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RCPsych Webinar 18th March 2021

Trauma-Informed Care in Early Intervention in Psychosis

Presenters

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- **Dr Peter Carter**
- **Consultant Psychiatrist, Joint lead for NELFT EIP**
  Director of Medical Education
- **Dr Miriam Fornells-Ambrojo**
- **Consultant Clinical Psychologist, Joint Lead for NELFT EIP**
  Assistant Professor Psychology DClinPsy UCL
- **Dr Mel O'Brien**
- **Clinical Psychologist, NELFT EIP**
- **Dr Ruby Rathbone**
- **Foundation Year 1 doctor NELFT**

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Structure

- Definitions and polls
- Case presentation
- Underpinning theory
- Theory in practice
- Discussion

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Learning Objectives

- To understand the principles of Trauma-Informed Care
- To understand the ways in which psychosis and its treatment can contribute to trauma
- To be able to incorporate principles of Trauma-Informed Care into clinical practice.

What is meant by trauma?

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- Refers to a wide range of traumatic, abusive or neglectful events or series of events in childhood (ACEs) and as an adult
- that are experienced as being emotionally or physically harmful, or life threatening.
- Whether an event(s) is traumatic depends on our individual experience of it, and how it impacts on our emotional, social, spiritual and physical wellbeing.
- We are all affected by traumatic events in different ways.

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Consider 3 E s

- The Event
- How it is Experienced
- What are its Effects

Definition

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- **‘Trauma Informed’ is the ability to recognise when someone may be affected by trauma, to collaboratively adjust work to take this into account, and respond in a way that supports recovery, does no further harm and supports their resilience.**

So what is ‘trauma informed?’

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- 4 R’s:
- **R**ealise how common the experience of trauma is
- **R**ecognise the different ways that trauma can affect people
- **R**espond by taking account of the ways that people can be affected by trauma to support recovery
- **R**esist re-traumatisating and offer a greater sense of control, empowerment and collaboration

- **Recognising the central importance of Relationships**

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Some Considerations

- Experience of restraint in hospital ?
- Where are her trusting relationships ?
- Transition @ 18 , how is continuity managed ?
- Could we anticipate these side effects?

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Dr Miriam Fornells- Ambrojo

- Trauma and psychosis literature
- Psychosis-related trauma
- Mechanisms and impact
- NICE recommendations & what we do
- Q&A

How common is trauma in psychosis?

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49-100% High rates of trauma, particularly multiple childhood victimisation, in psychosis compared to the general population (Grubaugh et al, 2011)

3.6x People with diagnosis of schizophrenia more likely to experience childhood victimisation than general population, rates comparable to depression, PD and PTSD (Matheson et al, 2013)

14% of people with SMI vs 4% of general population report violent crime in past year

10x Women with SMI 10x more likely to experience sexual violence than general population (Khalifeh et al, 2016)

Amy Hardy

Trauma & risk of psychosis

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Childhood adversity (sexual, physical or emotional abuse, neglect, parental loss and bullying) is associated with increased risk of psychosis (OR= 2.78, (95% CI = 2.34- 3.31)

Dose-response effect reported in 9/10 studies

Varese et al., (2012) meta-analysis

Severe forms of childhood adversity, i.e. involving **psychological threat**, hostility and violence, **most** strongly associated with increased odds of psychosis

Exposure to multiple adversities increased odds

Morgan et al., (2020): case-control study

Impact on psychosis and EIS?

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- Trauma and PTSD are associated with ***worse*** clinical and functional outcomes in psychosis (Subica et al, 2013, Soews et al, 2016):

  - **Higher rate of admissions, worse engagement with community services**

  - **Increased severity of psychotic and PTSD symptoms**

  - Other poor outcomes (incl. quality of life, higher prevalence of drug and alcohol misuse, neurocognitive impairment, suicide attempts, housing instability)

Psychosis-related trauma

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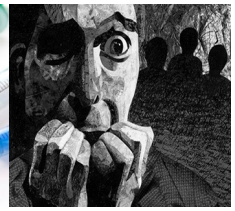
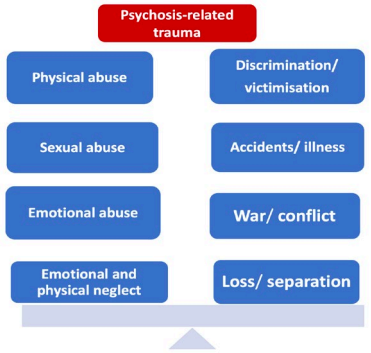
- **The experience of psychosis itself and the treatment received can be traumatic** (Berry et al. (2013); Fornells-Ambrojo et al. (2016) Brewin et al., 2019; Rodrigues & Anderson, 2017, Buwell et al. 2020):
- **Unusual experiences, such as hearing voices, seeing visions or having worries about other people causing you harm**
- **Contact with mental health services (e.g. admission) that involved threatening or upsetting events (e.g. restrained, coerced, secluded, assaulted, forced to take medicine)**





