arising from child abuse. The two other known studies, Pabst,et al. (2012) and Dömen et al., 2012 (as cited in Jongedijk, 2014) are discussed in the introduction. Briefly, in the first study the patients also had borderline personality disorders which may have interfered with the

therapeutic relationship and the second study was published in Japanese which makes the quality difficult to determine. Also both studies had low numbers of patients. This makes the findings of the present study of special interest. In this study 16 sessions of NET were sufficient to obtain clinically significant reductions observed with the CAPS for both patients. Although less positive findings were observed with the self-report data, it appears, at least from these preliminary results, that NET can be seen as an effective treatment for this patient group. More data is needed however, to confirm these findings. If proven effective, the existence of NET would increase the number of therapies available to patients with PTSD providing them with greater choice. The existence of a milder PTSD treatment than traditional exposure therapy exposure is desirable and patients may experience NET as milder since it also involves a narrative element. Indeed, drop-out observed from several studies on NET is low (Jongedijk, 2014). It is also probably partly due to this reason that it is a preferred PTSD treatment among therapists (Jongedijk, 2014). Low drop-out could also mean that more patients, often desperately needing treatment, could avail of it. Furthermore, in the exit questionnaire, used in this study, patients revealed that NET had effects in other ways besides on the PTSD symptoms. These included feeling less guilty, being milder towards one's self and others and having better emotional regulation all of which may be valuable in improving a patient's QOL. The fact that trauma processing in NET takes the context of the trauma and the patient's whole life history into account (Jongedijk, 2014) may account for these added effects. E.g., Timmers (2015) suggests that the reduction in the feelings of guilt of the patient may have been brought about by recognition from the therapist for the abusive manner in which the patient was treated.

The exclusion of a third patient in this study (for which data is not included) provided us with valuable information on the generalizability of NET. This patient was excluded since he had much difficulty with emotion regulation and regularly reported that he felt suicidal after NET sessions. It is likely that this patient had a more complex form of PTSD since, according to Herman (1992) and Ford (2015) emotion regulation is one of the domains in which patients with child-abuse related "complex PTSD" have difficulty with over patients with simple PTSD. The inability of this patient to withstand the emotions brought up by NET indicates that this form of therapy is unsuitable for the treatment for patients with limited emotional regulation. This is in line with findings of others (Levitt & Cloitre, 2006; Dorrepaal et al., 2014) who suggest that patients with PTSD from child abuse and those with difficulties in emotion-regulation are at risk for dropout from therapy and worsening of symptoms.

However, the requirement of reasonable emotion regulation in patients also holds for other PTSD treatments since the ability to regulate emotions, and particularly anxiety, is necessary for the processing of trauma-related anxiety. Also, concerning the generalizability of NET, although the two patients were of different nationalities and cultures, similar results were obtained. The number of patients, however, is too small to draw definite conclusions on the generalizability of NET for this patient group with respect to nationalities and cultures.

4.6 Limitations and future research

Some limitations of this work deserve comment. On some occasions, when patients did not fill in the questionnaires after repeated reminders, therapists asked patients to fill in the questionnaires. This revealed to the patients that the therapists were also, at least indirectly, involved with the research and this may have somewhat influenced the patients' answers. To avoid this it would have been desirable that all matters concerning the research be carried out by the researchers. Also the NET protocol used by the therapists was not controlled (therapy adherence) with their first patients in this study. This is desirable so that all patients receive the therapy according to the official NET protocol. However, this will be carried out for both therapists later on in this study. Although it is known that the full effects of NET can often only be seen 6 months after the end of therapy (Jongedijk, 2014), no 6-month follow-up data were obtained for Patient 1 due to illness of the patient around this time. A further possible limitation is that the study was not blinded. Thus experimenter expectancy effects, as outlined above in section 4.3, may have played a role in the results obtained. Such expectancies can adversely influence the construct validity of the study (Kazdin, 2010). The inter-rater reliability was also not determined for the CAPS in this study but will be carried out at a later stage. Finally, the intervals between the filling-in of questionnaires during the baseline phases were much lower (2 days) than for the treatment phases (6 days). There were several reasons for choosing to decrease of the interval in the baseline phase. Most importantly it was assumed a patient's mood can vary sufficiently over a 48-hr period, and particularly when 5 measurements were taken, to allow the desired realistic variation in the baseline measurements to be included. Indeed, it was noted that for one patient's scores for the PSS-SR varied between 27 and 19 over a 48-hr period. Also patients were keen to begin with the therapy as soon as possible and in order to provide this, the baseline phase was kept to a minimum.

