Summary and general discussion

1. Summary of main findings

This section summarizes the main findings per chapter. The overall objective of this thesis was to study the relationship between trauma-related disorders, dissociative disorders, and personality disorders in survivors of early childhood trauma and emotional neglect. The second aim of this thesis was to contribute to the research on the relationship between trauma-related, dissociative, and personality disorders by attempting to add quantitative data to Draijer's (2003) two dimensional model of the spectrum of trauma-related disorders, dissociative disorders, and personality disorders. The first dimension of Draijer's model, situated on the y-axis, consists of the reported severity of the trauma endured. This severity fluctuates, depending on such factors as the age at which the trauma occurred, how much force was used, how frequently it occurred, and the relationship to the perpetrator. This dimension is thought of as being related primarily to trauma-related disorders. The second dimension, situated on the x-axis, consists of the severity of emotional neglect. This dimension is thought of as being related primarily to personality pathology.

In **Chapter two**, we gave a theoretical outline of the scientific history of research on early childhood trauma, emotional neglect, trauma-related disorders, dissociative disorders, and personality disorders. We conclude that the relationship between trauma-related disorders, personality disorders, and early childhood trauma and emotional neglect is far from clear and that more research on how the relationship between these disorders must be understood is needed. In the absence of such knowledge, especially survivors of early childhood trauma and emotional neglect with severe personality pathology run the risk of being 'left out' when it comes to specialized treatment. Therefore, in **Chapter three**, we tested the usefulness of the diffuse process that characterizes clinical decision making in the context of established, diagnostic driven treatment programs by investigating the similarities

and differences in symptomatology and reported histories of childhood trauma and emotional neglect between two naturalistic patient groups in a specialized mental health care setting. The first group consisted of patients being referred to a trauma-related disorders treatment program, aimed specifically at survivors of early childhood trauma, the second group consisted of patients being referred to a personality disorders treatment program.

High rates of severe childhood trauma were reported in both groups: for patients in the trauma program this was an expected finding, however, also in the personality disorders treatment program more than half of the patients reported severe childhood trauma. Patients in both groups characterized their primary caregiver's style of parenting as 'affectionless control'. After controlling for socio-demographic variables, reports of trauma and neglect, and personality pathology, the differences between both groups in rates of trauma-related disorders no longer maintained significant. Considering rates of personality disorders in both groups we found a similar picture, indicating that the presence of a (specific) PD does not distinguish between patients in both treatment programs, except for the presence of borderline personality disorder (BPD). In conclusion, our results indicate that in a naturalistic clinical setting, patients referred to a trauma program and patients referred to a personality disorders treatment program are in fact highly similar in terms of their clinical profile.

In **Chapter four**, we quantified the y-axis, or the trauma axis, of the model. A 'trauma-diagnosis severity index' for trauma-related and dissociative disorders was created, ranging from none, (chronic) posttraumatic stress disorder (PTSD), complex PTSD to dissociative disorder not otherwise specified, and finally dissociative identity disorder. Also a sum score of aversive childhood experiences was constructed to create a trauma severity scale. The observed correlation (r_s = .54) between reported trauma severity and severity of trauma-related and dissociative disorders indicates that retrospectively reported trauma severity in child- and adulthood is strongly associated with more severe pathology. The

findings support the existence of the y-axis of the two dimensional model of the impact of early childhood trauma and emotional neglect, which presumes a relationship between a dimension of trauma-related and dissociative disorders on the one hand and differences in the severity of the trauma endured at the other.

In **Chapter five**, we quantified the x-axis of the model, investigating whether an association between retrospective reports of emotional neglect and the presence and severity of personality pathology exists. The results indicate that there is little evidence to support a link between emotional neglect and problematic personality functioning at the disorder level, but that there might be a link between emotional neglect and problematic personality functioning in a dimensional way. Findings indicate a relationship between lack of parental warmth and problematic personality functioning. The findings support the existence of the emotional neglect-axis of the two dimensional model of the impact of early childhood trauma and emotional neglect in a dimensional framework of viewing personality pathology.