Ethnicity & compulsory admission

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- **Black Caribbean and Black African ethnic groups more likely to be compulsory admitted compared to White ethnic groups (OR: 2·53, 95% CI 2·03–3·16, p<0·0001 and (2·27, 1·62–3·19, p<0·0001 respectively) (Barnett et al., 2019)**

- **Most marked in Black African women: 7 to 8 times greater odds than White British women (Mann et al., 2014)**

Black women's experiences of the decision being made to section them

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UCL DClinPsy thesis (2020)Samantha Rennalls

Early in the morning when I was sleeping … they just knocked on the door… I got up and put on my nightdress, that was all, and I went to answer the door, and I saw 8 people coming in.

They just stormed in the house and said you are sectioned under mental health act…when I go in the toilet, they're following me, when I go in the bedroom, they follow me…

I told them "give me privacy, let me try and just put on something on my body please", then they were just standing there, they couldn't even allow me to close the door

How common is PTSD in psychosis?

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- **Current and lifetime prevalence estimates are 12-16% and 14-53% (compared to 3.5% and 7-12% in the general population)** (Grubaugh et al, 2011; Kessler et al, 2017; Steel et al, 2017; de Bont et al, 2015)

Psychosis-related PTSD:

- **Prevalence estimates are 14% to 47%** (Buswellet al., 2020)
- **In first episode group: prevalence of a PTSD diagnosis was 30% (95% CI 21%–40% *PTSD symptoms* was 42% (95% CI 30%–55%)** (Rodrigues, R., & Anderson 2017)

Trauma & Psychosis: Models

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- **Models explaining the association between trauma and psychosis** (Barker et al., 2015; Hardy et al., 2017; Read et al. 2001, 2014; Steel et al., 2005; van Nierop et al., 2014; Varese et al., 2012):

- **Biopsychosocial vulnerability triggered by traumatic events encoded in a way that leads to sensory and decontextualised memories**

- **Repeated exposure to stressors results in hypersensitivity to stress**

- **Sensory-perceptual intrusions appraised as externally or internally generated (search for meaning)**

Potential impact of trauma

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Traumatic events

Proposed mechanism

Psychological
- Attachment
- Emotion dysregulation
- Beliefs
- Social defeat
- Dissociation

Biological
Hyperactivity to stress (HPA axis) & dopaminergic system

Impact

Emotions (e.g. fear, shame)

Numbness, detachment

Impairment in functioning

Relationship difficulties (trust)

Self-harm, substance misuse

Impact Psychosis and PTSD

Voices (sexual abuse) (content theme)

Paranoia (neglect,bullying)

Re-experiencing memory of trauma (intrusions, nightmares)

Hyper-arousal

Avoidance

Insecure attachment in psychosis

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- Highly prevalent (76%)
- Fearful attachment
- Poorer therapeutic alliance and engagement
- Poorer outcomes (severity positive symptoms, longer hospitalisations)
- Mediate impact of childhood trauma and neglect on voices and paranoia

(Berry et al., 2007; Carr et al. 2018; Chatziioannidis et al., 2019; Gumley et al., 2014; Korver-Nieberg et al., 2014; Sitko et al., 2014)

Two key NICE recommendations adopted in EIS NELFT

1. **Assess trauma and its consequences in all people with early psychosis**

2. **If PTSD identified offer *trauma-focused CBT interventions (*e.g. Narrative Exposure Therapy (NET), Prolonged Exposure Therapy); *EMDR* can be considered**

PTSD treatment in people with psychosis: Evidence

- **Prolonged Exposure and EMDR: safe and effective in reducing PTSD in people with chronic psychotic disorder** (de Bont et al., 2016; van den Berg et al. 2018)
- **Trauma-focussed psychological interventions reduce psychotic symptoms post tx (e.g. paranoia)** (Brand et al. 2018)
- **Cognitive restructuring is <u>not</u> effective in reducing PTSD in people with psychosis** (Steel et al., 2017)
- **NET: emerging literature** (Cherestal et al., 2019; Katsounari et al., 2015; Mauritz et al., 2021)

TALE

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Trauma And Life Events Checklist (Carr et al., 2018)

