Evaluation of an Outpatient Intervention for Women With Severe Depression and a History of Childhood Trauma

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Objective: **The study examined the effectiveness of a three-month structured outpatient intervention developed for women with severe depression and childhood trauma that used brief psychodynamic psychotherapy by comparing it to standard treatment recommended in clinical guidelines issued by the Chilean Ministry of Health.** ***Methods:*** **Eighty-seven women who sought treatment from a public health service in Curicó, Chile, and who had severe depression and a history of childhood traumatic experiences were randomly assigned to receive either the intervention (N=44) or standard treatment (N=43). The participants were assessed at baseline and at three months (completion of the intervention) and six months with use of the Hamilton Depression Scale (Ham-D); Lambert's Outcome Questionnaire (OQ-45.2), which rates psychiatric symptoms, interpersonal relationships, and social role functioning; and the Post-traumatic Stress Treatment Outcome scale, which assesses symptoms of posttraumatic stress disorder. An intent-to-treat design was used with multiple analyses of variance.** ***Results:*** **At three months significant differences were found in favor of the intervention group in Ham-D scores ($p<.01$) and OQ-45.2 scores ($p<.05$). At six months a significantly greater proportion of the intervention group had indicators of remission as measured by the OQ-45.2 (39% versus 14%, $p<.05$) and by the Ham-D (22% versus 5%, $p<.05$).** ***Conclusions:*** **An outpatient intervention that screened for and focused on childhood traumas and that helped patients understand current psychosocial difficulties as a repetition of past traumas was effective in reducing psychiatric symptoms and improving interpersonal relationships and social role functioning among women with severe depression and a history of childhood trauma. (*Psychiatric Services* 60:XXXX, 2009)**

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Depression is a significant public health problem. It affects twice as many females as males (1,2). Risk factors involved in its development and clinical course include a history of childhood physical and sexual abuse (3,4). Patients with an abuse history often present with a severe and complex psychopathology, including posttraumatic stress disorder (PTSD), chronic symptoms of anxiety and depression, impulsiveness, and interpersonal difficulties (5–8).

The complex clinical picture observed among adults who have a history of childhood trauma has been explained as a process of neurobiological and psychological vulnerability (9). It has been argued that traumatic events should be taken into account in the treatment of these patients (10). However, early trauma and its consequences are not always addressed when patients consult health services (11). Therefore, it is important to develop effective treatments and evaluate their impact (12).

In the United States and Canada, several treatments have been developed to deal with the consequences of early trauma (12–16). The clearest empirical evidence of effectiveness in treating the symptoms associated with PTSD has been found for the cognitive-behavioral approach (17,18). This approach has also been shown to be effective in treating women with alcohol dependence and PTSD (19) and in treating depressive symptoms

among adults with a primary diagnosis of PTSD (20).

A U.S. multicenter study of patients with depression showed that those with early trauma responded better to cognitive-behavioral-analytic therapy than to pharmacotherapy (21). However, the study did not consider the impact of this therapy on other consequences among adults of childhood trauma (22).

The efficacy of a cognitive-behavioral orientation in addressing psychosocial difficulties among persons with complex symptoms resulting from childhood trauma has not yet been demonstrated (23). In addition, the effectiveness of a psychodynamic orientation in the treatment of these individuals has not been empirically validated (24).

In Chile depression is the second-highest contributor to disability-adjusted life years among women (25). Findings of Chilean national epidemiological studies have confirmed those of international studies with respect to the relationship between early trauma and affective disorders (26–28). However, standardized programs in Chile for the treatment of depression do not include routine screening for traumatic childhood experiences and analysis of their consequences (29).

In 2002 at Curicó Hospital, located 180 km south of Santiago, we found a prevalence rate of childhood sexual abuse of 42% among patients with chronic depression (30). A majority of cases featured important psychosocial factors that had not been considered in the patients' treatment (31). In view of such evidence, we developed an intervention for this patient group. In addition to standard pharmacological treatment, the model incorporated a three-month structured intervention by a multidisciplinary team. Its objectives were to actively explore early traumatic experiences among women with depression and to focus treatment on interpersonal difficulties with use of a psychodynamic orientation (32).

The objective of the study was to compare the efficacy of this intervention and a standard intervention recommended in clinical guidelines issued by the Chilean Department of Health for women with severe depression and childhood trauma.

