TRAUMA AND FIRST EPISODE PSYCHOSIS

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FACULTY/PRESENTER DISCLOSURE

- Presenter: Francesca Schiavone
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LEARNING OBJECTIVES

AT THE END OF THIS SESSION, PARTICIPANTS WILL BE ABLE TO:

① Conduct a safe assessment of trauma history and PTSD symptoms

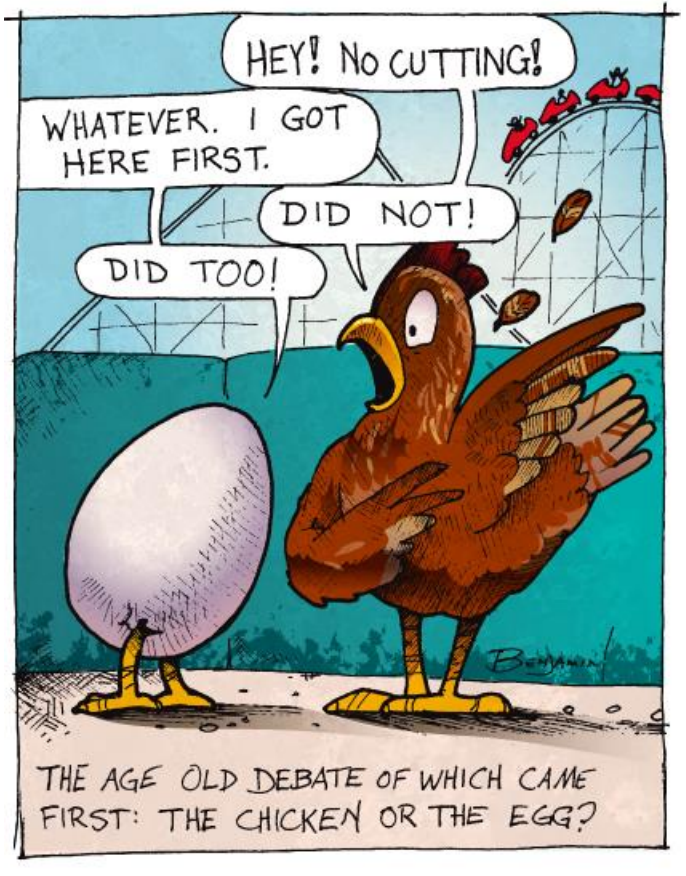
② Describe the diagnostic and epidemiologic overlap between trauma, PTSD, and first episode psychosis

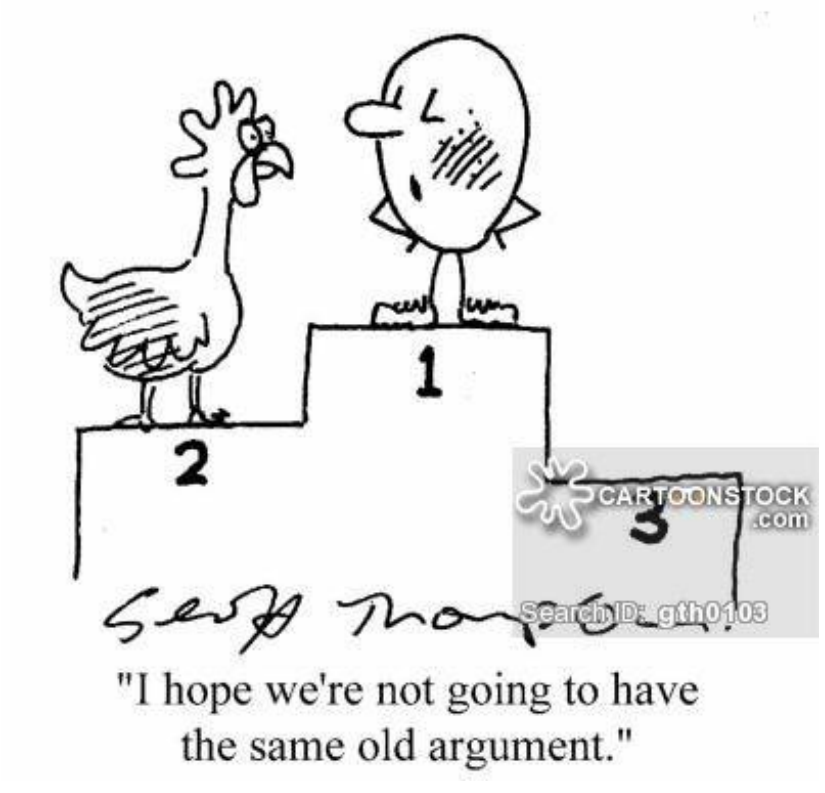
③ Name the preferred treatment approaches to PTSD and BPD and discuss a pragmatic approach when these are not available

