“You could still be, what you want to. What you said you were, when I met you.”

Daughter, lyrics from ‘Medicine’
CHAPTER 1

General introduction
GENERAL INTRODUCTION

Childhood adversities are prevalent in the general population and often associated with adult mental well-being.\(^1\) Annually, about 3.5% of the general population has trauma-related symptoms that meet the criteria for posttraumatic stress disorder (PTSD).\(^2^4\) Trauma-focused treatments are individually delivered psychotherapeutic treatments for PTSD that mainly utilise trauma-focused cognitive and/or behavioural techniques.\(^5\) Eye movement desensitization and reprocessing (EMDR) therapy is also considered to be a trauma-focused treatment.\(^6^7\) Trauma-focused treatments for PTSD are among the most effective in mental healthcare, and are more effective than both non-trauma-focused psychotherapies and pharmacological interventions.\(^7\) Patients appear to have a positive attitude towards evidence-based trauma-focused treatments;\(^8\) moreover, most patients prefer trauma-focused treatment to medication.\(^9^11\) There is strong empirical support for the effectiveness of both prolonged exposure (PE) therapy and EMDR,\(^12^13\) and both of these trauma-focused treatments are recommended in PTSD guidelines worldwide.\(^14^15\)

Experiencing childhood trauma increases the chance of developing psychotic symptoms\(^16^17\) and there are indications that trauma is associated with the persistence of psychosis.\(^18\) Traumas are highly prevalent in patients with psychotic disorders\(^19\) and in those at ultra-high risk of psychosis.\(^20\) For example, one review found that 28.3% of the males and 47.7% of the females with a psychotic disorder has experienced sexual abuse in childhood;\(^21\) later reviews also reported similar percentages.\(^22\) For purposes of comparison, the worldwide prevalence rate of sexual abuse is reported to be 1.6%.\(^1\) Moreover, individuals with psychotic disorders are at greatly increased risk of revictimization.\(^23\) As a result, many individuals suffering from psychosis (CI 4.0%-20.8%) have symptoms that meet the full diagnostic criteria for PTSD.\(^24^25\)

Symptoms of PTSD and psychosis both interact and overlap.\(^26^28\) In psychosis, the presence of comorbid PTSD is associated with more severe psychiatric symptoms, lower levels of social functioning, and more suicide attempts.\(^28^31\) Also, traumatised patients with psychotic disorders show more problems in service engagement and treatment adherence,\(^13\) receive higher doses of psychotropic medications,\(^31\) and respond less well to antipsychotics.\(^34\) Both trauma and a comorbid PTSD aggravate symptoms of psychosis\(^35\) and appear to function like ‘accelerators’ behind the psychosis via an array of ‘vicious’ interactions. Thus, many patients with a combination of trauma, psychosis and PTSD become stuck in a vicious cycle of ‘stable instability’, often for as long as the PTSD symptoms remain untreated.
At the time that we started the research for this thesis, little was known about the efficacy and safety of trauma-focused treatments in individuals with psychotic disorders. In clinical practice, virtually all comorbid PTSD is missed. In the unlikely event that PTSD is diagnosed in patients with psychotic disorders, clinicians generally refrain from offering trauma-focused treatments. The reason for this is that clinicians fear that trauma-focused therapy will exacerbate symptoms and destabilise patients, resulting in adverse events such as crises, suicide attempts, hospitalization, and dropout. Similarly, researchers exclude patients with psychotic disorders from randomised controlled trials (RCTs) that study trauma-focused therapies. In fact, the presence of psychosis is the most frequently applied exclusion criterion in these RCTs.

Before we started our work, only three studies had been published in which PTSD was treated in patients with a psychotic disorder. The research group of Kim Mueser performed a pilot study (n=22) in which they tested the feasibility of a 12 to 16-week adapted cognitive restructuring programme in a sample of participants with severe mental illness. In that sample, 45.5% had a psychotic disorder and direct exposure to trauma memories was avoided. The authors found a moderate reduction in PTSD symptoms, but the dropout was high (49.9%). Then, they proceeded to test this protocol in a RCT that included another sample of patients with severe mental illness and found positive results; however, in that trial, only 15.7% of the participants had a primary diagnosis in the psychosis spectrum. In another open pilot study that included 20 participants with a psychotic disorder, the application of PE therapy (preceded by a 7-week group stabilization phase) had a positive effect on PTSD and no adverse effects were reported; however, in that study, over one third of the participants dropped-out during the stabilization phase, which considerably limits the generalizability of the results. Since then, no other studies had been published. Consequently, it remained unknown whether (or not) standard trauma-focused treatment protocols with direct exposure to trauma memories were effective and safe in patients with a psychotic disorder.

In summary, trauma is highly prevalent and PTSD is a major problem in patients with psychotic disorders. Traumatic experiences are under-assessed and PTSD is underdiagnosed and undertreated, and patients’ needs are largely neglected. Robust evidence is lacking regarding the efficacy of trauma-focused treatments in individuals with psychosis. There is a need for thorough empirical testing of the effectiveness and safety of trauma-focused treatments in psychosis, preferably in a real-world clinical setting.
OBJECTIVES

The first aim of the work in this thesis was to test the feasibility of EMDR, a trauma-focused treatment that is increasingly applied to treat PTSD, in patients with a psychotic disorder, because EMDR had not previously been tested in psychotic disorders. For this, we conducted an uncontrolled feasibility pilot study using the standard EMDR treatment protocol. The rationale for this is that this would also give us an indication of whether standard trauma-focused treatment protocols, without modifications, could be used. This pilot study also allowed investigating the effects of trauma-focused treatment on the symptoms of psychosis (CHAPTER 2). The next step was to set up a multicenter RCT. This RCT examined the effects of standard PE and EMDR protocols on PTSD symptoms, compared to a waiting list condition for PTSD, in patients that received treatment-as-usual for psychosis. In this RCT we adopted few exclusion criteria and designed the study to mimic clinical practice as much as possible (CHAPTER 3). This RCT also tested the effects of PE, EMDR, and a waiting list condition for PTSD on the symptoms of psychosis, depression and social functioning (CHAPTER 4). Because most clinicians fear or expect some ‘harm’ related to trauma-focused treatments in psychosis, safety is an important factor in determining the clinical utility of trauma-focused treatments for patients with psychotic disorders. Therefore, we tested whether trauma-focused treatment induced symptom exacerbation, adverse events, and/or revictimization (CHAPTER 5). For the dissemination of trauma-focused treatments in psychosis it is also important to identify which factors influence treatment outcome. This information provides insight into the factors that may need to be taken into account when initiating trauma-focused treatment in these patients. Therefore, we examined whether baseline PTSD severity and/or seven psychosis-specific factors predicted trauma-focused treatment outcome and whether these factors were associated with dropout (CHAPTER 6). Also, in view of the dissemination of trauma-focused treatments in psychosis, it was considered important to learn how clinicians’ beliefs about the credibility, burden and harm of these treatments in individuals with psychosis could be influenced. Therefore, we explored the impact of the different stages of specialised trauma-focused treatment training on these beliefs among the therapists that participated in our RCT (CHAPTER 7).
REFERENCES