Methods

Sample and procedures

The study was approved by the hospital's Ethics Committee and was authorized by the Committee of Ethics of the Health Service of Maule. Between April and August of 2006, all women over 20 years of age were given a diagnosis of severe depression in a primary care clinic or other health service were sent by the clinic or service to the Curicó Hospital for an outpatient evaluation (N=154). They were randomly assigned to one of three senior psychiatrists. Each psychiatrist had experience in diagnosing and treating affective disorders and worked in the mental health unit of the hospital. One of the psychiatrists was a member of the team providing the intervention.

During an initial psychiatric interview the psychiatrist assessed the severity of depression according to *ICD-10* (33). Interpersonal difficulties were also assessed. The need for pharmacological treatment was determined in accordance with the practice guidelines established by the Chilean Ministry of Health (29). The guidelines offer algorithms about prescription of antidepressants (fluoxetine, sertraline, paroxetine, and venlafaxine), mood stabilizers (lithium, valproate, and lamotrigine), and second-generation antipsychotics (risperidone, olanzapine, and quetiapine).

Intervention

Patients with severe depression according to *ICD-10* were referred to a clinical psychologist, who inquired in a climate of safety and confidence about whether they needed to speak about their history and link past traumatic experiences to present interpersonal difficulties. A total of 136 patients agreed to be evaluated by the psychologist, who administered the Hamilton Depression Scale (Ham-D) (34) and the screening scale for early trauma developed by Marshall and colleagues (35) and validated in Chile by one of the authors (36). This scale asks whether an individual has memories of having one or more of the following traumatic experiences before the age of 15: traumatic separation from a parent or caregiver, alcohol or drug abuse of a family member, physical injury associated with punishment, and forced sexual contact with a relative or a nonrelative.

Two trained psychology students who were blind to the results of the trauma screening scale administered the section of the Composite International Diagnostic Interview that is used to determine an *ICD-10* diagnosis of posttraumatic stress (37). Patients who met *ICD-10* diagnostic criteria for severe depression were invited to participate in the study. Criteria for exclusion included organic symptoms, hypoacusia (hearing loss), current substance abuse, psychosis, and receipt of psychiatric treatment in the year before study intake. Patients with an Ham-D score of 21 points and three or more positive answers on the Marshall scale were admitted to the study after providing written informed consent (N=87). They were randomly assigned either to the intervention (N=44) or to standard treatment (N=43).

Each patient assigned to the intervention was asked to meet with a multidisciplinary team, which used a psychodynamic orientation (24,37) to determine whether the patient had experienced as an adult an established pattern of mistreatment and aggression. Such a pattern was seen as a repetition of childhood traumatic experiences. After the initial meeting with the team, the patient met for a weekly session with one of the team members for a psychological intervention that focused on developing a cognitive understanding of personal characteristics and behaviors that allowed the repetition of traumatic experiences in the present. Behavioral changes that would alter the relationship between the victim and aggressor were addressed. Sexual trauma was validated as a real experience, and recollected memories were not challenged. Instead, the focus was on changing feelings of guilt and shame that could trigger new situations of abuse.

The psychiatrist conducted a monthly checkup that incorporated psychoeducational elements and monitored symptom change, adherence to pharmacological treatment, and the presence of self-destructive

behaviors. The psychiatrist told the patient that these behaviors were a repetition of past mistreatment in the present. The multidisciplinary team met weekly with the therapist to address possible transference or countertransference. The social worker made home visits or telephone calls as needed. At any stage patients who did not want to talk about their traumatic experiences could choose to continue standard treatment with the same team.

Standard treatment

Standard treatment followed the recommendations in clinical guidelines issued by the Chilean Ministry of Health. Psychotherapy was supportive and was provided by a psychologist according to the patient's needs. The therapy was not routinely focused on traumatic experiences and their consequences. Team meetings were held only in more severe cases. Home visits by a social worker were performed when the team requested them.