Given the seriousness of the effects of child abuse on the mental health of the victims, more research on treatments for PTSD in these patients is of great importance. Specifically, further studies determining the efficacy of NET on the treatment of child abuse-related PTSD are clearly needed. In such studies it would also be useful to measure symptoms in the three areas besides PTSD symptoms in which these patients are believed to have difficulty, namely their (negative) self-concept, in the processing of emotions and in relationships. If findings from such studies are still positive, an RCT could be carried out comparing NET with prolonged exposure for treatment efficacy, drop-out and the effect on other general factors such as kindness towards one's self. Future research with NET could also further explore the mechanisms by which NET is effective.

5. Conclusions

Findings on the efficacy of NET for the treatment of PTSD arising from childhood abuse from the patients in this study were somewhat equivocal. Self-report data for total PTSD symptoms and QOL ratings indicate little improvement with NET. However, when data was divided into PTSD symptoms groups, significant changes in re-experiencing and avoidance were observed. RCIS from CAPS data also suggest that NET produced clinically significant reductions in PTSD symptom scores for both patients and that reductions were even greater 3 months following therapy. This preliminary data indicates thus that NET is effective for the treatment of child-abuse related PTSD. However, results from a greater number of patients of this group are needed to more definitely determine the efficacy of NET.

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Appendix 1

Calculation of the Reliable Change Index (RCI; Jacobson and Truax, 1991)

$$RCI = \frac{X_2 - X_1}{S_{Diff}}$$

X_2 = post therapy score from the relevant questionnaire

X_1 = pre-therapy score (average of baseline scores) from the relevant questionnaire

$$S_{Diff} = \sqrt{2(S_E)^2}$$

$$S_E = S_1 \sqrt{1 - r_{xx}}$$

r_{xx} = test-retest reliability of the relevant questionnaire

S_1 = pre-test standard deviation from the relevant population

Table 5. Test-retest reliability values and pre-test standard deviations from the psychiatric population for the PSS-SR, the MANSA VN-12 and the CAPS instruments.

	Test-retest reliability	Pre-test standard deviation of score from the psychiatric population
PSS-SR	0.74	9.96 ^b
MANSA VN-12	0.74	5.27 ^c
CAPS	0.63 ^a	15.2 ^d

^afrom Weathers et al. (1999)

^bfrom Foa et al. (1997)

^cfrom Van Nieuwenhuizen et al. (2015)

^daverage of 14.2 (Morath et al., 2014) and 16.2 (Van den Berg et al., 2015)

Table 6. Pre-test (prior to therapy), post-test (after therapy) and 3-month follow-up PSS-SR PTSD symptom scores and MANSA VN-12 quality of life (QOL) scores

	PSS-SR PTSD Symptoms score		MANSA VN-12 QOL ratings		CAPS total severity scores	
	Pre-test	Post-test	Pre-test	Post-test	Pre-test	Post-test
Patient 1						
-Start/end of Therapy	38.0	40.0	31.0	29.0	90	63
-3 mo follow-up	-	32.0	-	33.0	-	49
Patient 2						
- Start/end of Therapy	44.6	30.0	40.8	46.0	105	70
-3 mo follow-up	-	NA*	-	NA*	-	NA*

*Data not yet available

Appendix 2

Dutch version of the PTSD Symptom Scale-Self-Report (PSS-SR)

