

The significance of addressing trauma in outpatient psychiatry

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Establishing post-traumatic stress disorder as a psychiatric diagnosis has only marginally increased awareness of traumatic experiences. Traumas are inconsistently recorded in initial psychiatric histories and, when observed, rarely reflected in the primary diagnosis and treatment. The present study aimed to investigate if there is an association between sufficiently addressing trauma and long-term outcome and what factors affect whether trauma, according to the patient's view, is sufficiently addressed or not. Socio-demographic data, experiences of trauma and treatment, and outcome, were collected retrospectively from Arabic, Iranian, Turkish and Swedish patients, who had visited a psychiatric clinic 3–4 years earlier. Fifty-one patients whose traumatic experiences had been sufficiently addressed were compared with 39 patients who perceived that their traumas had not been addressed. Logistic regression analyses were performed to examine relationships between clinical variables and whether or not traumas had been addressed. Patients with trauma sufficiently addressed reported high confidence in staff (odds ratio, OR = 7.2, $p < 0.001$), high self-rated health (OR = 8.0, $p < 0.01$) and low scores on the Self-rating Inventory for PTSD (OR = 7.7, $p < 0.05$) and Depression Scale (OR = 3.0, $p < 0.15$). Reporting less than five different traumas (OR = 4.6, $p < 0.01$) and being an ethnic Swede (OR = 2.4, $p < 0.10$) were the background variables independently related to having trauma sufficiently addressed. Addressing trauma may improve patients' confidence in staff, self-rated health and trauma-related symptoms. Multiplicity of traumas and belonging to an ethnic minority implied that trauma was less addressed.

• *Ethnic minorities, Outcome, Outpatient psychiatry, PTSD, Trauma.*

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Over the years, various studies have shown under-reporting of serious trauma in routine psychiatric settings because clinicians often fail to enquire about and detect traumatic experiences (1). Jacobson et al. (2) found that only 9% of assault histories were known to clinicians. Although several studies report high prevalence of post-traumatic stress disorder (PTSD) in general psychiatric populations, trauma and PTSD often remain undetected in clinical practice (3–6). Furthermore, there are diverging opinions as to whether traumatic experiences should be addressed and re-experienced in therapy, once revealed, especially if specialist trauma-therapeutic skills are missing. “There is no evidence that just talking about the trauma is in itself sufficient” (7). Other authors suggest that re-experiencing painful emotions in an unstructured fashion may in fact be harmful and point out that the benefit of focusing on trauma in treatment is not evidence based (8, 9). Recent meta-analyses show that single session debriefing after major traumas has not

proved efficient in long-term outcome (10, 11). On the other hand, the re-experiencing and reworking of traumatic memories is the rule at institutions specializing in trauma and this is supported by different therapeutic traditions (12–14). Recent studies show that both exposure therapy and cognitive behavioural therapy are effective for PTSD (15, 16).

In spite of the controversy, there is no study focusing on the question of whether outcome differs when trauma was addressed in treatment or not, i.e. when a trauma has been acknowledged and attended to according to the patient's view, regardless of therapeutic methods. The main aim of this study was to investigate whether the long-term outcome differs between patients who report that their trauma has been sufficiently addressed in treatment, and those who report that it has not. A second aim was to study how socio-demographic background, ethnicity, and number and types of traumas affect whether or not an experienced trauma is sufficiently addressed.

Material and Methods

The Ethics Review Committee at the Karolinska Institute, Stockholm, Sweden, approved the study, and all patients gave informed consent.

The psychiatric outpatient clinic and its patient register

In a suburban area of Stockholm, an annual cohort of 839 patients visited the psychiatric outpatient clinic. The clinic was part of the general healthcare services. It was the sole general outpatient psychiatric resource for patients living in the catchment area.