- 20-item trauma easy to use screen for people with psychosis
- covers relevant childhood and adult trauma as well as psychosis-related trauma
- Used across a number of NHS trusts, and in many countries clinically and for research purposes, including Oregon service in Melbourne, STAR and AVATAR trials. Translations available in Dutch, French, Spanish, Danish
- Role play: https://us02web.zoom.us/rec/share/DW7cgnETrsZshzU-Wonucqpq9xD_E9eQ85j-L-OU9N2Usy5-BZ-ilsdqut-ri8Eq.iDHcRCycb0tRirMk
- If trauma(s) identified we complete PTSD/cPTSD screen (International trauma questionnaire; ITQ; Cloitre et al.,2018)

Mini-TALE Checklist

(Mini Trauma And Life Events Checklist, Version 1, Carr, Hardy & Fornells-Ambrojo, in prep)

This checklist includes a list of common traumatic or stressful life events. We would like to know whether or not you have ever experienced these events and, if so, which has the most impact on you now. If you chose to answer, please just indicate which events you experienced, if they happened more than once, and how old you were when they happened. Thank you.

Have you ever experienced…?	**Yes (✓) or No (×)**	**More than once? Yes (✓)/ No (×)**	**Age(s) -** range if repeated
1. Being insulted, put down or humiliated (e.g. by family, friends, or strangers)?			
2. Feeling unsafe, unloved or as if no one would protect you when you were growing up?			
3. Someone being physically violent towards you at home or in public (e.g. fights, assaults, mugging)?			
4. Sexual contact that either at the time or looking back on it now was unwanted (e.g. touching, talking, looking, penetration)?			
5. Apart from the above, has anything else happened in your life that you found distressing? Please specify:			
6a. Do any of the events you have mentioned, <u>that ended at least 1 month ago</u>, still affect you now? Yes / No			
6b. Which event or events currently affect you most? Event number(s):			

Narrative exposure therapy(NET)

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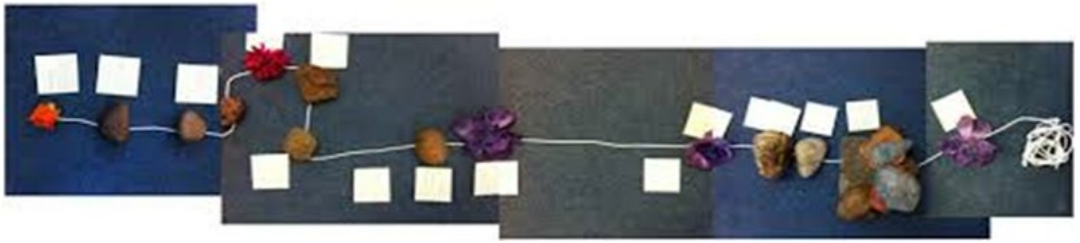
- Suitable for prolonged/ repeated/ multiple trauma
- Core techniques: exposure + embedding traumatic events in autobiographical context
- Training offered to all psychologists across NELFT EIS and planned research



- Other interventions available include EMDR, formulation of traumatic events within CBT for psychosis, addressing other impact of trauma

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Thank you for listening!

