TRAUMA AND PTSD IN PERSONS WITH SERIOUS MENTAL ILLNESS
PART II:
A BRIEF EDUCATIONAL AND ANXIETY MANAGEMENT INTERVENTION

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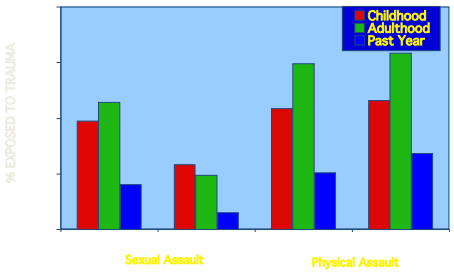
AGENDA

- Brief review of Seminar 1: "Overview and Screening"
- Links among trauma, PTSD, SMI, and psychosis
- Case Study: "Rosemary"
- Overview of PTSD treatment options
- Overview of "Brief Treatment for PTSD in SMI" Components
- Recent findings on effectiveness of "Brief Treatment"
- Conclusions and next steps in this work

REVIEW OF SEMINAR I: OVERVIEW OF TRAUMA AND PTSD IN SMI

TRAUMA IN SMI (N=779)



Goodman et al. (2001)

TRAUMA IN SMI: CORRELATES

- Severe psychiatric symptoms
- Substance abuse
- Medical problems
- Higher service utilization and hospitalization
- HIV; risky behaviors
- Re-victimization
- Higher rates of PTSD

TRAUMA, PTSD, & PSYCHOSIS

- Traumatic experiences important predictor of psychotic symptoms
- Psychotic symptom content in schizophrenia often linked to traumatic experiences (e.g., childhood sexual abuse, bullying)
- Psychotic symptoms common correlate of PTSD in non-SMI populations (hallucinations, delusions, bizarre behavior)

(Braakman et al.,2009; Hardy et al., 2005; Varese et al., 2012)

TRAUMA/PTSD IN SEVERE MENTAL ILLNESS

- Trauma and other adverse events in childhood increase risk of developing SMI
- High rates of trauma and PTSD in SMI population
- Multiple traumas common
- Additional traumatization via the mental health system (violent hospitalizations, forced medication, etc.)
- History of trauma associated with more severe symptoms, distress, functional impairment, acute care treatment
- **Service users report traumatic experiences are important but neglected treatment priority**

(Figueroa et al, 1997; Greenfield et al, 1994; Briere et al, 1997; Mueser et al, 2002; McFarlane, 1998; Nishith, et al, 2002)

COMMONLY ENDORSED TRAUMA-RELATED BELIEFS

- The world is a dangerous place
- You can never know who will harm you
- People can't be trusted
- My life has been destroyed by the trauma
- I have to be on guard all the time
- People are not what they seem
- I will never be able to have normal emotions again
- I'm worthless and "damaged goods" because of what happened to me

CASE STUDY: "ROSEMARY" (CBT/CR CASE)

"Rosemary:" Background

Background:
-- Caucasian Female, age 49, single, no children
-- Schizoaffective disorder, History of drug/alcohol dependence; sober 2 years
-- Living in supported housing in New Jersey

Trauma Information:
-- History of neglect, physical abuse, and sexual abuse in childhood by parents and others – parents involved in drug use and dealing; client frequently in unsafe situations
-- Index Trauma: "Held captive in a drug ring from age 3 to 17 that my parents were involved in"
-- PTSD Checklist (PCL) Score at screening = 77

"Rosemary:" Symptoms

Psychotic Symptoms:
--Delusional Elaboration: drug smuggling, forced to fly plane as teenager during drug drop, dove underneath boats to pick up drugs, planted bombs underneath boats, jumped out of helicopters during drug runs
-- Voices: related to thoughts and memories about trauma; brother's voice
-- Disorganization, tangentiality

PTSD Symptoms:
-- Avoidance
-- Intrusive thoughts and images
-- Voices
-- Guilt and shame
-- Drug/alcohol abuse

Working with "Rosemary"

-- Consistent redirection back to current distressing situations
-- Shaping behavior in sessions towards current problems and skill use
-- Focus on how trauma affecting current functioning
-- Not getting bogged down in details of delusions
-- Not challenging veracity of delusional beliefs or "elaborations"
-- Understanding underlying content of beliefs:
"I had to jump out of a helicopter when I was 10" → *fault that my family did these terrible things"* → *"I was a child and it was wrong that I was mistreated and put in situations that a child should never be put in"*