The study, a part of the Stockholm multiethnic psychiatry study, utilized the outpatient register that has been described earlier (6, 17). At the end of each calendar year, or at the end of the contact, the following data were recorded in an outpatient register as part of the routine of the clinic: country of birth, socio-demographic and socio-economic conditions, diagnoses according to DSM-III-R (18), different treatment measures and professions of treatment staff involved. The three most common Axis-I diagnoses were anxiety disorders (22%), mood disorders (21%) and psychotic disorders (14%). Twenty-two per cent of the patients had a personality disorder. As a measure of immediate treatment outcome, staff also made a global assessment of improvement, recorded as a three-point response (improved/unchanged/deteriorated).

The register was used to:

- Select the study sample;
- Control for differences between study sample and drop-outs;
- Supply clinical data regarding diagnoses, treatment including professional background of main therapist, utilization of interpreter, type of intervention/therapy, type of medication and immediate treatment outcome

Procedure

The study sample included those patients from the year's cohort who were born in Persian and Arabic speaking parts of the Middle East, an equally large group of Swedish-born patients of similar age and gender distribution as well as all patients born in Turkey. To assess long-term outcome 3–4 years after they had been in active contact with the clinic, 233 patients were invited by mail to participate in the study. If they agreed, they were asked to complete a questionnaire. Patients also had the opportunity to give their reasons for not participating and to contact the researchers. Some reasons for not participating are illustrated by the following quotations:

“Thank you for the letter and the questions you pose, but I have neither the time nor energy to answer them. I am so worried and have a lot of anxiety. I therefore apologise for not

being able to answer the questions. Good luck with the investigation!”

“I didn't get any better from the treatment I received. Thanks for sending me the letter and for caring about me!”

“I want to be left in peace and don't want anyone to peek into my life any more than is necessary. Don't trust computers with registers and secrecy.”

“I'm studying abroad.”

“After so many questions I became sad.”

All written and oral communication with the patients was held in their native language. Members of the research group had cultural and linguistic knowledge from the four studied patient groups.

Questionnaires

The questionnaire was translated and culturally validated by a sample of non-patients from each of the four language groups. Apart from socio-demographic and socio-economic data, the questionnaire contained detailed data about the clinical contact: estimated duration of untreated symptoms, estimated number of visits, utilization of interpreter, continuous or completed treatment. Whether the patient felt confidence in treatment staff was registered on a five-point scale from “always” to “never”. The questionnaire included questions about trauma exposure, self-rated assessment of global health and standardized symptom assessments. It also contained social network variables.

TRAUMA EXPOSURE

Questions (yes/no) about exposure to events “outside the range of normal human experience” as defined in DSM-III-R were included (18). Nine items of major trauma directed towards oneself and nine items of trauma towards a relative or close friend (virtually the same examples) were given. For both categories, respondents had the opportunity to mention any other event that they had perceived as equally traumatic. Items included serious accidents, losing a relative in an accident or due to violence, physical abuse, rape and threats to one's life. As the sample contained a high proportion of political refugees, acts of war, arrest by police, imprisonment, torture and the disappearance of a relative were also included. If the patients confirmed any of the trauma-focused items, they were asked whether the trauma had been mentioned and if it had been sufficiently addressed during their treatment.

SELF-RATED ASSESSMENT OF GLOBAL HEALTH

The following self-rating items were included:

- Global health during the past 3 months was measured by Self-Rated Health (SRH), which is a well-docu-

mented, internationally validated scale with a five-point scale from “Very good” to “Poor” (19);

- Worries about health (four-point scale from “Very worried” to “Not concerned”) (20);
- Symptom changes since beginning treatment (four-point scale from “much better” to “much worse”). The item was constructed for this study (6).

SYMPTOM ASSESSMENT

The following standardized symptom scales were included in the questionnaire to measure outcome:

- The Hopkins’ Symptom Check List-25 (HSCL-25) was used to identify psychiatric symptoms (21–23);
- The Depression Subscale (13 items) from Symptom Check List-90 (24);
- The Psychosomatic Symptom Scale (22 items) was used to measure psychosomatic symptoms (25);
- The Self-rating Inventory for Posttraumatic Stress Disorder (SIP) was used in its 47-item version to measure trauma-related symptomatology (26, 27).