Q&A

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Therapeutic approaches

Dr Mel O'Brien, Clinical Psychologist

Trauma informed care – practice levels

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Supported housing

EIP team + SW

Psychology

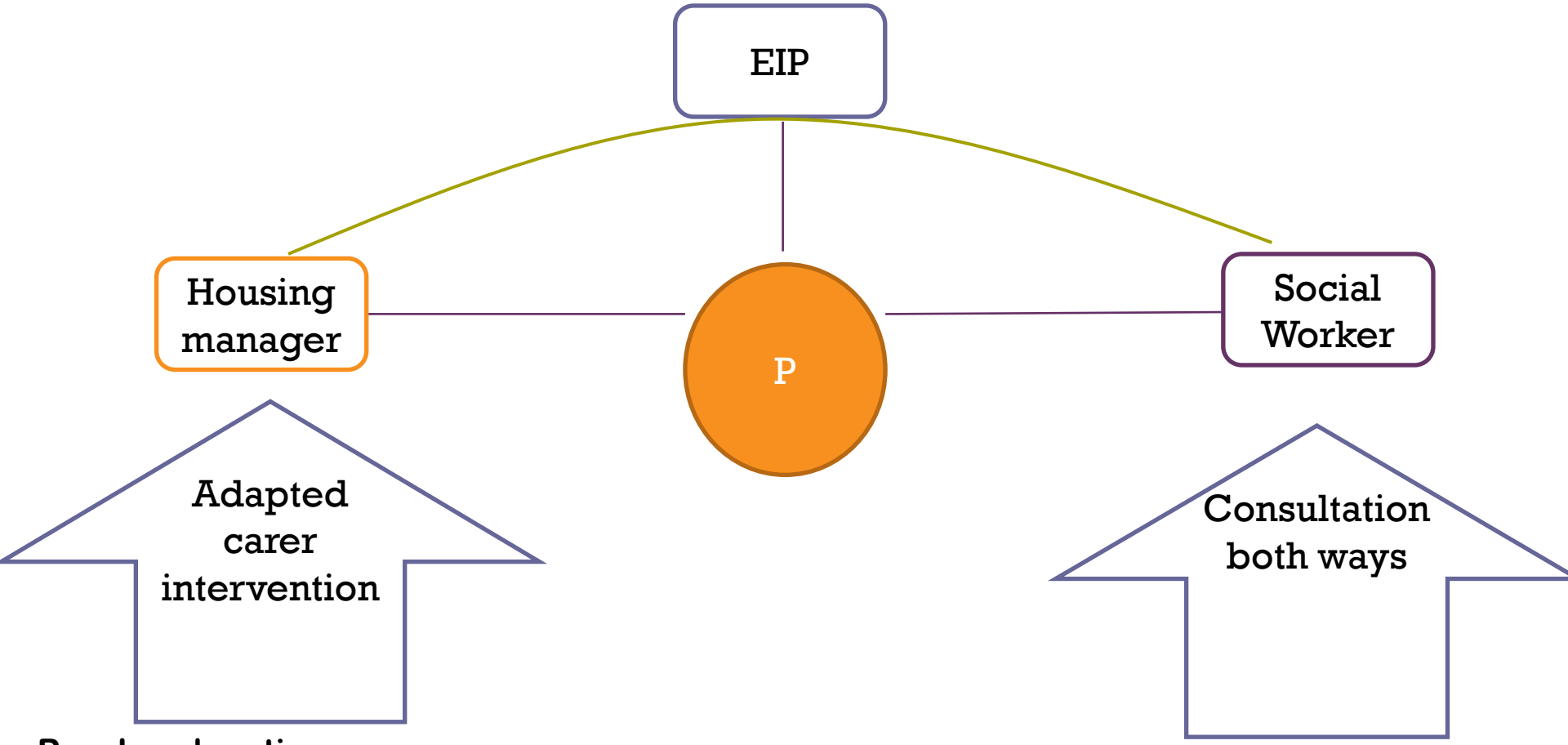
Table 1 – Practice Level Definitions

TRAUMA **INFORMED** PRACTICE	TRAUMA **SKILLED** PRACTICE	TRAUMA **ENHANCED** PRACTICE	TRAUMA **SPECIALIST** PRACTICE
All workers.	Workers who are likely to be coming into contact with people who may have been affected by trauma.	Workers who have a specific remit to respond to people known to be affected by trauma —AND— are required to provide advocacy support or interventions	Workers who have a specific remit to provide specialist interventions or therapies for people known to be affected by trauma with complex needs.

UCATION FOR SCOTLAND AND SCOTTISH GOVERNMENT (2019) The Scottish Psychological Trauma Training Plan

Key principle: relationships matter.
"Each contact a chance to afford safety, enhance resilience"

