

**+ Assessment and
Treatment of PTSD in
Individuals with
Schizophrenia-
Spectrum Disorders:

Clinical Tips and
Guidelines**

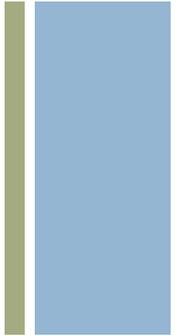
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+ Disclaimer & Disclosures



- Disclaimer: The views in this presentation are those of the author only.
- Disclosure: I have no commercial relationships to disclose.

+ Learning Objectives

Describe the relationship between trauma exposure, PTSD and psychosis

Understand and overcome barriers to assessing and treating PTSD in individuals with psychosis

Assess PTSD and engage in treatment planning

Implement evidence-based treatments for PTSD with individuals with psychosis

Tips & guidelines

Empirical support



+ Trauma Exposure, PTSD and Psychosis



Individuals with psychosis have a higher prevalence rate of Criterion A traumas and PTSD than general population



Individuals with psychosis are at a greater risk of future traumatization



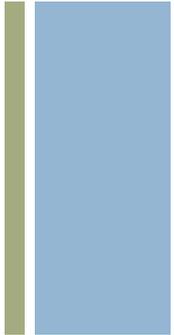
Traumas in childhood increase the risk of developing psychosis threefold



PTSD is a risk factor in the subsequent development of psychosis



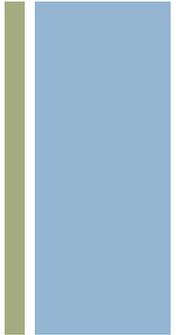
In individuals with psychotic disorders, comorbid PTSD is associated with poorer outcomes





Barriers to Treating + PTSD in Individuals with Serious Mental Illness

+ In Early Psychosis Treatment Centers



Belief in increased mental health risks

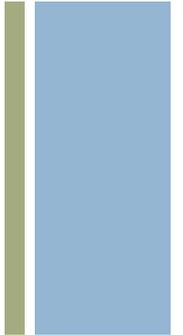
Belief that clients won't be interested

Other workload pressures

Lack of institutional support

Lack of training

+ In Community Clinics



If psychosis is present, no further assessment

If psychosis is present, assumption that it must be the focus of treatment

Referrals are limited to psychiatry

Lack of clinician training in working with trauma or PTSD

Clinician biases

+ In Veterans Affairs Medical Centers

Clinician fears

Belief that patients
are not stable
enough for EBT's for
PTSD

Belief that EBT's for
PTSD would be
ineffective due to
cognitive
impairments



+ Assessment of Trauma Exposure and PTSD

+ Tips for Assessment

If you find psychosis, don't stop there

Use well-validated measures to assess trauma exposure

- Life Events Checklist
- Trauma History Questionnaire

Have client choose an index trauma

- Index trauma must have been an actual event
- Assess the same way we would for patients without psychosis
- Due to high rate of traumatization in this population, remind patients that EBTs for PTSD are not one-trauma therapies

Use well-validated measures to assess PTSD

- The PCL has been found to be a valid and reliable screening measure of PTSD symptoms for individuals with SMI

+ Tips for Assessment

Conduct thorough assessment of psychotic symptoms

- Brief Psychiatric Rating Scale
- SAPS/SANS
- PANSS
- SCID psychotic spectrum module