Statistical analysis

All variables were summarized using standard descriptive statistics such as means, standard errors (*s*) and frequencies. Due to skewed distributions, differences between addressed and non-addressed trauma subjects concerning socio-demographic, type of trauma, clinical and outcome variables were analysed by Mann–Whitney *U*-test, χ^2 -test/Fisher’s exact test. Comparisons of the mean values ($\pm s$) of the number of traumas, and scale scores of different symptoms between the two groups were performed by one-way analysis of variance (ANOVA), and post hoc test by Tukey’s honesty significance test. Significance level was set at 0.05 (two-tailed). In order to avoid over-interpreting the relationships between trauma addressed/not addressed on the one hand and background variables and the self-rated variables on the other, the unique contribution of each variable was studied in a stepwise logistic regression analysis (forward). In this analysis, inclusion criteria were $p \leq 0.10$ and exclusion criteria $p \geq 0.15$. All variables were dichotomized before being entered into the analysis. Thus, age was coded: up to 40 years/more than 40; vocational training: trained/not trained; and multiplicity of total traumas: less than four vs. more than four different traumas. Confidence in staff was classified as High (“Always/Often”) vs. Low (“Sometimes/Seldom/ Never”), Self-rated Health as Low (“Poor/Pretty poor”) vs. High (“Fair/Quite good/Very good”), HSCL-25 as Low (≤ 1.50) vs. High (> 1.50), Depression Scale as Low (≤ 1.00) vs. High (> 1.00), Psychosomatic score as Low (≤ 1.00) vs. High (> 1.00), and SIP as Low (≤ 2.00) vs. High (> 2.00). The classifications were chosen to obtain approximately equally large groups,

and not according to the clinical caseness on different scales. The result of the logistic regression analysis was presented as odds ratios (OR).

Results

Respondents

One hundred and thirty of the 233 patients completed the questionnaire, rendering an overall response rate of 56% with an even distribution over ethnic groups. Drop-outs and respondents were compared with reference to about 40 variables from the outpatient register. There were only two significant differences. Drop-outs contained a greater number of men than women ($\chi^2 = 5.88$, $p < 0.05$) and had lower prevalence of anxiety syndrome ($\chi^2 = 7.75$, $p < 0.01$) than respondents. There was no significant difference in immediate treatment outcome.

One hundred and eleven (85%) of all respondents had experienced at least one trauma, and 90 of them confirmed that they had mentioned it during their treatment. Fifty-one of these patients reported that trauma had been sufficiently addressed and 39 that it had not. These two groups were compared regarding data from the patient register at the time of treatment and data from the questionnaire at time of follow-up, 3–4 years later.

Patient register data

When subjects were categorized into trauma sufficiently addressed/not addressed according to the discriminating questionnaire item, only a few differences were noted in the patient register data. There were no significant differences in the prevalence of Axis I and Axis II diagnoses, but on Axis IV “cultural conflict” was recorded for 2% of trauma sufficiently addressed vs. 21% of trauma not addressed patients (Fisher’s Exact $p < 0.01$). “Exile existence” was recorded for 10% of trauma sufficiently addressed vs. 31% of trauma not addressed patients respectively ($\chi^2 = 6.34$, $p < 0.05$). No other significant differences on Axis IV were recorded (housing problems, occupational problems, economic problems, family problems, death of a relative, violence, accident/injury, mental trauma, torture, asylum problems/extradition and lack of language).

The two groups had similar patterns in treatment variables and no significant difference was found concerning immediate treatment outcome. Trained members of staff (physicians and psychologists) as the main contact were involved to the same degree for both groups ($\chi^2 = 0.794$, ns), and the prescription of different psychotropic medications (anti-depressants, anti-psychotics, minor tranquillizers, hypnotics and no medication) was similar for the two groups. Visits to different staff categories were evenly distributed, with the one exception that physiotherapists attended more often to non-addressed patients ($z = 2.882$, $p < 0.01$).

Questionnaire data

There was no significant difference between the two groups concerning mean age; 43 ± 1.3 for trauma addressed patients vs. 39.2 ± 1.65 at time of follow-up.