PDS: Naam: _____

Datum: _____

<p>Onderstaand volgt een lijst van problemen waar mensen soms mee te maken krijgen na een traumatische gebeurtenis. Lees deze zorgvuldig door en omcirkel het cijfer (0 – 3) dat het best aangeeft in hoeverre dit bepaalde probleem u bezig hield/houdt gedurende de afgelopen week.</p> <p>0 <i>Nooit</i> 1 <i>1 keer per week of minder/ eens in de zoveel tijd</i> 2 <i>2 - 4 keer per week/ de helft van de tijd</i> 3 <i>bijna de hele tijd</i></p>		<p>11. Gevoelloosheid, zoals niet kunnen huilen, geen liefde kunnen voelen 0 1 2 3</p> <p>12. Gevoel dat uw toekomstplannen de grond in geboord zijn, dat er geen hoop meer is (b.v. voor het maken van carrière, een gelukkige relatie hebben, (klein)kinderen hebben, of een lang leven leiden) 0 1 2 3</p> <p>13. Problemen met inslapen of doorslapen 0 1 2 3</p> <p>14. Last van snel geïrriteerd zijn of van woede-uitbarstingen 0 1 2 3</p> <p>15. Moeilijkheden met concentreren, zoals de draad kwijt raken tijdens een gesprek, de t.v. niet kunnen volgen, niet meer weten wat u zojuist gelezen heeft 0 1 2 3</p> <p>16. Erg waakzaam of op uw hoede zijn (b.v. controleren wie er zich achter u bevindt, ongemakkelijk gevoel als u zich met uw rug naar een deur bevindt, etc.) 0 1 2 3</p> <p>17. Schrikachtig, gespannen zijn (b.v. als iemand achter u loopt) 0 1 2 3</p> <p>Geef aan in hoeverre de problemen die u in het voorgaande aankruiste u hinderden op één of meer van de volgende levensgebieden gedurende de afgelopen maand. Omcirkel 'ja' of 'nee'.</p> <p>1. Werk Ja Nee 2. Huishoudelijke werkzaamheden en plichten Ja Nee 3. Vriendschapsrelaties Ja Nee 4. Vrijtijdsbesteding, uitgaan Ja Nee 5. Studie Ja Nee 6. Relaties met uw familieleden Ja Nee 7. Seksueel leven Ja Nee 8. Algemene voldoening in het leven Ja Nee 9. Algemeen functioneren op alle levensterreinen Ja Nee</p>
<p>1. Pijnlijke gedachten of beelden over de traumatische gebeurtenis, terwijl u er niet aan wilde denken 0 1 2 3</p> <p>2. Onprettige dromen of nachtmerries over de traumatische gebeurtenis 0 1 2 3</p> <p>3. De ervaring alsof de traumatische gebeurtenis weer plaats vindt, dat u handelt of het voelt alsof het weer gebeurt 0 1 2 3</p> <p>4. Emotioneel overstuurd raken bij het herinnerd worden aan de traumatische gebeurtenis (b.v. gevoelens van angst, kwaadheid, bedroefdheid, schuldgevoelens) 0 1 2 3</p> <p>5. Lichamelijke reacties ervaren wanneer u aan de traumatische gebeurtenis herinnerd wordt (b.v. in zweet uitbreken, hartkloppingen krijgen) 0 1 2 3</p> <p>6. Proberen niet aan de traumatische gebeurtenis te denken, er niet over te spreken, of om de gevoelens erover te vermijden 0 1 2 3</p> <p>7. Proberen activiteiten, mensen, of plaatsen te vermijden die aan de traumatische gebeurtenis doen herinneren 0 1 2 3</p> <p>8. Niet in staat zijn een belangrijk deel van de traumatische gebeurtenis te herinneren 0 1 2 3</p> <p>9. Aanzienlijk minder interesse voor, of deelname aan voor u belangrijke activiteiten 0 1 2 3</p> <p>10. Het gevoel hebben mensen in uw omgeving op een afstand of afgesneden van u te ervaren 0 1 2 3</p>		

Appendix 3

The Manchester verkorte Kwaliteit van Leven meting (MANSA VN-12)

MANCHESTER VERKORTE KWALITEIT VAN LEVEN METING (MANSA VN-12)

© Ch. van Nieuwenhuizen, A.H. Schene & M.W.J. Koeter (2000).

INSTRUCTIE BIJ HET INVULLEN

Hieronder staan 12 vragen die gaan over uw leven. Graag willen we van u weten hoe tevreden u op dit moment over uw leven bent. U kunt dat aangeven door steeds een kruisje te zetten bij het antwoord dat het beste uw mening weergeeft.

Wilt u, voordat u de vragen beantwoordt, onderstaande gegevens invullen?

Naam: _____

Geboortedatum: - -

Invuldatum: - -

Geslacht: Man Vrouw

1. Kunt u vertellen hoe u op dit moment uw leven als geheel ervaart?

- Kan niet slechter
- Ontevreden
- Meestal ontevreden
- Gemengd (tevreden en ontevreden)
- Meestal tevreden
- Tevreden
- Kan niet beter

2. Geef aan wat voor u van toepassing is:

- Ik heb een betaalde baan (of werk op een sociale werkplaats, of volg onderwijs/opleiding als voornaamste daginvulling). **GA VERDER MET VRAAG 2A.**
- Ik heb geen betaalde baan of ben gepensioneerd. **GA VERDER MET VRAAG 2B.**

2a. Hoe tevreden bent u met het feit dat u een betaalde baan heeft (of op een sociale werkplaats werkt, of onderwijs/opleiding volgt als voornaamste daginvulling)?

- Kan niet slechter
- Ontevreden
- Meestal ontevreden
- Gemengd (tevreden en ontevreden)
- Meestal tevreden
- Tevreden
- Kan niet beter

2b. Hoe tevreden bent u met het feit dat u geen betaalde baan heeft of gepensioneerd bent?

