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## Editorial

# Treating the trauma of first episode psychosis: A PTSD perspective

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Over the past decade there has been a huge growth of interest in identification and rapid intervention for recent onset of psychosis (Linszen & Dingemans, 2002; McGlashan *et al.*, 2001; McGorry & Jackson, 1999). Effective treatment in the early years after the onset of psychosis is thought to be important for several reasons. First, the duration of untreated psychosis in first episode patients is predictive of short- and long-term outcomes (Lieberman *et al.*, 2001). Second, deterioration in symptoms and psychosocial functioning in schizophrenia occurs rapidly after the first episode, usually within 2–5 years (Birchwood *et al.*, 1998; McGlashan, 1988). Third, adherence to treatment is especially problematic in recent onset psychosis (Edwards & McGorry, 2002). These problems suggest that if effective and engaging interventions can be delivered in a timely fashion to individuals who have recently experienced an onset of psychosis, the long-term trajectory of the illness could be improved.

In this same decade, a number of research studies have also begun to delineate a complex set of inter-relationships between psychotic illness, trauma exposure and post-traumatic stress disorder (PTSD; Rosenberg *et al.*, 2002). Consistent results suggest that: 1) persons hospitalized for psychotic illness have unusually high rates of trauma exposure prior to illness onset; 2) severe psychiatric illness entails increased risk of trauma exposure, including violent victimization; and 3) psychiatric disorder increases risk for PTSD following exposure to trauma. However, important nosologic and conceptual questions remain in regards to these findings. For example, questions have been raised regarding the validity of patients' reports of victimization, as well as the potential symptom overlap between depression, schizophrenia and PTSD. These artifacts may conflate the apparent rates of PTSD in persons with recent onset psychotic disorders (Franklin & Zimmerman, 2001; Priebe *et al.*, 1998). Alternatively, PTSD associated with psychotic

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symptoms may be misdiagnosed as a primary psychotic disorder (Hamner *et al.*, 1999). Even more controversial is an emerging set of findings that first episode psychosis itself, and patients' associated treatment experiences, may be traumatic for many persons. We will attempt to outline our rationale for hypothesizing that interventions for recent onset psychosis can be made more effective if they begin to address the post-traumatic issues of these patients.

### Treatment of recent onset psychosis

Despite the importance of treatment in recent onset psychosis, only antipsychotic medications have been shown to be effective (Gitlin *et al.*, 2001), and these benefits are often offset by medication non-adherence (Edwards & McGorry, 2002). Controlled research on psychosocial treatments, including family intervention, cognitively-oriented psychotherapy, and cognitive therapy for psychosis, have yielded disappointing results (Jackson *et al.*, 2001; Lewis *et al.*, in press; Linszen *et al.*, 1996). Thus, more effective psychosocial treatments are needed for persons with a recent-onset psychosis.

While a number of explanations have been offered to account for poor treatment engagement and outcomes of recent onset clients, we suggest that findings from multiple studies support the importance of trauma-related issues in complicating the early course of illness in many, if not most, clients. There is growing evidence that the experience of a psychotic episode can be understood as a traumatic event (McGorry *et al.*, 1991; Meyer *et al.*, 1999; Shaner & Eth, 1989; Shaw *et al.*, 1997). In this sense, post-traumatic symptoms appear to represent an important secondary problem related to psychotic illness, with a significant group of first episode clients reporting post-traumatic symptomatology.

In addition, early treatment episodes are frequently experienced by clients as even more traumatizing than the symptoms that precipitate intervention, putting clients at risk for iatrogenic psychiatric morbidity (e.g. PTSD and depression), and very likely increasing avoidance of helpful treatments. Both the common finding of poor medication adherence, and the limited success of psychosocial treatments for recent onset psychosis, may be partly due to their failure to adequately address both the traumatizing effects of a psychosis on the sense of self, and the potentially traumatic components of treatment, particularly the experiences associated with first psychiatric hospitalization.

We propose systematic experimentation with efforts, drawing on evidence-based strategies from PTSD research and proven cognitive interventions for psychosis, aimed at: 1) ameliorating the traumagenic aspects of early illness and treatment related events; 2) developing specific interventions to help first episode clients better understand and cope with the most stressful aspects of their illness and related treatment experiences; and 3) developing interventions for trauma/post-traumatic stress disorder (PTSD) that are suited for clients with, or in recovery from, a first episode of psychosis.

### Trauma, PTSD and severe mental illness

Abundant research shows that people with severe mental illnesses such as schizophrenia, bipolar disorder, and severe major depression are highly vulnerable to traumas such as physical and sexual assault in both childhood and adulthood (Goodman *et al.*, 1997). Considering that PTSD is the most common and well-established psychiatric consequence of trauma exposure, it is not surprising to find that trauma exposure in

persons with severe mental illness is accompanied by high rates of PTSD, with most estimates of current PTSD ranging between 28% and 43% (Cascardi *et al.*, 1996; Craine *et al.*, 1988; McFarlane *et al.*, 2001; Mueser *et al.*, 1998, 2001, in press; Switzer *et al.*, 1999), as contrasted with the point prevalence rate of PTSD in the general population of approximately 2% (Stein *et al.*, 1997). These rates of PTSD are also far in excess of the lifetime rate of PTSD in the general population, with estimates ranging between 7% and 12% (Breslau *et al.*, 1991; Kessler *et al.*, 1995; Resnick *et al.*, 1993).