Swedes had their trauma sufficiently addressed to a higher degree than ethnic minorities ($\chi^2 = 6.33, p < 0.05$) (Table 1). There was no difference in the utilization of an interpreter amongst those who had their trauma(s) addressed and those who had not ($\chi^2 = 0.597, ns$).

Patients who had not had their traumas sufficiently addressed reported a greater number of traumas, both their own (4.10 ± 0.33 vs. $2.73 \pm 0.33, z = 3.36, p = 0.001$) and traumas concerning a relative or close friend (3.74 ± 0.46 vs. $2.80 \pm 0.40, z = 1.68, p < 0.01$).

Particular types of traumas were significantly more frequent among those whose trauma had not been sufficiently addressed in treatment. These traumas were: having lost a close relative through accident or violence ($\chi^2 = 4.03, p < 0.05$), having been physically assaulted ($\chi^2 = 11.78, p < 0.001$) or subjected to torture ($\chi^2 = 9.95, p < 0.01$) or having had a relative or close friend subjected to torture ($\chi^2 = 4.66, p < 0.05$).

Although there was no significant difference in the total number of visits, patients whose trauma had been addressed had waited longer before making contact with

Table 1. Socio-demographic background characteristics of patients with trauma sufficiently addressed ($n = 51$) vs. not sufficiently addressed ($n = 39$).

	Trauma addressed, n (%)	Trauma not addressed, n (%)	χ^2 (df = 1)	p
Ethnicity				
Arab	11 (22)	13 (33)	1.56	ns
Persian	6 (12)	8 (21)	1.29	ns
Swedish	25 (49)	9 (23)	6.33	0.05
Turkish	9 (18)	9 (23)	0.41	ns
Gender			1.28	ns
Female	28 (55)	26 (67)		
Male	23 (44)	13 (32)		
Childhood area			1.91	ns
Urban	28 (55)	27 (69)		
Rural	24 (46)	13 (32)		
Education			0.10	ns
Only primary	18 (35)	15 (39)		
High School	33 (65)	24 (62)		
Vocational training			1.02	ns
None	13 (28)	12 (38)		
1–2 years	19 (41)	13 (41)		
>2 years	14 (30)	7 (22)		
Civil status			2.60	ns
Single, divorced or widow/er	15 (30)	6 (15)		
Married/cohabiting	35 (70)	33 (85)		

the psychiatric care unit ($z = 2.53, p < 0.05$), and less often had terminated their contact at the time of follow-up ($\chi^2 = 6.31, p < 0.05$).

Patients whose trauma had been addressed rated their health as better, had more confidence in treatment staff, and had improved more since beginning treatment (Table 2). However, the psychosocial situation at follow-up did not differ significantly between the two groups.

Trauma-addressed patients had significantly lower scores on all symptom scales (Table 3).

A stepwise logistic regression analysis of outcome variables is shown in Table 4. Of seven tested independent variables, four passed the inclusion criteria (cf. Statistical analysis). Confidence in staff (High), Self-rated health (High), SIP (Low) and the Depression Scale (Low) were independently related to the fact that a

Table 2. Self-rated health and psychosocial outcome at time of follow-up amongst patients with trauma sufficiently addressed ($n = 51$) vs. not sufficiently addressed ($n = 39$).