Monitoring

An evaluation team not associated with the study assessed all participants at the beginning of the study, at three months (either after the intervention ended or after three months of standard treatment), and at six months. A clinical psychologist on the external team administered the Ham-D at each evaluation. Psychology students, blind to treatment assignment and Ham-D scores, administered Lambert's Outcome Questionnaire (OQ-45.2) (39) and the Post-traumatic Stress Treatment Outcome scale (PTO 8) (40). The OQ-45.2 can be completed by the patient or administered by another person. It consists of 45 items divided into five categories. The items assess the patient's state in three areas: symptoms, interpersonal relationships, and social role functioning. The established cutoff score for the Chilean population is 73 (41), with higher scores representing a dysfunctional population. The PTO 8 is an eight-item scale used to assess the results of PTSD treatment. The items focus on the three symptom criteria for a *DSM-IV* diagnosis of PTSD. A cutoff score of 12 or higher indicates the presence of PTSD (42).

Adherence to treatment and attrition

There was some early attrition from the intervention group. Of the 44 patients in the group, four dropped out shortly after the baseline interview with the psychiatrist and could not be located. One patient who did not want to talk about her traumatic experiences dropped out after the baseline interview with the psychologist. Thus a total of 39 patients remained in the intervention group at the end of the first month. In the subsequent months two patients dropped out of the intervention group because they moved out of the city and four dropped out when they felt better. No statistically significant differences were found in sociodemographic characteristics and baseline test scores between those who dropped out of the intervention group and those who remained. The 44 patients assigned to the experimental group were included in the intent-to-treat analysis.

After the baseline interview with the psychologist, only one patient in the intervention group continued medication treatment solely for depression. After the baseline interview with the multidisciplinary team, two additional patients in the intervention group continued medication treatment solely for depression. All other patients in the group were taking at least one additional type of medication and attending weekly therapy. At the end of the first month, all 39 patients in the intervention group were adherent to pharmacotherapy. At the three-month assessment, 30 patients in this group were adherent, and at the six-month assessment 26 of these patients were adherent.

There was also some attrition in the control group. Of the 43 patients in the control group, three discontinued treatment after the first interview. During the first month four patients dropped out of treatment for unknown reasons, six patients continued only pharmacological treatment, seven attended only one therapy session and continued pharmacological treatment, and the rest received at the same time pharmacological treatment and supportive psychotherapy

Analyses

The primary outcomes of interest were a reduction in depressive symptoms as measured by the Ham-D and improved total score on the OQ-45.2. Data were analyzed with SPSS version 12.0. The intent-to-treat analysis used the averages of each group with multiple analyses of variance (MANOVAs). Between-group differences were assessed with Student's t test (significance level of .05). Seventy-nine participants (91%) were evaluated by the external team at three months (39 in the intervention group and 40 in the control group). At six months 71 (81%) were evaluated (36 in the intervention group and 35 in the control group).

A second analysis considered remission as a total OQ-45.2 score below 73 and improvement as a decrease in total score of 17 points from the baseline score. A Ham-D score below 8 was considered to indicate remission, and improvement was a decrease of at least 50% from the baseline score. For the PTO 8, patients with a baseline score over 12 points were considered to have improved when their score decreased by at least 40% since baseline; patients were considered to b in remission when PTO 8 scores at the two follow-up assessments were below 7 points (39).

Results

Table 1 presents baseline data for the two groups. No statistically significant differences were found in sociodemographic characteristics, presence of childhood trauma, and mean test scores. The prevalence of PTSD did not differ between groups.

During the six months of follow-up, seven patients in the intervention group (16%) were hospitalized for a mean±SD of 6.0±5.0 days and six patients in the control group (14%) were hospitalized for a mean of 21.3±8.2 days. The mean number of visits with a psychiatrist during the six-month period was 7.0±3.7 for the intervention group and 2.5±2.0 for the control group. The mean number of visits with a psychologist over six months was 5.7±3.8 for the intervention group and 4.5±4.9 for the control group. Over the study period no serious suicide attempts were

Table 1

Baseline characteristics of women with severe depression and a history of childhood trauma, by treatment group[a]