Utilize books, online or in-person trainings or webinars

Consult with providers with expertise in this area



Pre-Treatment
+ Considerations and
Collaborative
Treatment Planning

+ Definition of “Stability” May Need to be Modified

Some intact reality testing

○ x 4

Cognitive disorganization is acceptable, especially if redirectable

Active hallucinations and delusions are acceptable

Imminent suicidal or homicidal risk vs. command auditory hallucinations

+ Pre-Treatment Considerations

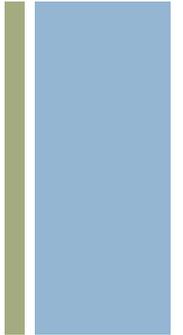
Patient's goals
for treatment

Medication non-
compliance

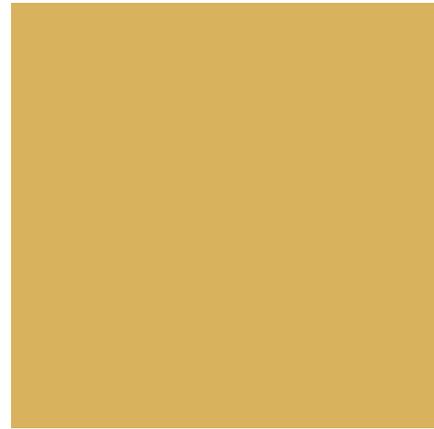
Communication
with treatment
team

Recovery
Model

Consent for
treatment



+ Treatment of
PTSD for
Patients with
Co-
Occurring
Psychosis





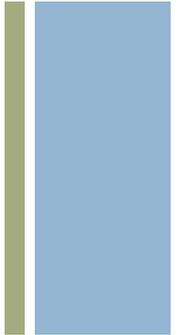
+ Cognitive Processing
Therapy (CPT)

+ CPT Tips and Guidelines

Broaden lens
for
assimilation

Trauma-
related
hallucinations

Socratic
dialogue



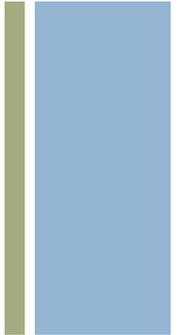
Assimilated beliefs may be unusual or bizarre interpretations about why the trauma happened:

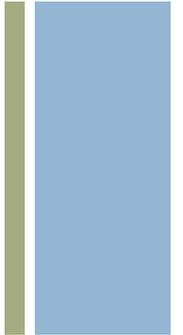
- “The trauma happened because an evil genius shifted the earth at the moment of the trauma.”
- “My friend died in Vietnam because after our plane crash, our Sergeant murdered him as part of an FBI plot.”



Assimilation may be in content of trauma-related perceptual disturbance/hallucination

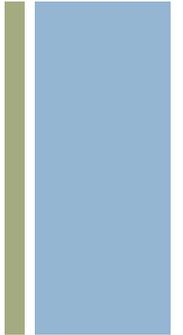
- Perpetrator's voice saying "It's your fault."
 - Stuck point might be "The rape was my fault."
- Deceased friend's voice saying "Cover me."
 - Stuck point might be "I should have covered him."
- Commander saying "Why aren't you running? Run!"
 - Stuck point might be "If I had run, the trauma wouldn't have happened."





Assimilation may be in appraisals of trauma-related perceptual disturbances/hallucinations

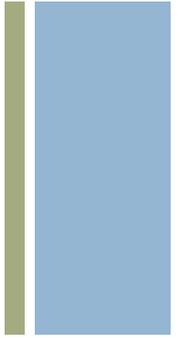
- Deceased friend's voice saying "I miss you."
- Stuck point might be "He should be alive."



**Treat these assimilated
SPs the same way you
would treat any
assimilation**

- **Prioritize these in treatment**
- **Have patients track these beliefs on their Stuck Point Log**
- **Use Socratic dialogue to evaluate and contextualize**

+ Socratic Dialogue and Psychosis



Paranoia

Cognitive
disorganization



Socratic Dialogue and Paranoia

Provide clear expectations about the process of Socratic dialogue

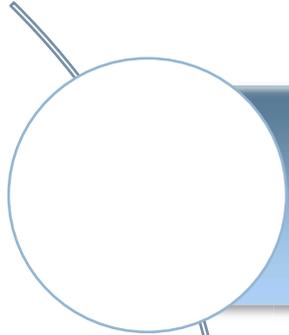
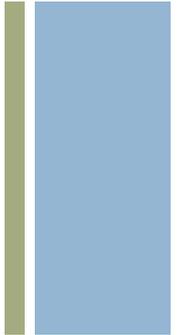
Educate that curiosity/flexibility is adaptive