	Trauma addressed, n (%)	Trauma not addressed, n (%)	Mann–Whitney	
			z	p
Self-rated health			3.34	0.001
Very good health	6 (12)	0 (0)		
Quite good health	14 (28)	5 (13)		
Fair	14 (28)	9 (22)		
Pretty poor	10 (20)	12 (31)		
Poor	6 (14)	13 (33)		
Worried about health			0.39	ns
Very worried	15 (29)	10 (26)		
For the most part	10 (20)	11 (28)		
Aware	17 (33)	7 (18)		
Not concerned	9 (18)	11 (28)		
Improvement after contact			-3.10	0.01
Much better	20 (40)	7 (18)		
Little better	20 (40)	12 (32)		
Little worse	6 (12)	8 (21)		
Much worse	4 (8)	11 (29)		
Confidence in staff			4.39	0.001
Always	29 (57)	7 (18)		
Often	12 (24)	9 (24)		
Sometimes	9 (18)	14 (36)		
Rarely	0 (0)	1 (3)		
Never	1 (2)	8 (21)		
Social network (passive)			1.47	ns
0	2 (4)	3 (8)		
1	8 (16)	9 (24)		
2	13 (26)	11 (29)		
3	27 (54)	15 (40)		
Social network (active)			1.77	ns
0	2 (5)	5 (16)		
1	12 (29)	9 (29)		
2	17 (41)	14 (45)		
3	11 (26)	3 (10)		

ns, not significant.

Table 3. Symptomatic outcome amongst patients with trauma sufficiently addressed ($n=51$) vs. not sufficiently addressed ($n=39$).

	Trauma addressed		Trauma not addressed		<i>p</i>
	Mean	<i>s</i>	Mean	<i>s</i>	
HSCL-25	1.15	0.108	1.65	0.119	0.01
SCL depression subscale	1.17	0.113	1.65	0.131	0.01
Theorell's psychosomatic scale	1.05	0.106	1.37	0.109	0.05
SIP – PTSD	0.56	0.042	0.71	0.053	0.05

s, standard error.

trauma had been addressed, and could correctly identify 74% of the patients. Thus, patients who had had their traumas addressed had more confidence in the staff, higher self-rated health and lower ratings of post-traumatic stress disorder and depression. There were no significant correlation between the outcome variables confidence in staff and self-rated health. Whereas self-rated health was correlated to all other outcome variables, confidence in staff was only significantly correlated to Improvement during treatment.

Three variables – improvement during treatment, HSCL-25 and the Psychosomatic Symptoms' Scale – did not make any independent contribution to whether trauma was sufficiently addressed.

In a stepwise logistic regression analysis, all socio-demographic background variables (e.g. gender, ethnicity and education) and multiplicity of trauma were included. Due to a high degree of collinearity between own and relatives' traumas, the sum of all traumas was chosen as the variable for logistic regression analysis. Two variables were independently associated with trauma(s) being sufficiently addressed (Table 5). These were low number of traumas and being Swedish. The prospect

Table 4. Odds ratios for outcome variables, i.e. ratings of confidence in staff and symptom ratings, in a stepwise logistic regression analysis independently related to having trauma(s) sufficiently addressed.

Variables in the equation	<i>B</i>	<i>s</i>	Wald	df	Sign.	Odds ratio
Confidence in staff	-1.978	0.554	12.760	1	0.000	7.227
Self-rated Health	-2.083	0.765	7.410	1	0.006	8.026
Self-rating for Posttraumatic Stress Disorder	-2.045	0.913	5.018	1	0.025	7.728
Depression Subscale	-1.105	0.721	2.350	1	0.125	3.020
Constant	3.615	1.054				

Variables with no significant contribution to the regression equation: Hopkin's Symptom Check List-25, Symptom Changes during Treatment, and Psychosomatic Symptom Scale.
s, standard error.

of having trauma sufficiently addressed was almost five times as high if the patient had less than five traumas, and twice as high if the patient was a Swede (Table 5). Together these two variables correctly identified 75% of the patients.

When the effect of these two background variables, less than five traumas and ethnic Swede, was controlled for in a separate stepwise logistic regression analysis, confidence in staff and Self-rated health had an independent and significant relationships with trauma addressed.

Discussion

This study shows that patients with trauma sufficiently addressed had in a significant respect better outcome – better self-rated health and fewer symptoms of PTSD, were less depressed and had greater confidence in staff – compared to patients who considered trauma insufficiently addressed. Reporting less than five different traumas and being an ethnic Swede were the only two background variables that were independently related to having trauma sufficiently addressed.