Characteristics	Intervention (N=44)		Standard treatment (N=43)	
	N	%	N	%
Age (M±SD)	36.68±10.75		41.09±11.80	
Education				
Completed elementary school	23	52	22	51
Completed high school	18	41	19	44
Completed technical school	3	7	2	5
Marital status				
Single	3	7	7	16
Separated	7	16	8	18
Married	19	43	19	44
Widowed	3	7	1	1
Living with a partner	12	27	8	21
Occupation				
Homemaker	21	48	24	56
Employed	20	46	15	35
Unemployed	2	5	3	7
Student	1	2	1	2
Hamilton Depression Scale (M±SD score)[b]	34.79±6.3		34.55±6.24	
Lambert's OQ-45.2 (M±SD score)[c]				
Total[d]	112.57±20.39		117.50±19.68	
Psychiatric symptoms[e]	70.55±12.18		75.62±11.85	
Interpersonal relationships[f]	24.71±6.42		23.45±6.77	
Social role[g]	17.52±5.96		18.58±6.18	
PTO 8 (M±SD score)[h]	16.50±8.22		19.50±7.93	
Marshall screen for childhood trauma (M±SD positive answers)[i]	4.19±1.34		4.14±1.35	
Childhood sexual abuse				
With a nonrelative	10	23	18	42
With a relative	19	43	22	53
Previous diagnosis of depression	38	86	36	84
Previous treatment for depression	19	43	21	49
Previous diagnosis of treatment-refractory depression	13	30	19	45
Past suicide attempt	27	61	18	42
Current diagnosis of posttraumatic stress disorder[j]	29	55	22	51

[a] No significant differences were found between groups for any variable.
[b] Possible scores range from 0 to 63 points, with higher scores indicating greater severity of depression.
[c] Lambert's Outcome Questionnaire
[d] Possible scores range from 0 to 180 points, with higher scores indicating worse functioning.
[e] Possible scores range from 0 to 100, points with higher scores indicating greater severity of symptoms.
[f] Possible scores range from 0 to 44, with higher scores indicating worse functioning.
[g] Possible scores range from 0 to 36, with higher scores indicating worse functioning.
[h] Post-traumatic Stress Treatment Outcome scale. Possible scores range from 0 to 32, with higher scores indicating greater severity of symptoms.
[i] The possible number of answers is 7, with a greater number of positive answers indicating multiple child traumas.
[j] The diagnosis was based on *ICD-10* criteria.

made by participants in either group.

Table 2 shows the mean scores at baseline and the two follow-up assessments. At three months significant differences were observed in favor of the intervention group in Ham-D scores (t=2.69, df=85, p<.01) and in the OQ-45.2 total score (t=1.98, df=85, p<.05). At six months MANOVA results indicated that total Ham-D scores improved significantly in the intervention group (Pillai's trace=.49, F=38.85, df=2 and 42, p<.01) as well as in the control group (Pillai's trace=.51, F=21.39, df=2 and 41, p<.01). The Ham-D scores indicated significantly greater improvement for those in the intervention group (t=2.41, df=85, p<.01).

Total scores on the OQ-45.2 also indicated improvement at six months for the intervention group (Pillai's trace=.42, F=18.60, df=2 and 42, p<.001) and the control group (Pillai's trace=.21, F=5.70, df=2 and 41, p<.01), with a significant difference in favor of the intervention group (t=2.16, df= 85, p<.05).

The OQ-45.2 scores for interpersonal relationships and social role functioning showed significant improvement at six months only for the intervention group (for interpersonal relationships, Pillai's trace=.37, F=12.71, df=2 and 42, p<.01; for social role, Pillai's trace=.32, F=9.99, df=2 and 42, p<.01). The between-group differences in scores at six months favored the intervention group only in the area of social role functioning (t=1.97, df=85, p<.05).

Scores on the PTO 8 indicated significant improvements in PTSD symptoms at six months for the intervention group (Pillai's trace=.36, F=11.82, df=2 and 42, p<.01) and the control group (Pillai's trace=.33, F=10.38, df=2 and 41, p<.01), with no significant differences between the groups (p=.058).

The number of patients who met criteria for remission and improvement on the basis of OQ-45.2, Ham-D, and PTO 8 scores is shown in Table 3. At six months a significantly greater proportion of patients in the intervention group met criteria for remission as measured by the OQ-45.2 (39%, compared with 14% for the control group, χ^2=5.48, df=1, p<.05) and the Ham-D (22%, compared with 5% for the control group χ^2= 3.99, df=1, p<.05).