OUTLINE

- The interplay between trauma, PTSD, psychosis, and psychosis-related PTSD
- Clinical tips for distinguishing between primary psychosis and psychotic-like symptoms related to trauma
- An approach to assessing for trauma and PTSD in a non-trauma specific context
- Preferred treatments and a pragmatic approach to management

TRAUMA AND PSYCHOSIS





TRAUMA AND PSYCHOSIS: A COMPLEX INTERPLAY

- Childhood trauma is highly prevalent in first episode psychosis:
  - Approximately 52-73% of FEP patients report histories of childhood trauma (Vila-Badia et al, 2021)
  - Childhood trauma may be associated with symptom severity (Bailey et al, 2018)

- First episode psychosis can itself be traumatic – estimates of PTSD prevalence with FEP as the index trauma range from 14%-47% of FEP (Buswell et al, 2021).
  - Can be psychosis-related and/or hospital-related
  - Childhood trauma history (OR = 27) and previous history of PTSD before FEP (OR = 20) are strongly associated with psychosis-related PTSD (Bendall et al, 2012)
  - Lifetime prevalence of PTSD in the Canadian population is about 9.2% with a current/1-month prevalence of 2.4% (van Ameringen et al, 2008)

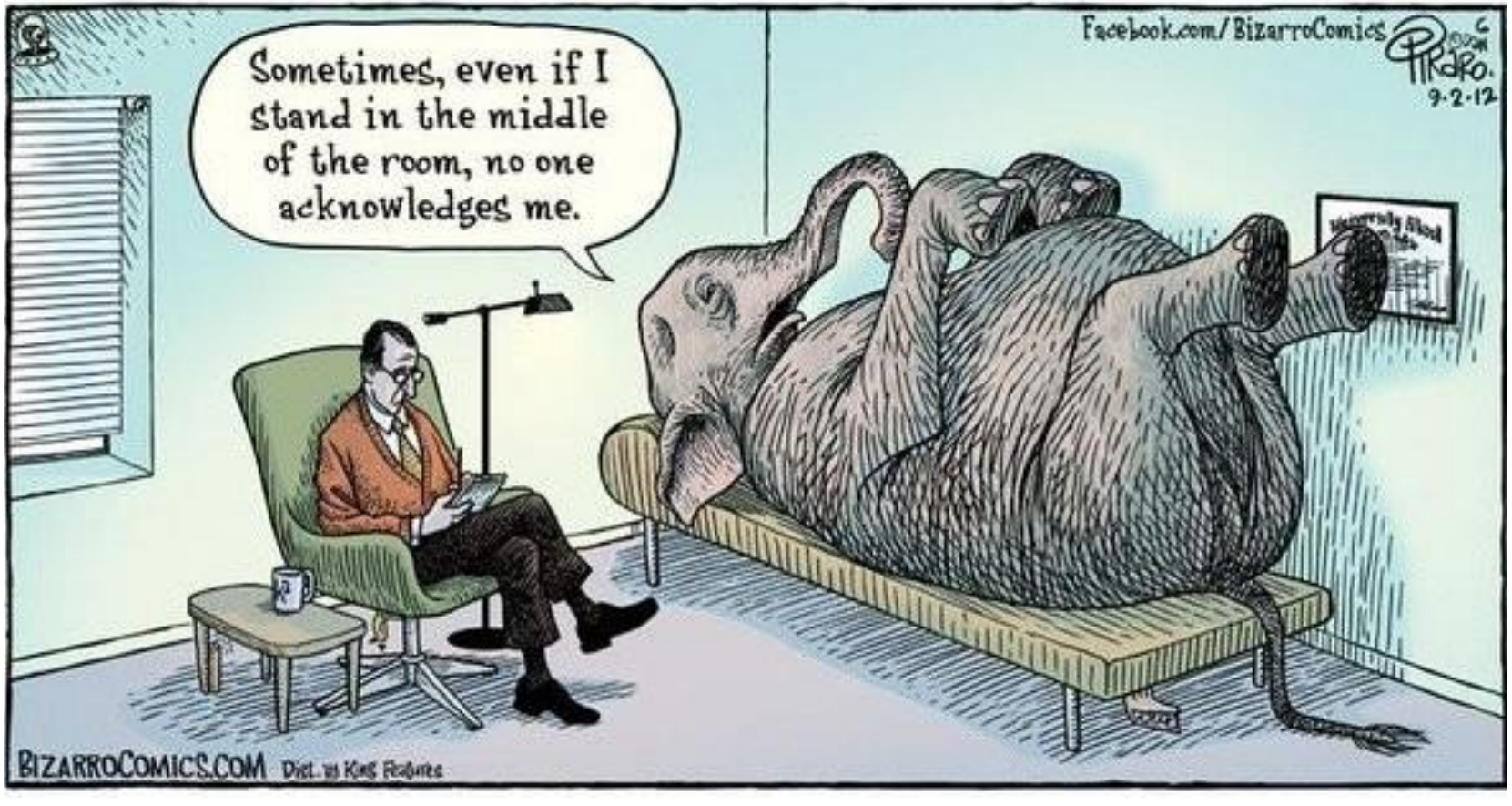
TRAUMA AND PSYCHOSIS: A COMPLEX INTERPLAY

- Psychotic-like symptoms are common in a wide range of disorders that are associated with trauma: PTSD, BPD, and the complex dissociative disorders. Dissociative identity disorder is commonly misdiagnosed as schizophrenia (Schiavone et al, 2018)
- People with trauma-related disorders are often mis-diagnosed with primary psychosis and referred to FEP programs
- People with trauma-related disorders may also have comorbid primary psychotic disorders
- While low dose antipsychotic medication has some evidence for core symptoms of PTSD and BPD, it is not recommended to treat trauma-related psychotic like symptoms (esp. hallucinations) that are dissociative in nature (ISSTD, 2011)
  - Tension between aggressive treatment/minimizing DUP in primary psychosis and causing unnecessary morbidity in trauma-related disorders

SOME CONSIDERATIONS FOR DIAGNOSIS

- **Psychotic Like Symptoms of Trauma-Related Disorders:** non-auditory hallucinations, absent/minimal negative symptoms, less complex delusional systems