Attrition and representativity

A strength of this study is that the attrition population is well defined through a multitude of data from a patient register. The only differences found, that the attrition population contained more males and less anxiety disorders, are not likely to influence the findings, as gender and diagnosis were not found to affect whether or not trauma was sufficiently addressed (cf. Patient register data and Table 5). However, the sample of the study, with 85% exposed to at least one extreme trauma, is not representative of a standard outpatient clinic, as it was stratified to include a large proportion of foreign-born patients, whose prevalence of trauma was assumed to be high.

Table 5. Odds ratios for socio-demographic background variables and multiplicity of trauma experience in a stepwise logistic regression analysis independently related to having trauma(s) sufficiently addressed.

Variables in the equation	<i>B</i>	<i>s</i>	Wald	df	Sign.	Odds ratio
Swedish-born	0.855	0.519	2.715	1	0.099	2.350
<5 different traumas	1.536	0.515	8.905	1	0.003	4.645
Constant	-2.684	0.488				

Variables with no significant contribution to the regression equation: Gender, Arab, Persian, Turkish, Swedish or Turkish, Childhood area, Education, Employed, and Age.
s, standard error.

Outcome

If trauma(s) had been sufficiently addressed in the view of the patients, several variables demonstrated better outcome. Trauma-addressed patients had better self-rated health and had fewer symptoms related to PTSD and depression. They also had greater confidence in treatment staff. The better outcome for those who had their trauma addressed could not be accounted for by other treatment variables, like medication or professional background of main therapist. Also, the selection of fewer traumas amongst those with trauma(s) addressed did not alone account for the difference. The fact that patients with non-addressed trauma(s) were more often referred to a physiotherapist suggests more somatic expression in this group.

The study was conducted at a general outpatient clinic with no special trauma focus and with only general therapeutic skills available. Formal psychotherapy was rare.

Despite formal similarities in treatment between the groups, a positive response to the question of whether trauma was sufficiently addressed singles out one group of patients who have a better outcome. It seems as if addressing the trauma in a clinical setting has a therapeutic effect *per se*. The results contradict Kinzie's view (7) that just talking about the trauma is not sufficient. Certainly, some qualities in the talking – like empathy and respect – are preconditions for a positive outcome. The act of sufficiently addressing trauma probably has to do with acknowledging the trauma and its relevance for the present condition. This would encourage the patient to talk about it and share his experiences, e.g. through exploratory follow-up questions. The therapist's ability to address trauma seems to have little to do with his or her basic training, nor with the type of therapy applied. To verify such suppositions about the content of "sufficiently addressed", it would be necessary to interview patients and therapists in a qualitative study.

The fact that those patients with trauma sufficiently addressed had waited longer before making contact with the clinic might indicate that a certain latency is helpful for the patients to focus on trauma. This could be in line with the negative results of debriefing immediately following a traumatic event (10, 11).

Obstacles to addressing trauma

This study, carried out at a general outpatient clinic in a multiethnic area, demonstrates neglect of addressing trauma in treatment. Forty-three per cent of the patients in our study, who mentioned a trauma in the treatment contact, perceived that the trauma had not been sufficiently addressed.

Patients who did not have their trauma sufficiently addressed had been exposed to a greater number of

different traumas. In fact, if the total number of different traumas exceeded four, the prospect of having trauma sufficiently addressed was little more than one-fifth compared with patients with fewer traumas (cf. Table 5). The patients who did not have their trauma(s) addressed also had been exposed to severe types of traumas such as torture, physical assault and having lost a relative through violence or accident. These two findings correspond to an observation from clinical work with traumatized individuals in Croatia according to which, the most severe problems occur in treating multiply traumatized patients (28). According to the authors, the reason for not addressing trauma could be that trauma stories are loaded with affective intensity and descriptions of human experiences that may be perceived as threatening to the treatment staff, and thus avoided. It would then be natural that some traumas are more frightening than others, and that multiple traumas are more frightening than single ones.

