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

1. Describe the relationship between trauma exposure, PTSD and psychosis
2. Understand and overcome barriers to assessing and treating PTSD in individuals with psychosis
3. Assess PTSD and engage in treatment planning
4. Implement evidence-based treatments for PTSD with individuals with psychosis

Tips & guidelines

- 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 EBTs for PTSD

Belief that EBTs 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
- 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

<table>
<thead>
<tr>
<th>Provide clear expectations about the process of Socratic dialogue</th>
<th>Educate that curiosity/flexibility is adaptive</th>
<th>Discuss how it counters avoidance</th>
<th>Encourage patients to learn the process of asking themselves questions</th>
</tr>
</thead>
</table>
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 derailing
**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)
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.”
<table>
<thead>
<tr>
<th>Feelings</th>
<th>Ask Yourself</th>
<th>Related Thoughts</th>
</tr>
</thead>
</table>
| Fear or Anxiety | What bad thing do I expect to happen? What am I scared is going to happen? | • 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? | • 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? | • 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? | • I am being treated unfairly  
• I am being taken advantage of  
• Someone has done something to wrong me |
<table>
<thead>
<tr>
<th>Study</th>
<th>Design</th>
<th>N</th>
<th>Psychotic Disorder</th>
<th>Retention</th>
<th>PTSD Drop</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mueser et al., 2007</td>
<td>Pilot, Group</td>
<td>80</td>
<td>12%</td>
<td>59%</td>
<td>24%</td>
</tr>
<tr>
<td>Mueser et al., 2008</td>
<td>RCT, Individual</td>
<td>108</td>
<td>16%</td>
<td>70%</td>
<td>Average drop in CAPS of 19 points</td>
</tr>
<tr>
<td>Lu, et al., 2009</td>
<td>Pilot, Individual</td>
<td>19</td>
<td>16%</td>
<td>74%</td>
<td>31%</td>
</tr>
<tr>
<td>Sacks, et al., 2016</td>
<td>Pilot, Group</td>
<td>14</td>
<td>50%</td>
<td>79%</td>
<td>70%</td>
</tr>
<tr>
<td>Steel et al., 2017</td>
<td>RCT, Individual</td>
<td>61</td>
<td>100%</td>
<td></td>
<td>No differences between CBT for PTSD and TAU</td>
</tr>
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Eye Movement Desensitization and Reprocessing (EMDR)
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 EBTs for PTSD in people with schizophrenia-spectrum disorders

Empirical literature supports that EBTs for PTSD are safe and effective

EBTs 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