  - Dissociative disorders specifically: multiple voices, hearing the voices of children, fewer delusional explanations for psychotic-like symptoms
  - Often associated with severe dissociative symptoms (non-epileptic seizures, episodes of amnesia)
  - Also want to think of epilepsy or other organic pathology
- **Not Indicative:** presence of auditory hallucinations, voices from inside/outside the head, Schneiderian FRS, delusional content, presence of trauma, trauma-related psychotic content
  - Because these disorders can be comorbid, the presence of key features of trauma-related disorders (e.g. BPD traits, trauma history, PTSD symptoms) is worth considering but not necessarily conclusive

ASSESSING TRAUMA



A BASIC TRAUMA HISTORY

- If you intend to assess trauma, explain at the beginning of the meeting that you will ask questions about trauma
  - Explain rationale for asking about trauma, and how the information will be stored/used
  - Clarify the amount of detail that will be asked – "just the headlines"
  - Encourage to "pass" on any question they do not want to answer
- Ask towards the middle of the interview, ensuring that there is adequate time to build rapport first, and to provide containment afterwards
- Ask without family present if possible, and be aware of potential ongoing victimization
- Use broad screening questions, do not probe for excessive detail
  - May ask minimal detail if highly dysregulated or disorganized
  - Interrupt or gently redirect if sharing excessive detail
  - Respond to disclosure with support and validation
- Inquire about dysregulation, monitor for excessive disclosure, and be alert for objective signs of dysregulation

A BASIC TRAUMA HISTORY

- Did you feel safe at home as a child? Who would you typically go to for help if you were hurt or scared?
- How was discipline handled in your household growing up?
- Were there any sexual experiences in your past that made you feel uncomfortable? How about currently?
- Have you experienced any other events that have overwhelmed your ability to cope?
- Have you been impacted by [e.g. racism, sexism, homophobia]?
- Have other people in your family experienced trauma or abuse?