Discussion

This study found that an outpatient intervention developed for depressed women with a history of childhood abuse that used brief psychodynamic psychotherapy was more effective than standard treatment in improving depressive symptoms, interpersonal relationships, and social role functioning. We think that the improved response to treatment is a product not only of the structured nature of the

Table 2

Scores at baseline and two follow-up assessments of women with severe depression and a history of childhood trauma, by treatment group

Instrument and treatment group	Baseline		3 months		6 months	
	M	SD	M	SD	M	SD
Hamilton Depression Rating Scale[a]						
Intervention	34.09	6.22	22.09	8.86	19.39	10.58
Standard treatment	34.42	6.69	27.47	9.69	25.02	11.14
Lambert's OQ-45.2[b]						
Total score[c]						
Intervention	112.73	19.76	92.70	28.26	85.84	37.57
Standard treatment	114.72	22.52	105.35	31.06	102.02	31.75
Psychiatric symptoms[d]						
Intervention	71.07	12.27	59.09	18.35	53.48	22.87
Standard treatment	73.37	13.66	65.60	17.05	63.44	18.90
Interpersonal relationships[e]						
Intervention	24.48	6.58	19.09	7.73	18.75	10.26
Standard treatment	23.12	6.94	22.60	11.12	21.67	8.73
Social role[f]						
Intervention	17.39	5.48	14.52	6.79	13.59	8.22
Standard treatment	18.33	6.73	17.14	7.95	16.86	7.13
PTO 8[g]						
Intervention	16.59	7.58	12.64	7.85	11.75	7.89
Standard treatment	19.16	8.40	14.98	8.07	15.00	7.84

[a] Possible scores range from 0 to 63 points, with higher scores indicating greater severity of depression. Significant between-group difference in favor of intervention group at both three months ($p<.05$) and six months ($p<.01$)

[b] Lambert's Outcome Questionnaire

[c] Possible scores range from 0 to 180 points, with higher scores indicating worse functioning. Significant between-group difference in favor of the intervention group at six months ($p<.05$)

[d] Possible scores range from 0 to 100, points with higher scores indicating greater severity of symptoms. Significant between-group difference in favor to intervention group at six months ($p<.05$)

[e] Possible scores range from 0 to 44, with higher scores indicating worse functioning.

[f] Possible scores range from 0 to 36, with higher scores indicating worse functioning. Significant between-group difference in favor of the intervention group at six months ($p<.05$)

[g] Post-traumatic Stress Treatment Outcome scale. Possible scores range from 0 to 32, with higher scores indicating greater severity of symptoms.

intervention but also of its psychotherapeutic orientation. Both the intervention and standard treatment view the symptoms and behaviors of these patients as resulting from a history of abuse and that patients can relive traumatic interpersonal experiences in the present (43,44) and experience retraumatization, even in a therapist-patient relationship (45).

The study sought to demonstrate the importance of a multidisciplinary approach to treatment, in terms of providing patients with structured treatment and emotional healing and proving therapists with support and help in managing transference and countertransference problems (46). These aspects of treatment are not included in standard guidelines in Chile for the treatment severe depression (29).

We also found that an approach that actively screened for and focused on childhood traumas and explored their connections with present psychosocial difficulties resulted in patients' improved understanding of current conflicts. This strategy was effective in improving interpersonal relationships and social role functioning in the intervention group. The results also suggest that therapeutic work on interpersonal problems effectively augments the use of antidepressants to treat depressive symptoms but not posttraumatic symptoms.

Symptoms of posttraumatic stress improved in both groups over six months, with no significant between-group difference. The improvements improvement may have resulted from pharmacological treatment alone, because the medications used by patients in this study have been shown to be effective not only for depression but also for PTSD (47). The steady downward trend over six months in PTO 8 scores for the intervention group, compared with the apparent leveling off of scores for the control group, may mean that PTSD symptoms would have improved significantly for the intervention group if a longer period of observation had been used. In light of these results, we believe that the impact of this intervention on PTSD symptoms requires further investigation and that the intervention should be compared with the cognitive-behavioral treatments.