In **Chapter six**, the two dimensional model of the impact of early childhood trauma and emotional neglect as a whole was quantified, relating the model to 'psychiatric disease burden' (using cluster analysis to discriminate patients in terms of psychiatric disease burden based on symptom severity scores, type of disorder, and level of maladaptive personality functioning), hypothesizing that patients with low burden are located in the south-west corner of the model, while patients with high burden are located in the north-east corner of the model. We mapped the clusters that differed in psychiatric disease burden in the trauma-neglect space and evaluated their position. We found three clusters and labelled them as the 'mildly impaired cluster' (26% of patients), 'moderately impaired cluster' (43% of patients), and 'severely impaired cluster' (31% of patients). Patients who report a range of traumatic experiences in combination with a lack of maternal care can be profiled as 'severely impaired', suffering from a wide range of trauma-related, dissociative, and personality

disorders, combined with a high level of psychiatric symptoms and a maladaptive style of personality functioning. These results support the validity of the model, which may be used to differentiate among treatment-seeking early traumatized and emotionally neglected patients.

2. Discussion of main findings

In this section the main findings are discussed and clinical implications are addressed, along with methodological considerations and recommendations for future research.

2.1 Survivors of early childhood trauma and emotional neglect: who are they and what's their diagnosis?

The current thesis shows that patients who report a range of traumatic experiences in combination with of a lack of care by their mother can be profiled as suffering from a wide range of trauma-related, dissociative, and personality disorders, combined with a high level of psychiatric symptoms (for example anxiety and depression), and a maladaptive style of personality functioning (considering for example problems in the capacity to tolerate, use, and control one's own emotions and impulses, the ability to see oneself and one's own life as stable, integrated and purposive, and the capacity to genuinely care about others as well as feeling cared about them). This leads us to a similar conclusion as Ross et al. (2014), namely that the patients' clinical profile might be best understood as part of an overall response to severe childhood trauma and neglect, and challenges the usefulness of categorizing these patients in terms of diagnostic constructs, especially in daily clinical practice.

2.2 Clinical implications

During the course of the research project, from 2011 until 2017, 6 of the 150 patients in our sample died. Three patients committed suicide, two were euthanized. One patient's

cause of death remained inconclusive, since the family refused autopsy. The youngest deceased patient was 20 years old, the oldest 38 years old. All cases concerned female patients who were diagnosed with both (one or more) trauma-related and personality disorders. Half of them were also diagnosed with a dissociative disorder. The fact that in a time frame of 6 years 4 percent of the patients in our sample died as a result of their mental illness presses the lethality of being exposed to early childhood trauma and emotional neglect and the need to provide survivors with adequate care.

The most important implication of our research is that it does not seem of use to divide survivors of early childhood trauma and emotional neglect into different diagnostic classes. This usually leads to fragmentation of treatment options and tunnel vision. As science practitioners, we see a lot of therapists only wanting or being pressed to treat part of the pathology ("we treat trauma in this department and I will refer patient A. to the personality disorders department after I've finished my treatment"), being facilitated by organizations and insurance companies who boost short treatment cycles. This style of compartmentalizing treatment is especially unwanted and perhaps dangerous for survivors of early childhood trauma and emotional neglect.

Survivors of early childhood trauma and emotional neglect share a common ground in suffering from longstanding disturbances in self-concept and relational capacities. Whether we call it a lack of mentalizing ability, structural dissociation, a lack of compassion for the self, a schema of mistrust, abandonment or emotional deprivation, a phobic reaction, problems in emotion regulation, or an attachment disorder: it is always important to keep in mind that the pathology is complex and that multiple DSM-5 classifications apply (our research demonstrates again that this is the rule instead of the exception). This also means that multiple treatment options apply. In general, this is positive, since multiple successful treatments have been developed for both trauma-related disorders, dissociative disorders, as

well as personality disorders throughout the last decades (see for example Bateman & Fonagy, 2016; Herman, 2001; Linehan, 2015; Shapiro, 2001; Van der Hart, Nijenhuis, & Steele, 2006; Young, Klosko, & Weishaar, 2003). Most of these treatments have not only proven to be effective, they are also developed by gifted scientists/therapists, with a good eye for the targeted pathology.