Trauma and PTSD are related to negative outcomes in persons with severe mental illness, including worse symptoms, more hospitalizations, substance abuse, and health problems (Goodman *et al.*, 2001; Mueser *et al.*, in press; Switzer *et al.*, 1999). Awareness of the high rate of PTSD in this population has led to a call for interventions to address this problem (Frueh *et al.*, 2002), and several programs have recently been developed (Harris, 1998; Rosenberg *et al.*, 2001). However, the major focus of these programs, and most other research on PTSD in severe mental illness, has been on the effects of life traumas such as physical and sexual assault, accidents, and the witnessing of violence to others, and not on the experience of psychosis and its treatment.

Along with a number of other researchers (McGorry *et al.*, 1991; Shaner & Eth, 1989; Williams-Keeler *et al.*, 1994), we propose that the experience of a first psychosis and its treatment may be fruitfully conceptualized as a traumatic event with the potential of leading to PTSD-like problems. We further suggest that this framework provides a way of understanding the problem of treatment non-adherence in clients with a first episode of psychosis. Early intervention strategies, and psychological treatment based on this formu-

lation, may improve the outcome of individuals who have recently developed a psychosis and/or are undergoing initial intensive treatments.

### **The psychological impact of psychosis and its treatment**

There are several arguments for considering the onset of psychosis, and its treatment, as potentially 'traumatic' events. According to DSM-IV (American Psychiatric Association, 1994), a traumatic event is something which presents a grave danger to the self or others and which results in severe negative emotions at the time of the event. Such events are generally external to the person, but may include internal events as well (e.g. heart attack). Psychosis often involves severe perceptions of threat (e.g. paranoia, delusions of control) accompanied by negative emotions, and may therefore constitute a traumatic event. In addition, social extrusion and stigma due to mental illness may be experienced as traumatic (or even more so) as the psychotic symptoms themselves (Beale & Lambric, 1995; Deegan, 1990; Fisher *et al.*, 1996).

Persons hospitalized for the treatment of a psychosis may also be at increased vulnerability to trauma in psychiatric institutional settings, or 'sanctuary trauma' (Frueh *et al.*, 2000). Furthermore, the treatment of psychosis often involves coercive interventions (e.g. forced medication, use of seclusion and restraints), which may be experienced as traumatic. Thus, the development of a psychosis, and receiving treatment for it, may be viewed as a psychologically traumatic event (Williams-Keeler *et al.*, 1994).

Consistent with this framework, a series of studies have examined PTSD in the wake of a psychosis and hospitalization, and have reported correspondingly high rates of PTSD

symptoms (Frame & Morrison, 2001; McGorry *et al.*, 1991; Priebe *et al.*, 1998; Shaner & Eth, 1989; Shaw *et al.*, 2002). Interestingly, there was limited consensus across studies as to what aspects of early illness were most traumatic: the psychotic symptoms themselves, treatment-related events (e.g. seclusion or restraint), or exposure to violence or threats from other clients.

Conceptualizing the experience of psychosis and its treatment as a traumatic event that can lead to PTSD-like symptoms may provide a useful formulation for understanding some of the problems that occur following the onset of a psychosis. One of the most common reactions in recent onset psychosis is depression (Addington *et al.*, 1998), which, given the strong association between PTSD and depression in the general population (Bleich *et al.*, 1997; Kessler *et al.*, 1995), may be related to PTSD symptoms. Non-adherence to treatment in first episode clients (Edwards & McGorry, 2002) may also be related to a PTSD-like reaction. One symptom of PTSD is avoidance of trauma-related stimuli (American Psychiatric Association, 1994). To the extent that clients' participation in treatment reminds them of the traumatic experience of the psychosis and its treatment, they may avoid valuable interventions, including medication, and not receive the beneficial effects of effective management of their disorder.

## Treatment implications

Understanding how psychosis and its treatment may be experienced as a traumatic event leading to a PTSD-like reaction has important treatment implications. First, it is incumbent upon providers to become more aware of the vulnerability of first episode clients to developing post-traumatic symptoms, and to take steps to reduce the likeli-

hood or impact of these secondary or iatrogenic disorders. Secondly, it is important to monitor and treat PTSD symptoms if they develop in first episode clients. Effective treatment programs for PTSD in the general population rely primarily on either cognitive restructuring or exposure techniques, either alone or in combination (Foa *et al.*, 2000). The adaptation and application of such methods has promise for helping individuals emotionally process traumatic memories related to their experience of psychosis. Being able to talk more openly about the trauma of psychosis and its treatment (including with others who have similar experiences), and challenging self-defeating and distorted beliefs about the world or self, may create the necessary groundwork for clients to actively collaborate with professionals in their own treatment. Such collaboration is crucial for optimizing the long-term outcomes of persons who have recently experienced an onset of psychosis.

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