May be especially important to be broad and open-ended if high degree of ongoing family involvement

Just because trauma is not endorsed initially, does not mean it isn't present

Recognize that not all people conceptualize adverse experiences using words like "trauma" or "abuse"

TROUBLESHOOTING DYSREGULATION

- Traumatized people typically dysregulate in one of two directions:
  - High arousal – sympathetically driven state – flushing, sweating, shaking, hyperventilating, agitation, re-experiencing past trauma
  - Low arousal – parasympathetically driven dissociative state – numb, flat, collapsed, unresponsive, spaced out
- Watch carefully for changes in tone of voice, eye contact, posture, and movements
- Name the state – e.g. "it looks like you're getting overwhelmed" – and interrupt further content – "let's stop for a minute and help you feel a bit safer"
- Coach grounding skills repeatedly until regulated
  - breathing, getting up and moving around, ice pack, naming things of a certain colour, naming differences between past and present

ASSESSING PTSD

- The open-ended approach: "How do you think that impacted you?"
  - Looking for DSM5 PTSD symptom clusters – re-experiencing (inc. nightmares), avoidance, changes in mood/cognition, and changes in arousal
- Can use a screening tool like the PCL-5, with or without LEC
- Not all people who have been through trauma develop PTSD or want trauma-specific treatment
  - Helpful to know for treatment planning whether trauma/PTSD are high priority treatment targets, and how much trauma impacts their day-to-day experience
  - Many are fearful to engage in trauma treatment even if they would benefit – normalize this reaction, validate freedom to choose, provide education, and open the door to revisit later

EVIDENCE BASED TREATMENT FOR BPD AND PTSD

- People with psychotic disorders are often excluded from clinical trials of trauma treatment and therefore the available literature is limited
- There is some evidence that standard exposure-based treatments for PTSD (Cognitive Processing Therapy, Prolonged Exposure, EMDR, etc.) are effective in people with psychotic disorders (Cragin et al, 2017).
- Expert consensus suggests that in FEP, integrated treatment of PTSD and psychosis would be ideal, and that sequential or parallel treatment would also be acceptable (Cragin et al, 2017)
- Patients who are severely disorganized or dysregulated, including those with comorbid BPD, may benefit from stabilization treatments before they are ready to do trauma processing work.
  - DBT is an excellent stabilization treatment and is first line for borderline personality disorder
  - There are specific protocols for treating comorbid BPD and PTSD (e.g. DBT-PE, DBT-PTSD)

A PRAGMATIC APPROACH

- There are major systemic barriers to accessing trauma treatment – however a lot can still be done
- If you cannot access trauma-specific treatment:
  - Do your best to build a safe, predictable relationship
  - Help to establish environmental safety from further violence
  - Express openness to hearing about trauma, and help to disclose safely if desired
  - Provide psychoeducation about the impact of trauma, and normalize a range of reactions to traumatic events if they arise, instill hope about the potential for recovery
  - Help to identify and manage trauma triggers proactively, particularly with respect to engagement with care
  - Teach skills to manage trauma-related symptoms (e.g. grounding skills from DBT) or help to access a DBT-informed skills group if possible

