The Trauma of First Episode Psychosis: Developing Psychological Interventions that Help People Adjust to the Onset of Psychosis.

Chris Jackson
Max Birchwood

Youth Programme, BSMHFT
and University of Birmingham, UK.
Plan

1. Can a first episode of psychosis cause ‘PTSD’ and trauma?
2. If so, what psychological interventions might help?
3. Does writing about a first episode help?
4. Can writing help carers?
Acknowledgements

Karen Barton
Mark Bernard
Max Birchwood
Graham Dunn
Marianne Hall
Jennifer Jones
Lizzie Newton
Imogen Reid
Kerry Ross
Rebecca Russell
Jo Smith
Peter Trower
Mike Townend
EIS Staff
Can a first episode of psychosis cause PTSD and Trauma?
Psychosis and Trauma

“Psychosis, because of its unique ability to disrupt mental processing, may result in psychological trauma of considerable magnitude”

Lundy (1992) *Am J. of Psychotherapy*
PTSD Diagnosis (DSM-IV-TR)

**Criterion A: Traumatic Event**
The person has been exposed to a traumatic event in which both the following are present: 1) the person experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury or a threat to the **physical** integrity of self or others; 2) the person’s response involved intense fear, helplessness, or horror.

- **Criterion B:** Persistent re-experiencing
- **Criterion C** Avoidance & numbing
- **Criterion D** Arousal

**Criterion E: Duration**

**Criterion F: Functioning**
Psychosis and Trauma

Psychosis and intrusive re-experiencing

“You get some image or feeling of what happened there, you’re often distracted by and go quiet in the middle of a conversation….it draws you in like the voices did, wanting you to listen harder or closer”

Intrusive recollections of 26 yr old man following a 1st episode of psychosis.
Psychosis and PTSD

- Incidence of PTSD symptoms (intrusive re-experiences and avoidance) in samples recovering from psychosis range from 11% to 67% (Morrison et al., 2003).
- Limited number of studies in 1st episode psychosis but rates converge around 35% (1 in 3).
- Comparable to rates of PTSD in other groups e.g., 35% for combat veterans, 18% for firemen, and 9% for general population.

PTSD and first episode psychosis

Brunet and Birchwood, in submission
Method

• Prospective design

• Acute phase of first episode:
  – Primary diagnosis
  – Appraisals of voices, persecutors and illness

• 18 months follow-up:
  – PTSD Symptom Scale (PSS  Foa et al)
  – Impact of Events - Revised
  – Childhood Trauma Questionnaire
Baseline sample N=50

Lost to follow up N=11

Follow up sample N=39

Acute phase of FEP
66% male
Wide range ethnicity

Mean = 18 months
Do you have any memories that bother you?

- None: 33%
- Admission: 28%
- Symptoms: 21%
- Other event: 18%
Diagnosable PTSD

No PTSD 69%

Admission 13%
Symptoms 5%
Other event 13%
Determinants of Trauma following Psychosis

Adverse pathways (MHA, police)

Malevolent symptoms (paranoia, voices)

The experience of treatment (hospitalisation, forced medication)

Subjective experiences (loss of control, “no escape from internal chaos”)
Appraisals & recovery style mediate the traumatic impact of a first episode

The trauma of first episode psychosis: the role of cognitive mediation

Chris Jackson, Chris Knott, Amanda Skeate, Max Blanchard

Objective: First episode psychosis can be a distressing and traumatic event which has been linked to continued symptomatology, including anxiety, depression and PTSD symptoms. Pharmacotherapy, interventions, etc. However, the links between events surrounding a first episode psychosis i.e., police involvement, admission, use of mental health act, etc. and PTSD symptoms remain unclear. In the PTSD literature, there has now turned to the patient’s appraisal of the traumatic event as a key mediator. In this study we aim to evaluate the diagnostic status of first episode psychosis as a PTSD triggering event and to determine the extent to which factors such as appraisal and coping mediate the impact of PTSD (traumatic) symptomatology.

Method: Approximately 10 years after their initial admission to hospital, patients were assessed for traumatic symptoms, common to DSM-IV criteria for post-traumatic stress disorder (PTSD), and their appraisals of the traumatic events and coping strategies. Psychiatric symptomatology was also measured.

Results: 54% of the sample of 65 patients who agreed to participate reported symptoms consistent with a diagnosis of PTSD. Although not statistically significant between PTSD (traumatic) symptoms and post-traumatic stress disorder (PTSD) symptomatology, a trend was found between PTSD symptomatology and the patients’ coping style. Those who were more likely to report intrusive re-experiencing had higher levels of intrusive re-experiencing (r=0.6; p=0.001).

Perceived ‘stressfulness’ of stay on ward sig correlated with intrusive re-experiencing (r=0.6; p=0.001)

‘Sealers’ have higher levels of avoidant symptoms.

- Perceived ‘stressfulness’ of stay on ward significantly correlated with intrusive re-experiencing (r=0.6; p=0.001)
- ‘Sealers’ have higher levels of avoidant symptoms.
A note of caution…..