Irrespective of the number of traumas, patients born outside Sweden less often perceived that their traumas were sufficiently addressed. The utilization of an interpreter did not influence whether or not traumas were addressed. It is possible that treatment staff regarded cultural difference as an obstacle for addressing the patient's trauma. Similarly, cross-cultural communication could also restrict the patients. A few patients, when completing the questionnaire, disclosed the view that, "Swedish staff cannot understand what we have gone through anyhow". Patients who perceived their traumas as not sufficiently addressed, more often had been given an Axis IV diagnosis of "cultural conflict" or "exile existence" according to the patient register. This fact raises the suspicion that if trauma is not enquired about in a structured fashion, patients from ethnic minorities run the risk of having their difficulties misinterpreted as "cultural" or being attributed to their exile situation. To summarize, cultural prejudice rather than language problems threaten to prevent traumas from being sufficiently addressed.

Clinical implications

One way of improving clinical practice would be to systematically screen for traumas by using a questionnaire. Apart from detecting traumas, such questionnaires listing different traumas could help both patient and therapist to talk about and evaluate the contribution of each trauma to the present condition of the patient. It was noted that some patients in our study felt relieved when asked about their extreme traumas, following the questionnaire. One explanation of this reaction might be that the pre-formulated questions told them that their experience was not unique and that the interviewer felt comfortable discussing such issues. To give therapists the confidence to approach and deal with horrifying and

multiple traumas, supervision is helpful and sometimes necessary. The need of addressing trauma also ought to be stressed in curricula and training. The high prevalence of traumas in general psychiatry, emphasizes the need of disseminating the knowledge and experience gathered at specialized treatment institutions dealing with specific traumas (e.g. torture or sexual abuse) to general psychiatric services. Cultural differences should not be seen as a legitimate reason to avoid addressing traumas. Human similarities, in spite of cultural differences, ought to be in focus during training and supervision.

Causality

With a cross-sectional design, causality has to be considered. Could one be convinced that the more confidence in staff reported by trauma-addressed patients was due to the fact that trauma was addressed? The confidence built up between therapist and patient in the course of treatment may not only be the result of, but a precondition for, trauma being addressed. It is possible to imagine a circular cause-effect model: more confidence facilitates addressing trauma and addressing trauma increases confidence.

Was better self-rated health at follow-up a result of trauma being addressed? Such causality seems less debatable, as staff noted no differences in immediate treatment outcome between patients who had their trauma(s) addressed and those who had not. It is thus not likely that patients' progress encouraged treatment staff to address trauma.

The design of this observational study is not ideal to resolve the question of causality, as logistic regression analyses may reflect random variations.

A qualitative study as suggested above might shed light on what, in the view of the patients, is covered by the concept "sufficiently addressed". However, causality ideally ought to be studied with a quasi-experimental, randomized design, in which the intervention group of patients have their traumas addressed in a systematic way and the control group receive treatment-as-usual. The efficacy of the two approaches could then be compared. Such a study could cross-validate the main findings of this paper of better outcome and greater confidence in the staff among trauma-addressed patients.