"Rosemary:" Outcome

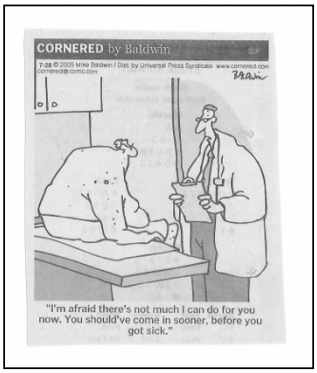
Treatment Outcome:

- Significant drop in both depression and PTSD symptoms
- Transfer from partial hospital program to outpatient and then to private practice
- Going to school for CNA degree
- Staff and client noted fewer psychotic symptoms; less disorganized speech
- Voices reduced and less related distress

OVERVIEW OF PTSD TREATMENT OPTIONS

TREATMENT OF PTSD IN GENERAL POPULATION

- CBT is most widely studied & replicated intervention, with primary support for:
  - ***Exposure Therapy (ET)***: Prolonged exposure to safe but anxiety-provoking, trauma-related stimuli (imaginal & in vivo) leads to emotional processing of event & habituation of fear
  - ***Cognitive Restructuring (CR)***: Identifying, challenging, & changing upsetting, inaccurate trauma-related thoughts & beliefs underlying PTSD facilitates incorporation of trauma experiences into self
- ET & CR equally effective, as is combination of ET + CR
  (Marks et al., 1998; Resick et al., 2002)
- Most studies employ exclusion criteria that rule most or all people with SMI & PTSD: psychosis, suicidal ideation, cognitive impairment, recent medication changes, & severe medical problems



"BRIEF TREATMENT FOR PTSD IN SMI" INTERVENTION OVERVIEW

"BRIEF" TREATMENT INTERVENTION

- 3 weekly individual sessions
- 4 "modules"
  1) Treatment Overview
  2) Breathing Retraining skill
  3) Psychoeducation about PTSD –with DVD
  4) Wellness Plan
- Client worksheets, plus a DVD for psychoeducation piece

MODULE 1: TREATMENT OVERVIEW

- Review of overall program
- Discussion of psychoeducation & breathing retraining
- Logistics of treatment program
- Homework, cancellations, etc.
- Instill hope***

MODULE 2: WELLNESS/CRISIS PLANNING

- Identification of warning signs of crisis
- Exploration of social supports
- Agreement on monitoring strategies
- Formulation of wellness/crisis plan
- Discussion of who to involve in crisis

EXAMPLES OF "CRISIS" SITUATIONS

- Suicidal thinking
- Emergence or worsening psychosis
- Severe depression & social withdrawal
- Emergence or increased self-injurious behavior
- Relapse or increased substance abuse

MODULE 3: BREATHING RETRAINING

- Education about impact of breathing on anxiety
- Instructions on how to modify breathing to reduce anxiety
- In-session practice and assigned homework
- Tailoring breathing retraining to individual clients
- Alternative relaxation methods: muscular relaxation, imagining a pleasant scene

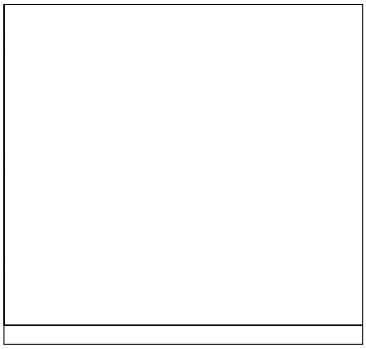
WHAT IS BREATHING RETRAINING?

- A Cognitive-Behavioral Therapy (CBT) skill
- Designed to be used to reduce anxiety and tension
- Brief, easy to use, and can be used anywhere

EDUCATE: RELATIONSHIP BETWEEN BREATHING AND STRESS

- Breathing affects how we feel
- Stress increases as breathing quickens and vice versa
- Impulse is to take long inhales
- Explanation of why long inhales are not useful
- Shorter inhales and long, directed exhales improve stress, tension, anxiety, etc.