- Psychosis is internal not external event.
- Self report measures (as used in most studies) may ‘over-diagnose’ PTSD (Middleton & Shaw, 2000)
- Memory deficits and delusions may affect recall and lead to inaccurate PTSD symptom ratings in people with psychosis (Tarrier, 2005)
Can a first episode of psychosis cause PTSD?

- Yes probably……… but it may not be PTSD as we know it (i.e. subtype, lack of criterion A, shame based)
‘PTSD’ or ‘Post Psychotic Trauma Symptoms’ (PPTS)?
Why should we care about Post Psychotic Trauma Symptoms (PPTS)?

- Rarely assessed or ‘looked at’ in standard clinical practice (Mueser et al, 1998; Kilcommons and Morrison, 2005).
- May in itself be disabling, reduce psychological functioning and be associated with suicidality (Tarrier et al, 2007).
- May have implications for engagement (i.e. ‘sealing over’) and optimum treatment strategies.
What can be done?

Possible interventions for ‘PPTS’ following a first episode of psychosis.
Treatment of PTSD in Psychosis

- To date interventions for PTSD following psychosis restricted mostly to case studies.
- Callcott et al., (2004) found reductions in overall severity of PTSD symptoms and avoidance of symptoms (IES) following CBT.
- Mueser et al, (2008) in RCT found significant reductions in PTSD symptoms following CBT.

Interventions for PTSD and Trauma

• Established interventions encourage the expression of trauma related thoughts and feelings through a combination of anxiety management, cognitive, restructuring, and exposure (Brewin & Holmes, 2003).

• Adaptation and application of such techniques to individuals experiencing a FEP may enable them to talk more openly about the trauma of psychosis and facilitate emotional processing (Mueser & Rosenberg, 2003).

Can CBT help reduce Post Psychotic Trauma Symptoms (PPTS) following a first episode?

Improving psychological adjustment following a first episode of psychosis: A randomised controlled trial of cognitive therapy to reduce post psychotic trauma symptoms


ABSTRACT

There are few evaluated psychological interventions or theoretical approaches which are specifically aimed at resolving problems related to adjustment and education following a first episode of psychotic symptoms. The present study tested the efficacy of a form of CBT (Cognitive Behaviour Therapy) in reducing trauma, depression and low self-esteem following a first episode of psychosis in a single-blind randomised controlled trial. A total of 61 patients who had recently experienced a first episode of psychotic symptoms were randomly assigned to CBT or treatment as usual (TAU) and followed up at 6 and 12 months. People receiving CBT tended to have lower levels of post-intervention trauma symptoms and demonstrated greater improvements than those receiving TAU alone. This was especially the case for patients with high pre-treatment levels of trauma. There was, however, no advantage for the CBT group with regard to reduced depression or improved self-esteem. In conclusion, CBT appears to be an effective intervention to help young people adjust to the traumatic aspects of a first episode of psychosis and offers further evaluation in a larger study is warranted.

Introduction

Psychological adjustment following a first episode of psychosis remains an important but understudied area (Jackson & Label, 2000). Whilst a significant minority of people experiencing a first episode may naturally adjust in the psychological impact of such an event (May, 2004), many may struggle and go on to develop a number of psychological and emotional dysfunctions, such as PTSD, depression, social anxiety disorders, low self-esteem and self-harm (Birchwood, 2004). The treatment of such emotional dysfunctions in psychosis (CBT) (Birchwood et al., 2004). Yet, despite this, there have been relatively few psychological interventions specifically developed in the context of psychosis in general (Birchwood & Trotter, 2000) and even less for young people experiencing the onset of psychosis. In the first time, Waddell and Zander (2001) evaluated the efficacy of a simple cognitive-behavioural intervention designed to improve self-esteem in people with multiple episodes of psychosis and found moderate levels of information that when used as an adjunct to treatment as usual (TAU), the intervention resulted in increased self-esteem, reduced psychotic symptoms and improved social functioning. These gains were maintained over 12 months. In another evaluation, the impact of CBT on self-esteem in people with psychosis. Conley et al. (2006) using a CBT protocol aimed at the early signs of psychosis, also found greater increases in self-esteem (as assessed by the Rosenberg Self-Esteem Questionnaire) for those receiving CBT than TAU. Unfortunately, the generalisability of these studies to younger first episode populations is difficult to ascertain as both studies included a large number of older people with multiple admissions and a history of relapse. This may be particularly important given recent evidence...
The CBT

• Engagement/formulation
• Promoting emotional processing: deliberate evocation of intrusive memories and encourage engagement with them
• Key appraisals: Loss, shame, entrapment
• Dealing with anxiety linked to intrusions.
A RCT of CBT for PPTS following a 1st Episode (Jackson et al, 2009)

FIG. 1: CONSORT DIAGRAM

Assessed for eligibility (n = 357)

Excluded (n = 231)
Refused (n = 60)

Randomised (n = 66)

Allocated to CBT (n = 36)
Allocated to TAU (n = 30)

Received treatment (n = 32)
Received treatment (n = 30)

Lost to follow up
(n at 6 months = 10
(n at 12 months = 3)
Lost to follow up
(n at 6 months = 6
(n at 12 months = 2)