Even though the treatment provided in the intervention was more effective than standard treatment, 61% of patients in the intervention group showed no or minimal clinical improvement. This might be explained by the brevity of the intervention and the relatively short observation period. These findings are in accordance with those of studies showing that depression treatments have little effectiveness when the primary outcome considered is remission of depressive symptoms (45). A lack of remission is

Table 3

Patients who met criteria for improvement and remission at two follow-up assessments among women with severe depression and a history of childhood trauma, by treatment group

Instrument and follow-up	Intervention		Standard treatment	
	N	%	N	%
Lambert's OQ-45.2[a]				
Improvement				
3 months	10	26	6	15
6 months	9	25	12	34
Remission				
3 months	12	30	8	20
6 months[b]	14	39	5	14
Hamilton Depression Rating Scale[c]				
Improvement				
3 months	13	33	6	15
6 months	17	47	11	31
Remission				
3 months	2	5	1	2
6 months[b]	8	22	2	5
PTO 8[d]				
Improvement				
3 months	11	32	10	29
6 months	10	29	6	17
Remission				
3 months	3	8	2	6
6 months	5	14	3	8

[a] Lambert's Outcome Questionnaire. Improvement was a decrease in total score of 17 points over the baseline score. Remission was a total score below 73.

[b] $p<.05$ for the difference between groups

[c] Improvement was a decrease of at least 50% from the baseline score. Remission was a score below 8.

[d] Post-traumatic Stress Treatment Outcome scale. For patients with a baseline score over 12, improvement was a decrease in score of at least 40% over baseline, and remission was a score below 7.

associated with the chronicity of depressive pathology and comorbid PTSD (49). In our sample 53% of the patients had a diagnosis of PTSD according to the *ICD-10* (33). Poor response to brief treatments among individuals with childhood trauma was also observed by van der Kolk and colleagues (48) in an evaluation of the effectiveness of eye movement desensitization and reprocessing for adults with PTSD and childhood trauma (50).

The principal strength of this study is its external validity. The intervention was developed with existing professional resources under normal working conditions in a public health service in a developing country. The exclusion criteria for sample selection were minimal. Patients in the sample were those who are encountered in routine treatment settings who have severe chronic symptoms and a risk of suicide. Many of them had been routinely excluded from studies conducted by the academic center. The intervention emphasized outpatient management. In contrast to the study by Stalker and colleagues (16), our study found no exacerbation of symptoms after the intervention ended. Another methodological strength of this study was its evaluation of various patient outcomes, including psychosocial outcomes, its use of instruments validated for the Chilean population, and its use of intent-to-treat analysis.

Among the limitations of the study was the lack of structured treatment for the control group, which made it difficult to identify components of the intervention that accounted for its relative effectiveness. In addition, although the Ham-D was administered by an evaluation team not associated with the study, the psychologist who administered it was not blind to the type of intervention to which the patient was assigned. Both of these limitations should be addressed in future investigations to improve the internal validity of the results.

Conclusions

A brief intervention developed for severely depressed women with a history of childhood trauma and delivered in an outpatient setting with the usual resources available at a public hospital was more effective than standard treatment. The intervention actively screens for patients' experiences of childhood trauma and focuses on these experiences and patients' current interpersonal difficulties, with the understanding that current difficulties may be repetitions of past traumatic situations. It is important to continue to develop, implement, and validate interventions for this patient subgroup that can be delivered in public health settings.

Acknowledgments and disclosures

This study was supported by grant Sa05i20037 from the Fondo Nacional de Investigación y Desarrollo en Salud of Chile. Additional financial support was provided by Curicó Hospital. The authors thank Ignacio L. Iturria, M.A., and Carolina R. Nuñez, M.A.

The authors report no competing interests.

References

1. Vicente B, Rioseco P, Saldivia S, et al: Chilean study of the prevalence of psychiatric disorders (DSM-III-R/CIDI)(ECPP) [in Spanish]. Revista Médica Chile 130:527–536, 2002.
2. Araya R, Rojas G, Fritsch R, et al: Common mental disorders in Santiago, Chile: prevalence and sociodemographic correlates. British Journal of Psychiatry 178:228–233, 2001
3. Kendler K, Kuhn J, Prescott C: Childhood sexual abuse, stressful life events and risk for mayor depression in women. Psychological Medicine 36:147–182, 2004
4. Weiss L, Longhurst J, Mazure C: Childhood sexual abuse as a risk factor for depression in women: psychosocial and neurobiological correlates. American Journal of Psychiatry 156:816–828, 1999
5. Oquendo M, Brent D, Birmaher B, et al: Posttraumatic stress disorder comorbid with major depression: factors mediating association with suicidal behavior. American Journal of Psychiatry 162:560–566, 2005
6. Gladstone G, Parker G, Mitchell P, et al: Implications of childhood trauma for depressed women: an analysis of pathways from childhood sexual abuse to deliberate self harm and revictimization. American Journal of Psychiatry 161:1417–1425, 2004