Trauma skilled practice – working with the wider system



Psychoeducation

Early warning signs Vs. understandable behaviours given trauma + psychosis

Trauma skilled practice – working with the wider network

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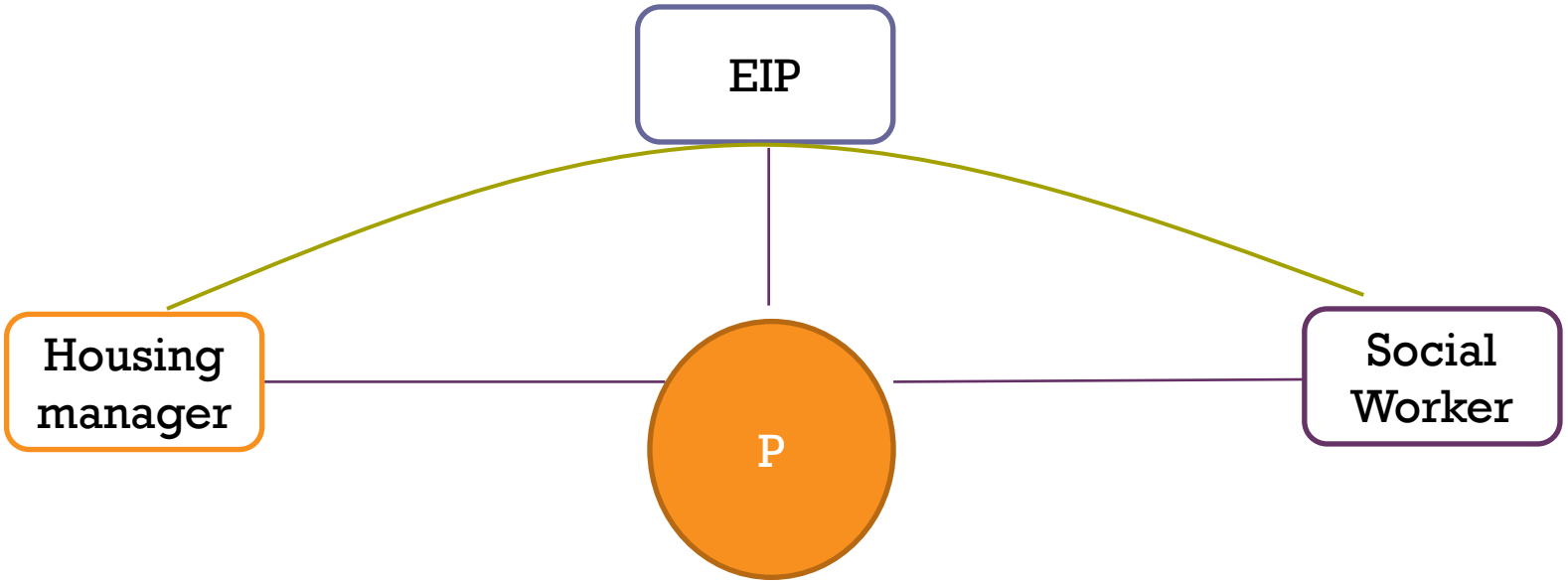

Professionals meetings are key:

- Different perspectives on causes and maintaining factors of psychosis can cause splits in the system.
- Care-coordinator organising opportunities to meet together

Assessment

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- Timing:
  - Introduced prior to transition from CAMHS to EIP
- Flexibility in approach (phone calls to start)
- Clinical interview + measures

Assessment

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- Trauma: TALE (Carr et al., 2018)

Multiple traumatic events + restraint (re-traumatising)

Flashbacks + intrusive memories

- PTSD: ITQ (Cloitre et al,, 2018)

- Auditory hallucinations severity: PSYRATS (Haddock., 1994)

Voices ceased

Distressing belief of being followed, being 'cursed'

- **P's description of difficulties:**
  - 'Can't speak', 'slowed down', unmotivated

⇩

'I'm stupid, different'

- Thinking about past [including intrusions]

⇩

feeling sad, angry, anxious, flat

⇩

smoke cannabis to feel more relaxed

- Relationships (strained – hard to trust others, ambivalent)

P's hopes/goals for therapy

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- To learn ways to cope with my thoughts and feelings (anxiety, low mood)
- To make sense of my experiences and speak about what has happened to me
- To be able to get out more (go to college, start to socialise)

Trauma-Informed Practice
General Principles

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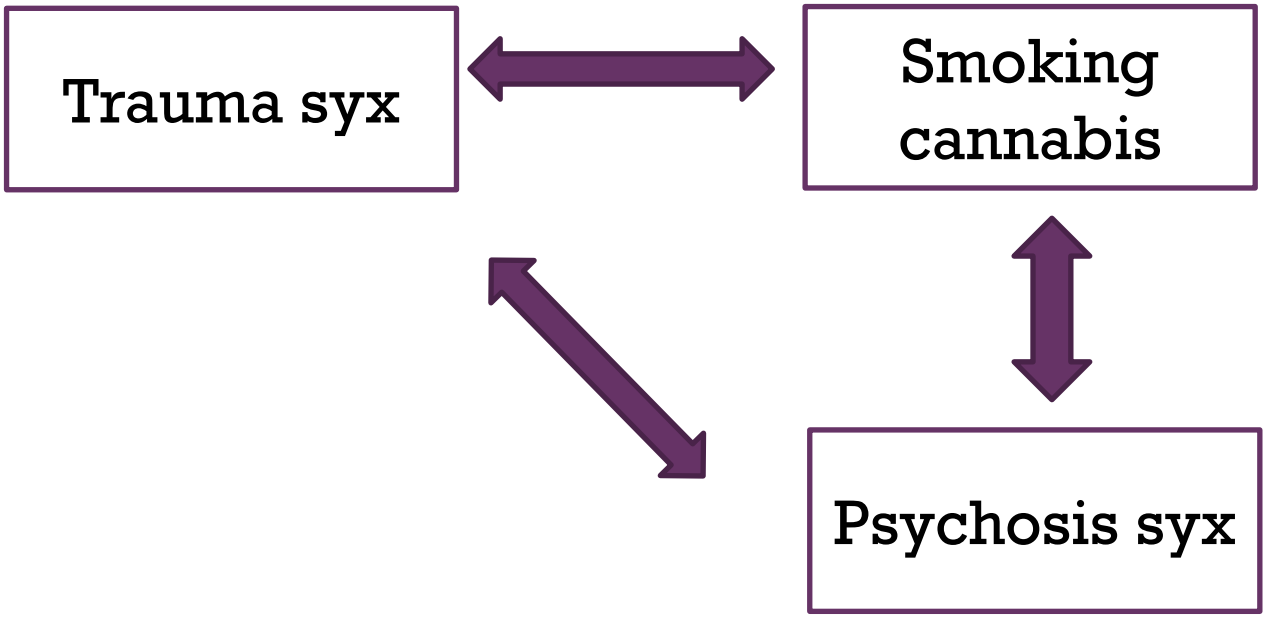
Understand and explore substance misuse (cannabis)