- Kan niet slechter
- Ontevreden
- Meestal ontevreden
- Gemengd (tevreden en ontevreden)
- Meestal tevreden
- Tevreden
- Kan niet beter

3. Hoe tevreden bent u met hoe goed u bij kas zit?
- Kan niet slechter
 - Ontevreden
 - Meestal ontevreden
 - Gemengd (tevreden en ontevreden)
 - Meestal tevreden
 - Tevreden
 - Kan niet beter
4. Hoe tevreden bent u met het aantal en de kwaliteit van uw vriendschappen?
- Kan niet slechter
 - Ontevreden
 - Meestal ontevreden
 - Gemengd (tevreden en ontevreden)
 - Meestal tevreden
 - Tevreden
 - Kan niet beter
5. Hoe tevreden bent u met de dingen die u in uw vrije tijd doet?
- Kan niet slechter
 - Ontevreden
 - Meestal ontevreden
 - Gemengd (tevreden en ontevreden)
 - Meestal tevreden
 - Tevreden
 - Kan niet beter
6. Hoe tevreden bent u met uw woonomstandigheden?
- Kan niet slechter
 - Ontevreden
 - Meestal ontevreden
 - Gemengd (tevreden en ontevreden)
 - Meestal tevreden
 - Tevreden
 - Kan niet beter
7. Hoe tevreden bent u met uw persoonlijke veiligheid?
- Kan niet slechter
 - Ontevreden
 - Meestal ontevreden
 - Gemengd (tevreden en ontevreden)
 - Meestal tevreden
 - Tevreden
 - Kan niet beter
8. Geef aan wat voor u van toepassing is:
- Ik leef samen. **GA VERDER MET VRAAG 8A.**
 - Ik woon alleen. **GA VERDER MET VRAAG 8B.**

8a. Hoe tevreden bent u met de mensen waarmee u samenleeft?

- Kan niet slechter
- Ontevreden
- Meestal ontevreden
- Gemengd (tevreden en ontevreden)
- Meestal tevreden
- Tevreden
- Kan niet beter

8b. Hoe tevreden bent u met het feit dat u alleen woont?

- Kan niet slechter
- Ontevreden
- Meestal ontevreden
- Gemengd (tevreden en ontevreden)
- Meestal tevreden
- Tevreden
- Kan niet beter

9. Hoe tevreden bent u met uw seksuele leven?

- Kan niet slechter
- Ontevreden
- Meestal ontevreden
- Gemengd (tevreden en ontevreden)
- Meestal tevreden
- Tevreden
- Kan niet beter

10. Hoe tevreden bent u met uw relatie met uw familie? (Deze vraag heeft betrekking op familieleden waarmee u niet samenwoont)

- Kan niet slechter
- Ontevreden
- Meestal ontevreden
- Gemengd (tevreden en ontevreden)
- Meestal tevreden
- Tevreden
- Kan niet beter

11. Hoe tevreden bent u met uw lichamelijke gezondheid?

- Kan niet slechter
- Ontevreden
- Meestal ontevreden
- Gemengd (tevreden en ontevreden)
- Meestal tevreden
- Tevreden
- Kan niet beter

12. Hoe tevreden bent u met uw psychische gezondheid?

- Kan niet slechter
- Ontevreden
- Meestal ontevreden
- Gemengd (tevreden en ontevreden)
- Meestal tevreden
- Tevreden
- Kan niet beter

Appendix 4

Dutch version of the Childhood Trauma Questionnaire–Short Form (CTQ–SF)

De onderstaande stellingen gaan over ervaringen gedurende uw kinder- en tienerjaren. Omcirkel steeds het antwoord dat het best bij u past. Hoewel sommige vragen persoonlijk zijn, willen we u toch verzoeken om alle vragen zo eerlijk mogelijk te beantwoorden. Uw antwoorden zullen vertrouwelijk worden behandeld.