Discuss how it counters avoidance

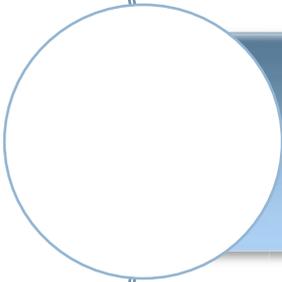
Encourage patients to learn the process of asking themselves questions



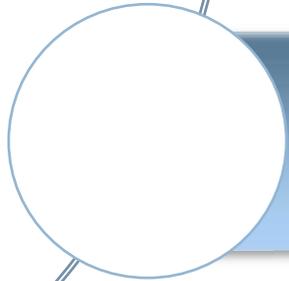
Socratic Dialogue and Cognitive Disorganization



Point out increased cognitive disorganization, function it might serve and normalize



Consider writing SP on a whiteboard, piece of paper or worksheet as you begin Socratic dialogue



Pay attention to what was being discussed before disorganized speech began

+ CPT: Empirical Support

CPT Rollout Data

N = 37

CPT Providers were new to CPT and in consultation

CPT was associated with significant drop in PTSD symptoms and depression

No diffs in outcomes for PTSD + psychosis vs PTSD only

Galovski SAMHSA Study

N = 36

All participants had SMI

PCL dropped 14 points

69% lost PTSD dx



+ Prolonged Exposure
(PE)

+ PE Tips and Guidelines

In Vivo Exposures

- **Social Skills deficits**
- **Negative symptoms**

Imaginal Exposures

- **Cognitive disorganization**

+ In Vivo Exposures and Social Skills Deficits

Individuals with psychosis often experience social skills deficits

Some in vivo exposures require that clients interact with others

Clinicians can use brief role plays and teach basic social skills when planning for in vivo homework

+ In Vivo Exposures and Negative Symptoms

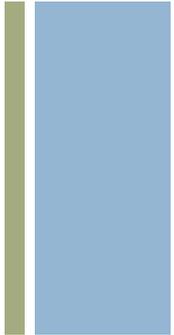
Avolition

- Schedule activities in calendar
- Use alerts and reminders
- Problem-solve barriers
- Reinforce rationale

Anhedonia

- Ensure hierarchy includes numerous “behavioral activation” activities
- May use schedule of positive activities list to generate ideas

+ Imaginal Exposures and Disorganized Speech



Discuss function and normalize

Use post-processing to help client explore tendency to derail during most difficult parts of imaginal exposure

Moment where cognitive disorganization increases may signal a “hot spot”

Over time might point out differences in frequency of derailling

+ PE: Empirical Support

2013 Pilot: PE vs. EMDR vs. WL

- N = 4
- 75% retention in PE
- 23 point drop on CAPS (PE + EMDR)
- 75% of PE completers no longer met criteria for PTSD
- PE patients had no more adverse events than those in other conditions

2015 RCT: PE vs. EMDR vs. WL

- N = 155
- 62% with delusions; 40% with hallucinations
- 75% retention in PE
- 35 point drop in CAPS
- PE group had significant reduction of PTSD (effect size = .78)
- No difference in adverse effects between groups

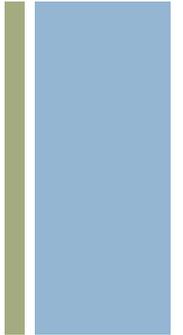
2016 Follow-Up: Secondary Effects of 2015 Study

- N = 155
- PE group had decrease in paranoid thoughts
- PE group was most likely to reach remission of psychotic disorders
- PE group had greatest decrease in depression



+ CBT for PTSD Program (Mueser)