RELATIONAL ASPECTS

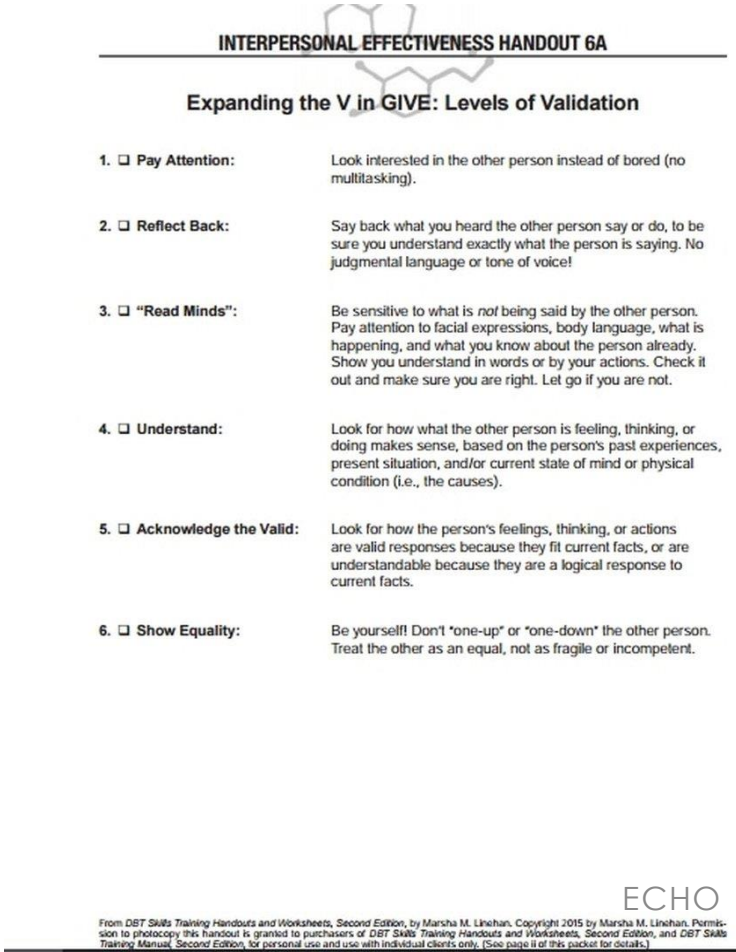
- Often highly seeking of contact (see themselves as weak/bad/in need of support) **and** highly fearful of contact (see others as dangerous, rejecting, potentially violent)
- They are often highly dysregulated and lack the skills to cope with the intense emotions they experience in interpersonal situations
- Anger is often driven by underlying terror and shame
- This leads to an array of perplexing and seemingly contradictory attachment behaviours that are often described as “manipulative,” “help-rejecting,” “splitting,” or “acting out”
- Dysregulation also leads to attempts at emotion regulation and safety that can be frightening or damaging (e.g. self harm, suicide attempts, violence)

RELATIONAL ASPECTS

- Patients are more often suffering from a deficit in the ability to self-regulate than deliberately attempting to manipulate – address skills deficits as best as possible by teaching skills, identify and validate the underlying need, help to problem solve
- Offer as much choice and control as possible, be predictable and consistent, offer clear explanations
- Try to avoid power struggles – pick your battles and reduce demands if needed
- Acknowledge the impact of involuntary treatment on PTSD symptoms
  - If possible, talk in advance about how to minimize harm, consider communicating the presence of trauma history to other providers (with consent)
  - Help to differentiate the past from the present if possible
- Observe your own limits, communicate limits clearly, and seek supervision/support
- Recognize and address likely triggers, including discharge, changes in care provider, time away, etc.
- Use validation liberally

VALIDATION

- People with BPD and/or trauma are hyper-alert for cues that you do not understand them, will abandon them, or will violate/traumatize them.
- Validation communicates understanding and empathy.
- Particularly validate the impact of trauma
- Try to find the "kernel of truth" in their position rather than getting polarized.



INTERPERSONAL EFFECTIVENESS HANDOUT 6A

Expanding the V in GIVE: Levels of Validation

1. ❑ Pay Attention:	Look interested in the other person instead of bored (no multitasking).
2. ❑ Reflect Back:	Say back what you heard the other person say or do, to be sure you understand exactly what the person is saying. No judgmental language or tone of voice!
3. ❑ "Read Minds":	Be sensitive to what is *not* being said by the other person. Pay attention to facial expressions, body language, what is happening, and what you know about the person already. Show you understand in words or by your actions. Check it out and make sure you are right. Let go if you are not.
4. ❑ Understand:	Look for how what the other person is feeling, thinking, or doing makes sense, based on the person's past experiences, present situation, and/or current state of mind or physical condition (i.e., the causes).
5. ❑ Acknowledge the Valid:	Look for how the person's feelings, thinking, or actions are valid responses because they fit current facts, or are understandable because they are a logical response to current facts.
6. ❑ Show Equality:	Be yourself! Don't "one-up" or "one-down" the other person. Treat the other as an equal, not as fragile or incompetent.

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THANK YOU! QUESTIONS?