However, until now no treatment fully serves the needs of those patients who grew up under extreme (mostly unseen, because taking place in the privacy of the home) circumstances during the crucial formative years. A mixture of therapeutic inventions, preferably both trauma and person oriented, would be recommendable for this group. It is this mixture however that is so hard to achieve in current health care facilities. The multitude of treatment options leads to rapid referral practices and a blurring of proper staging of therapy, since no therapist is responsible for 'the whole picture'.

Our research project aimed at offering an alternative model of viewing the pathology of survivors of early childhood trauma and emotional neglect in a dimensional way and advocates treatments that offer both a trauma-oriented as well as a person-oriented approach, offered by the same therapist or the same multidisciplinary treatment team/department. Considering the attachment problems of survivors of early childhood trauma and emotional neglect it is not wise and probably counterproductive or harmful to aim at short treatment interventions with different therapists. In all cases, the main therapist needs to be an attachment figure and therefore needs to be involved with the patient for quite some time. This does not mean that other therapists cannot fulfill a short crucial role during the course of treatment, but switching therapists in going from one department to the next seems to be counterproductive (being in-between therapies is also a known suicide risk).

2.3 Methodological considerations

Besides the methodological considerations and limitations concerning the individual studies of this thesis (described in the individual chapters) there are some general methodological points that deserve further attention.

Our sample consisted of treatment seeking individuals in a naturalistic setting, namely a specialized mental health care setting in the north of The Netherlands. The sample consisted of both outpatients, inpatients and patients in intensive outpatient care, leading to a sample of quite severely impaired patients (with, for example, an unemployment rate of 74%). We believe that the fact that we were able to assess this sample systematically and extensively (using five structured interviews and eight questionnaires, leading up to six to eight hours of administration time per patient) is an important strength of our study, making it of interest not only to researchers, but also to front-line clinicians. An important limitation of our study is that due to the fact that it was conducted in a naturalistic setting, interviewers were not blind to which treatment program (a trauma treatment program or a personality disorders treatment program) the patient was referred.

2.4 Recommendations for future research

In this thesis the relationship between trauma-related disorders, dissociative disorders, and personality disorders in survivors of early childhood trauma and emotional neglect was examined cross-sectionally, with retrospective reports of early childhood trauma and emotional neglect. To derive more insight into the course of this relationship, a longitudinal study should be preferable or in future research retrospective reports of trauma and neglect should be corroborated with for example reports from protective youth services.

In future research we will address the predictive value of the two dimensional model of the spectrum of trauma-related disorders, dissociative disorders, and personality disorders considering course of pathology and treatment success (Swart et al., 2017).

References

Bateman, A. & Fonagy, P. (2016). *Mentalization-based treatment for personality disorders: a practical guide.* Oxford: Oxford University Press.

Draijer, N. (2003). Diagnostiek en indicatiestelling bij (een vermoeden van) seksueel misbruik in de voorgeschiedenis. In N. Nicolai (Ed.), *Handboek psychotherapie na seksueel misbruik* (pp. 21-47). Utrecht: De Tijdstroom.

Herman, J.L. (2001). *Trauma and recovery.* London: Pandora.

Linehan, M.M. (2015). *Dialectical behavior therapy skills training manual.* New York: The Guilford Press.

Ross, C.A., Ferrell, L., & Schroeder, E. (2014). Co-Occurrence of Dissociative Identity Disorder and Borderline Personality Disorder. *Journal of Trauma & Dissociation, 15,* 79-90. doi: 10.1080/15299732.2013.834861

Shapiro, F. (2001). *Eye movement desensitization and reprocessing: basic principles, protocols, and procedures.* New York: The Guilford Press.

Swart, S., Wildschut, M., Draijer, N., Langeland, W., & Smit, J.H. (2017). The clinical course of trauma-related disorders and personality disorders: study protocol of two-year follow-up based on structured interviews. *BMC Psychiatry, 17,* 173. doi: 10.1186/s12888-017-1339-6

Van der Hart, O., Nijenhuis, E.R.S., & Steele, K. (2006). *The Haunted Self. Structural Dissociation and the Treatment of Chronic Traumatization.* New York: W.W. Norton & Company.

Young, J.E., Klosko, J.S., & Weishaar, M.E. (2003). *Schema therapy: a practitioner's guide.* New York: The Guilford Press.