BRT: Step-by-Step Guide



HOW BREATHING RETRAINING MIGHT BE DIFFERENT FROM OTHER RELAXATION SKILLS

- NO DEEP INHALES
- Regular breaths in
- To avoid taking in too much air and increasing hyperventilation
- Exhaling *long and slow* is the key here

TEACH AND PRACTICE BRT SKILL

1. Demonstrate the skill on your own
2. Practice the skill together
3. Provide reinforcement and corrective feedback
4. Observe the client practice
5. Provide additional corrective feedback as needed
6. Have client continue to practice during meeting as needed

MODULE 4: PSYCHOEDUCATION I

- Common Reactions to Trauma I: PTSD Symptoms
  - Re-experiencing
  - Avoidance: Active & Passive (numbing)
  - Overarousal

MODULE 5: PSYCHOEDUCATION II

- Common Reactions to Trauma II: Associated Difficulties
  - Negative feelings: Fear & anxiety, sadness, depression, guilt, shame, anger
  - Relationship difficulties
  - Alcohol and drug abuse

GOALS OF PSYCHOEDUCATION

- Help client conceptualize their trauma-related symptoms as part of a cohesive disorder about which much is known
- Let clients know "they are not alone" in experiencing common symptoms
- Explore how trauma & PTSD have affected client's life
- Motivate client to try the BRT skill & set positive expectations for change

PRINCIPLES OF PSYCHOEDUCATION

- Interactive
- Pause frequently & ask questions to help clients relate information to their own experiences
- Adopt client's language
- Use worksheets (and DVD) to help clients identify their own symptoms & trauma consequences
- Complete some worksheets in session; assign homework to complete others
- Ask review questions to check client understanding
- Abbreviate material when working with severely impaired clients

OUTSIDE PRACTICE (AKA: HOMEWORK)

Between Sessions 1 & 2:

1) Review and share Wellness Plan with supportive person.

2) Practice Breathing Retraining daily and when *not distressed* (create detailed practice plan and troubleshoot obstacles)

Between Sessions 2 & 3:

1) If above completed, practice Breathing Retraining daily, beginning to use during times of distress (plan ahead for anticipated appropriate situations)

2) Share PTSD knowledge gained during psychoed with supportive person

After Session 3:

1) Continued plan for integration of Breathing Retraining

RECENT FINDINGS ON EFFECTIVES OF BRIEF TREATMENT

NJ CBT FOR PTSD IN SMI STUDY

- Collaboration with Rutgers/UMDNJ/UBHC in NJ
- RCT conducted at 5 sites in urban settings
- Interventions delivered by frontline clinicians employed by clinics
- Clients randomized to CBT or Brief treatment
- Both interventions were billable services
- Baseline, Post-tx, 6 mo, and 1 year follow-up
- N = 201

(Mueser, Gottlieb, Xie, et al, in press)

RCT PARTICIPANT ELIGIBILITY CRITERIA

- "SMI" according to state of NJ
- Axis I diagnosis of schizophrenia, schizoaffective, bipolar, or major depression (borderline PD accepted)
- Current diagnosis severe PTSD (CAPS Total 65+)
- No hospitalization or suicide attempt past 3 months
- Not currently dependent on substances
- Receiving mental health services at UBHC-NJ
- Willing and able provide informed consent and participate

SUMMARY OF FINDINGS

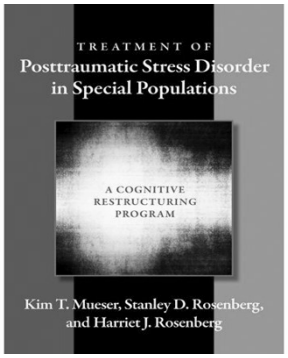
Good participation in treatment: 94% of those in Brief Treatment were "exposed" – completed at least 2/3 sessions

Predominantly minority clients living in poor, urban areas can benefit from this PTSD program

Although CBT program produced greater improvement, Brief program also showed significant reduction in PTSD symptoms (CAPS) and depression symptoms (BDI-II)

NEW QUESTIONS AND NEXT STEPS

- Apparent effectiveness of Brief program raises question: should treatment of PTSD in SMI be provided in a "stepped" fashion, with Brief first?
- Can treatment of PTSD in SMI be provided more efficiently in group format?
- "Stepped-Care" approach: combine Brief intervention with CBT group program for clients with persisting PTSD symptoms
- Increased training, dissemination, implementation, and *sustainability* at community mental health agencies nationwide for Brief and/or CBT intervention



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THANK YOU!