+ CBT for PTSD Tips & Guidelines



**Prioritize
blame/undoing
beliefs**

**CR worksheets
for
metacognitive
deficits**

+ Prioritizing Self/Other-Blame

Ask directly if thought may be trauma-related

Mention commonly heard themes

Remind client of previously identified trauma-related beliefs

Pull items from PCL

Overtly linking general thoughts to trauma

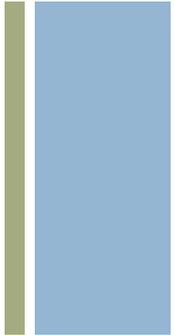
- "I'm a bad person" because: "I should have stopped the rape from happening." / "I experienced arousal during the rape."
- "I must be on guard at all times" because: "the trauma happened because I was complacent." / "I should have known the trauma would happen."

Guide to Thoughts and Feelings

Feelings	Ask Yourself	Related Thoughts
Fear or Anxiety	What bad thing do I expect to happen? What am I scared is going to happen?	<ul style="list-style-type: none">• Some terrible thing is going to happen• I am going to be attacked or hurt• I am going to be rejected or abandoned• I am going to lose control or go crazy
Sadness or Depression	What have I lost hope in? What's missing in my life?	<ul style="list-style-type: none">• I am worthless• I don't have anyone I can depend on• Nothing will ever get better
Guilt or Shame	What bad thing have I done? What is wrong with me?	<ul style="list-style-type: none">• I am a failure• I am to blame for what happened to me• I am a bad person
Anger	What's unfair about the situation? Who has wronged me?	<ul style="list-style-type: none">• I am being treated unfairly• I am being taken advantage of• Someone has done something to wrong me



CBT for PTSD: Empirical Support



Mueser et al., 2007

Pilot, Group Program

N = 80

12% with psychotic disorder

59% retention

24% lost PTSD dx

Mueser et al., 2008

RCT, Individual Program

N = 108

16% with psychotic disorder

70% retention

Average drop in CAPS of 19 points

Lu, et al., 2009

Pilot, Individual Program

N = 19

16% with psychotic disorder

74% retention

31% lost PTSD dx

Sacks, et al., 2016

Pilot, Group Program

N = 14

50% with psychotic disorder

79% retention

70% lost PTSD dx

Steel et al., 2017

RCT, Individual Program

N = 61

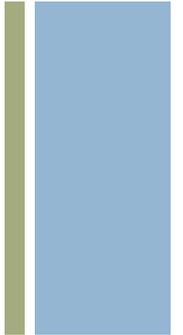
100% with psychotic disorder

No differences between CBT for PTSD and TAU



+ Eye Movement Desensitization and Reprocessing (EMDR)

+ EMDR Tips & Guidelines



**Multiple Traumatization and
Length of Treatment**

+ Empirical Literature for EMDR

Pilot studies

2013

N = 4

80% retention

75% lost PTSD dx

23 point drop in CAPS
(+ PE)

No more adverse events
than waitlist (or PE)

2015

N = 27

72% retention

31 point drop in CAPS

77% lost PTSD dx

RCT

2016

N = 155

80% retention

8 EMDR sessions

35 point drop in CAPS
(effect size = .65)

60% lost PTSD dx

2016 follow-up

Decrease in paranoid
thinking

More likely to be in
remission of psychotic
disorder

+ Conclusions

Great need for availability of EBT's for PTSD in people with schizophrenia-spectrum disorders



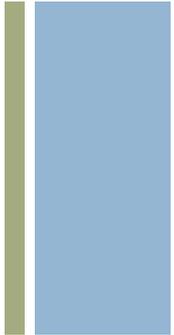
Empirical literature supports that EBT's for PTSD are safe and effective



EBT's for PTSD should be delivered without modifications



Need for ongoing support for clinicians working with patients with PTSD and Psychotic Disorders





PTSD Consultation Program

FOR PROVIDERS WHO TREAT VETERANS



PTSDconsult@va.gov



(866) 948-7880



www.ptsd.va.gov/consult