7. Holtzheimer P, Russo J, Zatzick D, et al: The impact of comorbid posttraumatic stress disorder on short-term clinical outcome in hospitalized patients with depression. American Journal of Psychiatry 162:970–976, 2005

8. Roth S, Newman E, Pelcovitz D, et al: Complex PTSD in victims exposed to sexual and physical abuse: results from DSM-IV field trial for posttraumatic stress disorder: Journal of Traumatic Stress 10:539–555, 1997

9. Nemeroff CB: Neurobiological consequences of childhood trauma. Journal of Clinical Psychiatry 65:18–28, 2004

10. Van der Kolk B: Clinical implications of neuroscience research in PTSD. Annals of the New York Academy of Sciences 40:1–17, 2006

11. Mueser K, Goodman L, Trumbetta S, et al: Trauma and posttraumatic stress disorder in severe mental illness. Journal of Consulting and Clinical Psychology 66:493–499, 1998

12. Rosenberg S, Mueser K, Friedman M, et al: Developing effective treatments for posttraumatic stress disorders among people with severe mental illness. Psychiatric Services 52:1453–1461, 2001

13. Harris M: Treating sexual abuse trauma with dually diagnosed women. Community Mental Health Journal 32:371–385, 1996

14. Talbot N, Houghtalen R, Cyrulik C, et al: Women's Safety in Recovery: group therapy for patients with a history of childhood abuse: Psychiatric Services 49:213–217, 1998

15. Najavits L, Weiss R, Shaw S, et al: "Seeking Safety": outcome of a new cognitive-behavioral psychotherapy for women with posttraumatic stress disorder and substance dependence. Journal of Traumatic Stress 11:437–456, 1998

16. Stalker C, Palmer S, Wright D, et al: Specialized inpatient trauma treatment for adults abused as children: a follow up study. American Journal of Psychiatry 162:552–559, 2005

17. Foa E, Keane T, Friedman M: Effective Treatments for Posttraumatic Stress Disorder. New York, Guilford, 2000

18. Foa E, Street G: Women and traumatic events. Journal of Clinical Psychiatry 63:1047–1048, 2002

19. Hien D, Cohen L, Miele G, et al: Promising treatments for women with comorbid PTSD and substance use disorders. American Journal of Psychiatry 161:1426–1432, 2004

20. Chard K: An evaluation of cognitive processing therapy for the treatment of posttraumatic stress disorder related to childhood. Journal of Consulting and Clinical Psychology 73:965–971, 2005

21. Nemeroff C, Heim C, Thase M, et al: Differential responses to psychotherapy versus pharmacotherapy in patients with chronic forms of major depression and childhood trauma. Proceedings of the National Academy of Sciences 100:14293–14296, 2003

22. Van der Kolk BA, Pelcovitz D, Roth S, et al: Dissociation, somatization, and affect dysregulation: the complexity of adaptation of trauma. American Journal of Psychiatry 153:83–93, 1996

23. Cohen L, Hien D: Treatment outcomes in women with substance abuse and PTSD who have experienced complex trauma. Psychiatric Services 57:100–106, 2006

24. Kudler H, Blank A, Krupnick J: Psychodynamic therapy, in Treatment of Posttraumatic Stress Disorder [in Spanish]. Edited by Foa E. Barcelona, Editorial Ariel, 2003

25. Concha M, Aguilera J, Salas J: The burden of disease in Chile [in Spanish]. Santiago, Chile, Ministerio de Salud, 1996

26. Weil K, Florenzano R, Vitriol V, et al: Child abuse and adult psychopathology: an empirical study [in Spanish]. Revista Médica Chile 132:1499–1504, 2004

27. Zlotnick C, Johnson J, Kohn R, et al: Epidemiology of trauma, post-traumatic stress disorder (PTSD) and co-morbid disorders in Chile. Psychological Medicine 36:1522–1533, 2006

28. Florenzano R, Weil K, Acuña J, et al: Borderline personality, somatization, childhood trauma and abuse: a study with larger sample [in Spanish]. Revista Chilena Salud Mental 149:155, 2002