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References

- Lipschitz DS, Kaplan ML, Sorkenn JB, Faedda GL, Chorney P, Ansis GM. Prevalence and characteristics of physical and sexual abuse among psychiatric outpatients. *Psychiat Serv* 1996;47:189–91.
- Jacobson A, Richardson B. Assault experiences of 100 psychiatric inpatients: evidence of the need for routine inquiry. *Am J Psychiatry* 1987;144:908–13.
- Jacobson A, Koehler JE, Jones-Brown C. The failure of routine assessment to detect histories of assault experienced by psychiatric patients. *Hosp Community Psychiatry* 1987;38:386–9.
- Davidson J, Smith R. Traumatic experiences in psychiatric outpatients. *J Traum Stress* 1990;3:459–75.
- Zimmerman M, Mattia JI. Is posttraumatic stress disorder underdiagnosed in routine clinical settings? *J Nerv Ment Dis* 1999;187:420–8.
- Al-Saffar S, Borgå P, Hällström T. Long-term consequences of unrecognised PTSD in general outpatient psychiatry. *Soc Psychiatry Psychiat Epidemiol* 2002;37:580–5.
- Kinzie JD, Boehnlein JK. Psychotherapy of the victims of massive violence; countertransference and ethical issues. *Am J Psychotherapy* 1993;47:90–102.
- MacFarlane AC. Individual psychotherapy for post-traumatic stress disorder. *Psychiat Clin North Am* 1994;17:393–408.
- Litrell J. Is the reexperience of painful emotion therapeutic? *Clin Psychol Rev* 1998;18:71–102.
- van Emmerik AA, Kamphuis JH, Hulsbosch AM, Emmelkamp PM. Single session debriefing after psychological trauma: a meta-analysis. *Lancet* 2002;360:766–71.
- Rose S, Bisson J, Wessely S, editors. *Psychological debriefing for preventing post traumatic stress disorder (PTSD)* (Cochrane Review). Oxford: Update Software; 2003.
- Rachman S. Emotional processing. *Behav Res Ther* 1980;18:51–60.
- Bady SL. The voice as a curative factor in psychotherapy. *Psychoanal Rev* 1985;72:479–90.
- Nichols MP, Efran JS. Catharsis in psychotherapy: A new perspective. *Psychotherapy* 1985;22:46–58.
- Paunovich N, Öst LG. Cognitive behavior therapy vs exposure therapy in the treatment of PTSD in refugees. *Behav Res Ther* 2001;39:1183–97.
- Rothbaum BO, Schwartz AC. Exposure therapy for posttraumatic stress disorder. *Am J Psychotherapy* 2002;56:59–75.
- Al-Saffar S, Borgå P, Edman G, Hällström T. The aetiology of posttraumatic stress disorder in four ethnic groups in outpatient psychiatry. *Soc Psychiatry Psychiat Epidemiol* 2003;38:456–62.
- American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders (DSM-III-R)*. Washington, DC: APA; 1987.
- Bjørner JB, Søndergaard Kristensen T, Orth-Gomér K, Tibblin G, Sullivan M, Westerholm P. Self-rated health. A useful concept in research, prevention and clinical medicine, Stockholm. FRN report 1996;96:9.
- Höglund E. Fråga patienterna på psykiatriska mottagningar. Stockholm: SPRI; 1993. Report No. 362.
- Derogatis LR, Lipman RS, Rickels K, Uhlenhuth EH, Covi L. The Hopkins Symptom Checklist (HSCCL): a self-report symptom inventory. *Behav Sci* 1974;19:1–11.
- Nettelbladt P, Hansson L, Stefansson C-G, Borgquist L, Nordström G. Test characteristics of the Hopkins Symptom Check List-25 (HSCCL-25) in Sweden, using the Present State Examination (PSE-9) as a caseness criterion. *Soc Psychiatry Psychiat Epidemiol* 1993;28:130–3.
- Smith Fawzi MC, Murphy E, Pham T, Lin L, Poole C, Mollica RF. The validity of screening for post-traumatic stress disorder and major depression among Vietnamese former political prisoners. *Acta Psychiatr Scand* 1997;95:87–93.
- Derogatis LR. SCL-90-R. Symptom Checklist-90-R. Administration, scoring, and procedure. National Computer Systems, Inc; 1994.
- Theorell T, Konarski-Svensson JK, Ahlmén J, Perski A. The role of paid work in Swedish chronic dialysis patients – a nation-wide survey: paid work and dialysis. *J Intern Med* 1991;230:501–9.
- Hovens JE, van der Ploegh HM, Bramsen I, Klaarenbeek MTA, Schreuder JN, Rivero W. The development of the self-rating

- inventory for posttraumatic stress disorder. *Acta Psychiat Scand* 1994;90:172–83.
27. Hovens JE, van der Ploeg HM, Bramsen I, Klaarenbeek MT, Schreuder JN, Rivero VV. The development of the Self-Rating Inventory for Posttraumatic Stress Disorder. *Acta Psychiat Scand* 1994;90:172–83.
28. Klain E, Pavic L. Countertransference and empathic problems in therapists/helpers working with psychotraumatized persons. *Croatian Med J* 1999;40:466–72.
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