	TIJDENS MIJN JEUGD	nooit waar	zelden waar	soms waar	vaak waar	zeer vaak waar
1	had ik niet voldoende te eten	1	2	3	4	5
2	wist ik dat er iemand was om voor me te zorgen en me te beschermen	1	2	3	4	5
3	noemden mensen in mijn gezin mij dingen als “dom”, “lui” of “lelijk”	1	2	3	4	5
4	waren mijn ouders te dronken of stoned (onder invloed van drugs) om voor het gezin te zorgen	1	2	3	4	5
5	was er iemand in mijn gezin die me het gevoel gaf dat ik belangrijk en bijzonder was	1	2	3	4	5
6	moest ik vieze kleren dragen	1	2	3	4	5
7	had ik het gevoel dat er van me gehouden werd	1	2	3	4	5
8	had ik het gevoel dat mijn ouders wensten dat ik nooit geboren was	1	2	3	4	5
9	ben ik door iemand uit mijn gezin zo hard geslagen dat ik naar een dokter of naar het ziekenhuis moest gaan	1	2	3	4	5
10	was er niets dat ik wilde veranderen aan mijn gezin	1	2	3	4	5
11	ben ik zo hard geslagen door mensen in mijn gezin dat ik er blauwe plekken of littekens aan overhield	1	2	3	4	5
12	ben ik gestraft met een riem, een plank, een touw, of een ander hard voorwerp	1	2	3	4	5
13	kwamen mijn gezinsleden voor elkaar op	1	2	3	4	5
14	zeiden mensen in mijn gezin kwetsende of beledigende dingen tegen me	1	2	3	4	5
15	geloof ik lichamelijk mishandeld te zijn geweest	1	2	3	4	5
16	had ik de perfecte jeugd	1	2	3	4	5
17	ben ik zo hard geslagen dat het opgemerkt werd door iemand zoals een leraar, een van de burens, of een dokter	1	2	3	4	5
18	had ik het gevoel dat iemand in mijn gezin me haatte	1	2	3	4	5

19	voelden de leden van mijn gezin zich met elkaar verbonden	1	2	3	4	5
20	probeerde iemand mij op een seksuele manier te betasten, of mij ertoe te brengen hem of haar te betasten	1	2	3	4	5

	TIJDENS MIJN JEUGD	nooit waar	zelden waar	soms waar	vaak waar	zeer vaak waar
21	dreigde iemand me pijn te doen of leugens over me te vertellen als ik niet iets seksueels met hem of haar deed	1	2	3	4	5
22	groeide ik op in het best denkbare gezin	1	2	3	4	5
23	wilde iemand mij seksuele dingen laten doen of naar seksuele dingen laten kijken	1	2	3	4	5
24	ben ik door iemand gemolesteerd	1	2	3	4	5
25	geloof ik emotioneel mishandeld te zijn geweest	1	2	3	4	5
26	was er iemand die me naar de dokter bracht als dat nodig was	1	2	3	4	5
27	geloof ik seksueel misbruikt te zijn geweest	1	2	3	4	5
28	was mijn gezin een bron van kracht en ondersteuning	1	2	3	4	5

Wat is uw leeftijd? jaar

Wat is uw geslacht? M / V

Appendix 5

Exit questionnaire

Exit Vragenlijst Narratieve Exposure Therapie (NET)

Naam deelnemer:

Datum:

Interviewer:

Effect op klachten

1. Heeft u tijdens de weken dat u de therapie had, gemerkt dat het effect had op uw klachten?

.....
.....
.....

2. Heeft de therapie effect gehad op een andere manier (denk aan kwaliteit van leven/gedragsveranderingen)?

.....
.....
.....

3. Waardoor had de therapie effect op uw klachten? (Denk aan: werkzame factoren, zoals meer bewustzijn, meer keuzevrijheid in handelen, betere emotieregulatie, milder naar jezelf en anderen zijn, minder reactief zijn, beter observeren. Bij deze vraag van belang dat het antwoord in een van de genoemde werkzame factoren is in te delen door interviewer; eventueel voorleggen aan deelnemer)

.....
.....
.....

4. Als de therapie geen effect heeft gehad, wat is daarvoor de reden volgens u? (denk aan patiënt factoren, inhoudelijke factoren, organisatorische factoren (afdeling/opzet), therapeutenfactoren)

.....
.....
.....

Verwachtingen

5. Wat verwachtte u vooraf van de therapie?

.....
.....
.....

6. Had u vooraf hoge, gemiddelde of lage verwachtingen van de therapie (Dus: dacht u dat het echt iets voor u was, had u niet zulke hoge verwachtingen, of had u van te voren al twijfels over deelname)?

.....
.....

Inhoud therapie

7. Wat vond u goed aan de therapie?

.....
.....
.....

8. Wat vond u niet goed aan de therapie (Denk aan inhoudelijke factoren, organisatorische factoren (afdeling/opzet), therapeutenfactoren)?

.....
.....
.....

Overige vragen

9. Heeft u hierna nog verdere behandeling nodig? Zo ja: meer NET of een ander soort behandeling?

.....
.....

10. Heeft u nog opmerkingen, vragen of suggesties?

.....
.....
.....

Hartelijk dank voor uw tijd en aandacht.