- Validating difficulties stopping
- Function and relationship between:



Integrated psychosis + PTSD model (Hardy., 2017)

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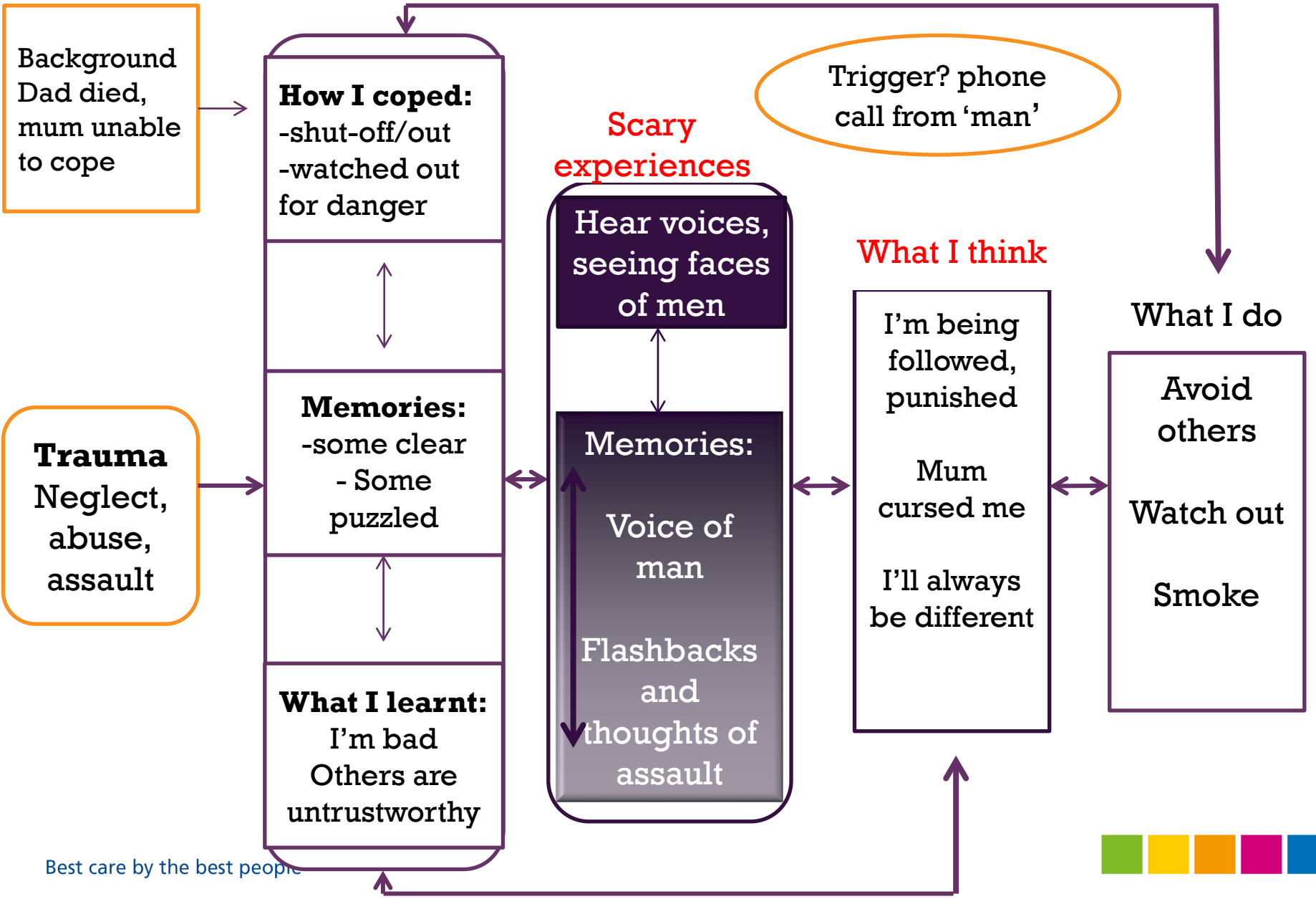