29. National Program for Detection, Diagnosis and Treatment of Depressive Disorders in Primary Care: Algorithms and Flow Charts for the Treatment of Severe Depression, Mental Health Unit Ministry of Health Progress] [in Spanish]. Santiago, Chile, Ministerio de Salud, 2003–2004

30. Vitriol V: Relationship between adult psychopathology and traumatic events in childhood [in Spanish]. Revista Chilena Neuro-Psiquiatría 43:83–87, 2005

31. Vitriol V, Gomberoff M, Basualto M, et al: Relationship between posttraumatic stress disorder, child sexual abuse and sexual revictimization [in Spanish]. Revista Médica Chile 10:1303–1305, 2006

32. Vitriol V: Specialized program for patients with trauma history at the mental health unit of Curicó Hospital, in Early Developmental Trauma and Adult Psychopathology [in Spanish]. Edited by Florenzano R, Weil K, Carvajal C, et al. Santiago, Chile, Editorial Corporación de Promoción Universitaria, 2005

33. WHO International Classification of Diseases: Clinical Descriptions and Diagnostic Guidelines [in Spanish]. Madrid, Ediciones Meditor, 1992

34. Hamilton M: A rating scale for depression. Journal Neurology, Neurosurgery, and Psychiatry 23:56–62, 1960

35. Marshall R, Schneier F, Lin S, et al: Childhood trauma and dissociative symptoms in panic disorder. American Journal of Psychiatry 157:451–453, 2000

36. Cuneo C, Gonzalez I, Jara M, et al: External validation of the Marshall trauma scale, in Early Developmental Trauma and Adult Psychopathology [in Spanish]. Edited by Florenzano R, Weil K, Carvajal C, et al. Santiago, Editorial Corporación de Promoción Universitaria, 2005

37. Robins L, Wing J, Witchen H, et al: The Composite International Diagnostic Interview. Archives of General Psychiatry 45:1069–1071, 1988

38. Davies J, Frawley M: Treating the Adult Survivor of Childhood Abuse. New York, Basic Books, 1994

39. Lambert M: Introduction to psychotherapy research, in Psychotherapy Research. Edited by Beutler L, Crago M. Washington, DC, American Psychological Association, 1991

40. Escalona R, Tupler LA, Saur CD, et al: Screening for trauma history on an inpatient affective disorder unit: a pilot study. Journal of Traumatic Stress 10:299–305, 1997

41. Von Bergen A, De la Parra G: OQ-45.2: an outcome questionnaire for monitoring change in psychotherapy: adaptation, validation, and indication for its application and interpretation [in Spanish]. Revista Terapia Psicológica 20:161–175, 2002

32. Bobes J, Calcedo-Barba A, Gracia M, et al: Evaluation of the psychometric properties of the Spanish version of five questionnaires for the assessment of posttraumatic stress disorder [in Spanish]. Actas Psiquiátricas Españolas; 28:207–218, 2000

43. Coid J, Petrucktevich V, Gender F, et al: Relation between childhood sexual and physical abuse and risk of revictimisation in women: a cross-sectional survey. Lancet 358:450–454, 2001

44. Van der Kolk BA: The compulsion to repeat the trauma: re-enactment, revictimization and masochism. Psychiatric Clinics of North America 12:389–411, 1989

45. Jennings AF: On being invisible in the mental health service. Journal of Mental Health Administration 21:374–387, 1994

46. Herman JL: Trauma and Recovery. New York, Basic Books, 1992

47. Marshall RD, Davidson JR, Yehuda R, et al: Pharmacotherapy in the treatment of posttraumatic stress disorder and other trauma-related syndromes, in Psychological Trauma. Edited by Yehuda R. Washington, DC, American Psychiatric Publishing, 1998

48. Trivedi M, Rush J, Wisniewsky S, et al: Evaluations of citalopram for depression using measurement based on STAR*D: implications for clinical practice. American Journal of Psychiatry 163:28–40, 2006

49. Green B, Krupnick J, Chung J, et al: Impact of PTSD symptoms in a one-year outcome depression trial. Journal of Clinical Psychology 62:815–835, 2006

50. Van der Kolk B, Spinnazzolla J, Blaustein M, et al: A randomized clinical trial of eye movement desensitization and reprocessing (EMDR), fluoxetine, and pill placebo in the treatment of posttraumatic stress disorder: treatment effects and long-term maintenance. Journal of Clinical Psychiatry 68:37–46, 2007