Complete outcome data 22
Complete outcome data 24
IES Total (N=66) (Jackson et al, 2009)
Improvements in ‘PTSD’ Symptoms for TAU and CBT at 12 months follow-up (chi^2= 6.01; p=0.01; phi=0.38) (Jackson et al, 2009)

<table>
<thead>
<tr>
<th></th>
<th>CBT</th>
<th>TAU</th>
</tr>
</thead>
<tbody>
<tr>
<td>PTSD symptoms worse or same</td>
<td>11%</td>
<td>45%</td>
</tr>
<tr>
<td>PTSD symptoms better</td>
<td>89%</td>
<td>55%</td>
</tr>
</tbody>
</table>
Can writing about the first episode of psychosis reduce Post Psychotic Trauma Symptoms?
Writing about Trauma

“One of the problems I have about those awful bombs here is that in those days I didn’t have any way of writing about it, so I didn’t have any way of coping with it, and it does stick with me in a way that I would like to get rid of it”

John Simpson 2004 (talking about the 1974 Dublin bombings)
NICE encourage writing about treatment experiences

“Ensure that the person with schizophrenia has the opportunity to write an account of their experience of rapid tranquilisation in their notes”

NICE 1.3.3.4.
Can writing about a 1st episode of psychosis reduce PTSD?

- Based on Pennebaker paradigm, an experiment was conducted in which participants recovering from a 1st episode wrote about their experiences of illness (experimental condition) or about non-illness topics (control condition).

- Main aim was to examine whether writing about psychosis reduces the traumatic impact of these events.
“the act of converting emotions and images into words changes the way a person organizes and thinks about the trauma”

James. W. Pennebaker
Procedure

• Majority of participants were from the Birmingham EIS.
• Participants were not acutely psychotic or suicidal.
• Half of the participants wrote about psychosis and half wrote about neutral topics in three 20-minute sessions.
• Participants re-completed measures 4-weeks later (follow-up).
• Design: 2(Writing Condition: Psychotic events vs. Innocuous events) X 2(Time Period: Baseline vs. Follow-up) mixed model ANOVA.
The Sample

- 37 participants (ICD10: F20,22,23,25) were approached to take part.
- 25 agreed to participate (response rate of 67.57%).
- One was excluded due to failure to follow instructions and one participant disengaged during study.
- One had a family bereavement during follow-up.
- Final sample was 22.
- 12 wrote about their psychosis (experimental group) and 10 wrote about innocuous topics (control).
- Mean age was 25
- 13 men and 9 women.
Content of Essays

- Debilitating effects of positive symptoms (e.g., voices and delusions)
- Difficulties with depression and loss of motivation.
- Association between onset of illness and stress.
- Insight and ambivalence about accepting their illness.
- Experiences of mental health system and medication.
- Negative impact on educational/vocational goals.
- Hope about the future.
“I would like to write about how the voices made me feel: desperate, lonely, and sad. They never say anything good about me and they always say negative comments in my ear. Life begins to feel a little unreal. Not knowing if a comment was real or unreal is surreal. I get very introspective of myself of which I have had to have help to deal with”

(Female, 28-years old)
Severity of PTSD Symptoms: Total Impact of Events Scale

\[ F (1, 20) = 4.03, \ p < .05, \ n^2 = .17 \]
Feedback about Writing

• “I never done anything like this before so it was helpful in the sense that I wrote things, down, which is better than talking about them” (Female, 21)

• “It was helpful to go back over my illness again as it makes you think about it in a different way” (Male, 21)

“the research has helped me to understand my illness and also telling someone for the first time how I really feel about my illness-what I had went through (Female, 18)
What about the carers?

Reducing symptoms of trauma among carers of people with psychosis: pilot study examining the impact of writing about caregiving experiences

Karen Barton, Chris Jackson

Objectives: To establish whether writing about experiences of the first episode of psychosis may alleviate trauma-like symptoms among carers of people with psychosis.

Method: A total of 37 people caring for someone with early psychosis were randomized to two conditions: either writing about the first psychotic episode, or writing about time management. Data were collected before and after intervention, and 8 weeks later.

Results: Those in the writing group were significantly less likely to avoid reminders and feelings associated with their relative’s episode at follow up. Furthermore, carers in this group who exhibited trauma-like symptoms had significantly greater reductions in trauma severity.

Conclusions: Written emotional disclosure can help carers who are experiencing trauma symptoms following a relative’s first episode of psychosis. If writing about emotional events is beneficial through mechanisms of exposure then screening participants for trauma symptoms may eliminate previous research inconsistencies. These results, however, need to be replicated in a larger study.

Key words: psychosis, relatives, traumatic stress, writing.

Australian and New Zealand Journal of Psychiatry 2008; 42:693-701
Reduction in PPTS for Carers with High and Low Trauma (N=33)
Overall Conclusions

- Approx 1 in 3 people report significant PPT symptoms following a 1st episode of psychosis.

- CBT and emotionally focussed writing can significantly reduce PPT symptoms in patients and carers following a FEP.

- May only be beneficial for patients and carers with high levels of PPTS.
Contact

chris.jackson@bsmhft.nhs.uk