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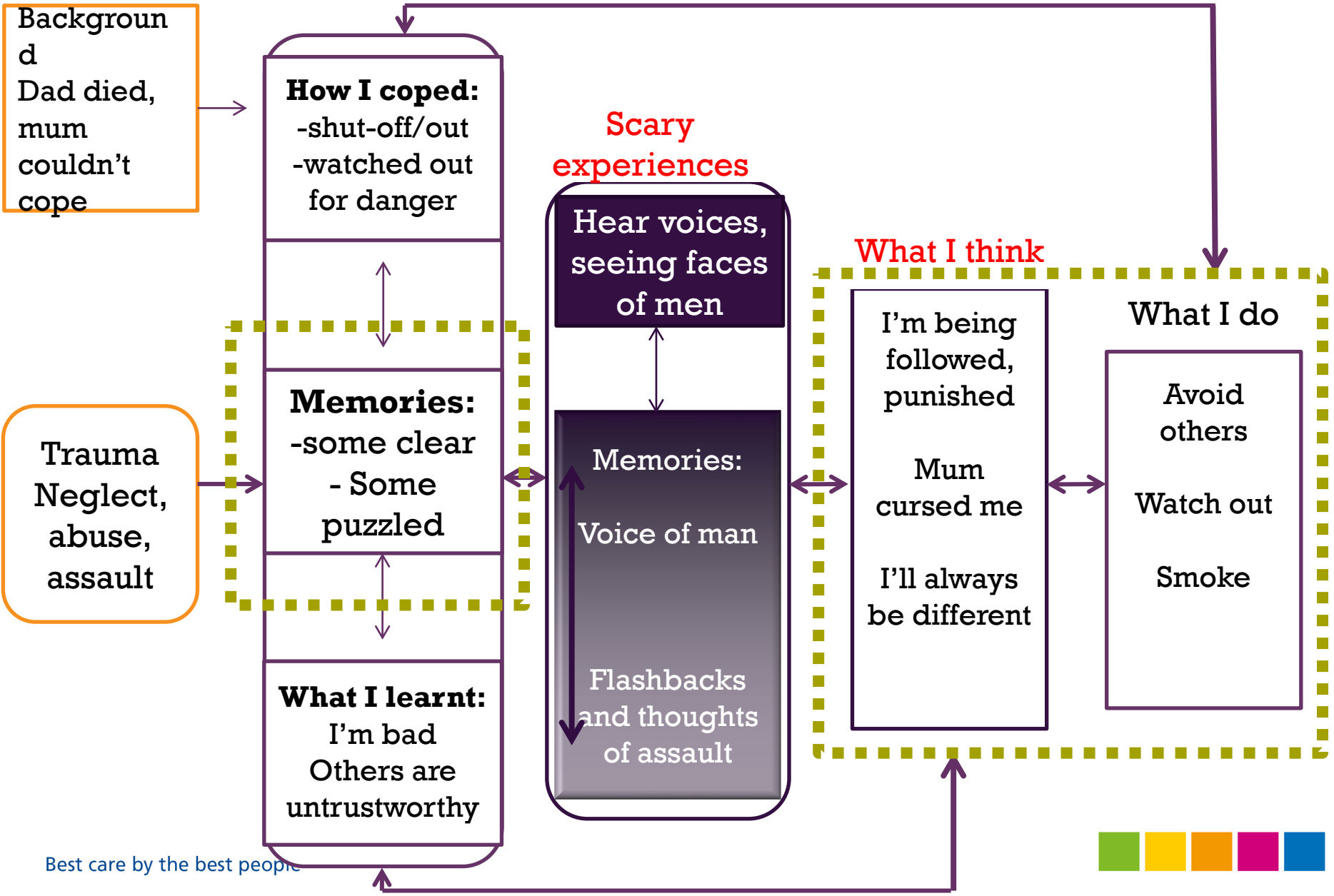

Intervention

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Promoting control & emotion regulation:

- Psychoeducation (trauma + psychosis)
- Links between thoughts-feelings-behaviours
- Emotion regulation (breathing, grounding)
- Cognitive strategies (e.g. biases, cognitive restructuring)

Intervention – next phase

Re-living work: Narrative Exposure Therapy (NET):

- ‘Creation of a consistent narrative ‘ using a lifeline approach of stones and flowers.

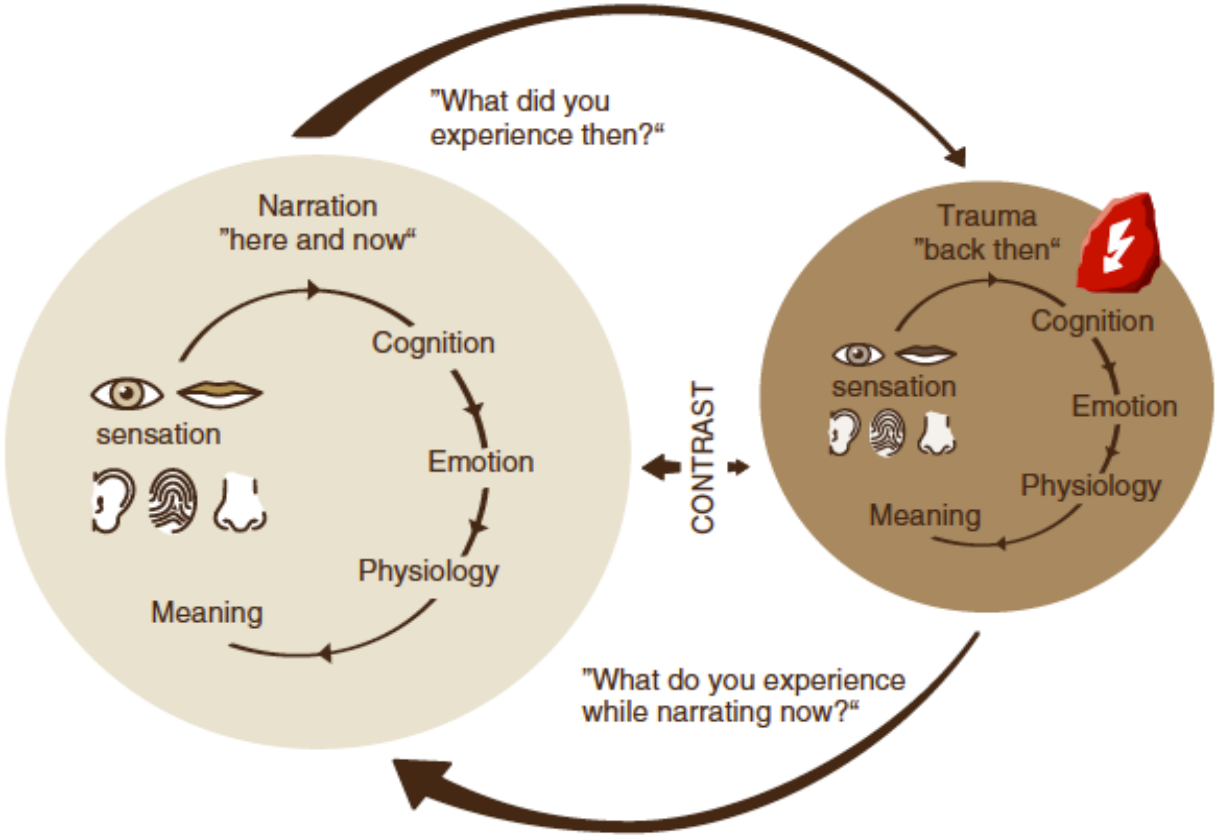

Fig. 11.1 The method of the NET narration procedure. During the imaginal exposure, the different levels of experiencing are continuously explored in detail while the child tells the story. Every now and then, the therapist invites contrasting the past (trauma) context from the current context (Schauer et al. 2011)

Aims:
Integration of 'hot and cold' memory

Cognitive re-orginisation

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Reflections:

- Working together as a team key

- Pacing:
  - Keeping cognitive symptoms in mind
  - Lots of summarises and checking-in

- Supervision key to consider:
  - Adaptations (e.g. working through covid-19)
  - Impact on therapist

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Areas for discussion

- How can we better identify trauma
- How could services adapt to avoid retraumatising
- How best to talk about drugs esp if not drug service

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Closing Summary

- Thinking about trauma is everyone's business
- Tale or mini-tale should be routine
- Patience flexibility adaptability of teams

- Hardy, A. (2017). Pathways from trauma to psychotic experiences: a theoretically informed model of posttraumatic stress in psychosis. *Frontiers in psychology*, *8*, 697.

- Transformingpsychologicaltrauma.scot
- https://www.youtube.com/watch?v=JPHa3fKaXWg

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THANKS

- **Miriam Mel Ruby**
- **Dr Mayowa Aina**
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