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Acceptance and Commitment Therapy for Posttraumatic Stress Disorder in Early Psychosis: A Case Series

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Persons with psychosis often report high levels of posttraumatic stress disorder (PTSD) symptoms, which render them more vulnerable to relapse, symptom exacerbation, and reduced well-being. However, less is known about how to adequately accommodate the needs of persons recovering from a first episode of psychosis, presenting with PTSD. Further, the existing evidence-based interventions for PTSD seem less equipped to deal with serious mental disorder and comorbid conditions. This study aimed to assess the efficacy, acceptability, and safety of Acceptance and Commitment Therapy (ACT) for persons suffering from PTSD with comorbid trauma and psychosis. Three consecutively referred participants meeting ICD-10 criteria for PTSD and a first-episode nonaffective psychotic disorder were treated in an outpatient service within a case-series analysis. A manual-guided ACT intervention of 12 sessions showed clinically relevant improvement on self-report measures of PTSD symptoms and emotional distress. These initial findings are promising and appear to justify a more controlled evaluation of this brief intervention.

Psychotic disorders are some of the most debilitating psychological disorders, causing enormous suffering for individuals and their families (Jablensky, 1997; Jansen, Haahr, et al., 2015). However, contrary to long-standing belief, many persons achieve full recovery or significant improvement (Lysaker & Buck, 2008) and recent years have seen a proliferation of research interest and psychosocial endeavors to intervene early to avoid chronicity. Central to the early intervention movement is the examination and management of risk factors known to influence a negative outcome, such as comorbid substance abuse and personality dysfunction (McGorry, Killackey, & Yung, 2008). One important risk factor that has received increasing attention recently is the presence of trauma and posttraumatic stress disorder (PTSD). Studies have found that between 28% and 73% of persons with a psychotic disorder have been victims of childhood sexual and/or physical abuse (Bendall, Jackson, Hulbert, & McGorry, 2008; Mueser, Lu, Rosenberg, & Wolfe, 2010). A recent study found that 89% of persons with first-episode psychosis reported significant childhood adversity compared to 37% in the control group (Trauelsen et al., 2015).

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The prevalence of PTSD in people with psychosis ranges from 12% to 29% (Achim et al., 2011; Buckley, Miller, Lehrer, & Castle, 2009). This is of great clinical importance as the presence of trauma symptoms often exacerbates psychotic symptoms and increases the risk of relapse (McGorry et al., 1991; Mueser et al., 2010).

However, counselors often fail to identify a client's trauma history and the symptoms of posttraumatic stress often go unnoticed (Grubaugh, Zinzow, Paul, Egede, & Frueh, 2011; Jansen, Pedersen, Hastrup, Haahr, & Simonsen, 2015; Jansen et al., 2016; Mueser et al., 2010). The types of trauma presented include childhood sexual and physical abuse, physical and sexual assaults, bullying, and trauma related to the experience of psychosis (Varese et al., 2012). The interaction between posttraumatic stress and psychosis can be cyclical; a person may have developed a psychotic disorder and PTSD after childhood traumas, but the traumatic experience of a psychotic episode itself can activate or reactivate PTSD (Morrison, Frame, & Larkin, 2003). While the presence of trauma and its relation to the development of a psychotic disorder has been highlighted in a number of studies (Varese et al., 2012), considerably less is known about how to treat comorbid PTSD and psychosis (Grubaugh et al., 2011). In general, clinicians treating persons with psychotic disorders are often reluctant to talk about trauma due to fear of causing distress and increasing the risk of relapse (Read, Hammersley, & Rudegeair, 2007).

There are a number of evidence-based psychological therapies for the treatment of PTSD, including Prolonged Exposure (PE; Foa, Hembree, & Rothbaum, 2007), Cognitive Processing Therapy (CPT; Shipherd, Street, & Resick, 2006), and Eye-Movement Desensitisation and Reprocessing (EMDR; Shapiro & Maxfield, 2002). However, there are some important challenges to implementing these evidence-based therapies in real-world settings (Bradley, Greene, Russ, Dutra, & Westen, 2005). First, there are challenges in engaging people in these treatments, as evinced from the considerable rates of dropout observed in trauma intervention programs and psychotherapy research: it is evident that large numbers of people do not want to engage because of fears about activating difficult memories and emotions in therapy (Rothbaum, Meadows, Resick, & Foy, 2000). Second, many clinicians are reluctant to deliver the exposure part of the therapy for PTSD, even when these therapists have been appropriately trained (Becker, Zayfert, & Anderson, 2004). Third, most of the studies on PTSD exclude participants with comorbid conditions, including psychosis, personality disorders, and substance abuse, which are very prevalent in persons presenting for treatment in psychiatric services. In other words, since many clients will either refuse or not respond to the most supported interventions, and many clinicians are reluctant to deliver the interventions, there is little evidence or clinical reports on how to treat the more complex conditions.

One approach to engage with this dilemma is to apply known trauma interventions to persons with psychosis, which a handful of studies have attempted. Bernard et al. (2006) found that written emotional disclosure reduced psychosis-related posttraumatic stress symptoms in persons with early psychosis. In a feasibility study, de Bont et al. (2013) found that PE and EMDR were both effective and safe in persons with psychosis and PTSD. In a cognitive behaviour therapy (CBT)–based open trial, Frueh et al. (2009) showed a significant reduction in PTSD symptoms in a sample of adults diagnosed with schizophrenia. Jackson et al. (2009) also found an effect of a CBT-based intervention on trauma symptoms in a randomized controlled trial with a first-episode psychosis sample. Based on the findings in these studies, there seems to be preliminary support for the feasibility, safety and efficacy of brief trauma interventions for persons with psychosis.

Another approach in dealing with the complexity of comorbidity has been to apply trans-diagnostic treatment programs that address common psychological processes underlying both (or all) disorders (Lang et al., 2012). One such approach is Acceptance and Commitment Therapy (ACT; Hayes, Strosahl, & Wilson, 2012). ACT is an acceptance-based behavior therapy that targets experiential avoidance and a lack of flexibility and persistence in pursuing valued life directions (Hayes, Strosahl, & Wilson, 1999). ACT is rooted in the philosophical tradition of functional contextualism and based on a program of basic research referred to as Relational Frame Theory (Hayes, Barnes-Holmes, & Roche, 2001; Hayes, Hayes, Reese, & Sarbin, 1993). One of the core psychological processes thought to be responsible for the development and maintenance of PTSD is experiential avoidance: individuals go to great lengths to avoid people, places, objects, thoughts, feelings, and bodily sensations associated with the traumatic event, even if these are personally valued (Marx & Sloan, 2005; Seligowski, Lee, Bardeen, & Orcutt, 2015; Tull, Gratz, Salters, & Roemer, 2004). For many suffering from PTSD, this significantly reduces social activities and meaningful interactions with the world (Orsillo & Batten, 2005; Walser & Hayes, 2006). Experiential avoidance and limited engagement in personally meaningful activities are also considered central psychological mechanisms in development and maintenance of psychotic symptoms, including hallucinations, suspiciousness, and unusual thought content (Morris, Garety, & Peters, 2014; Udachina, Varese, Myin-Germeys, & Bentall, 2014). So reducing experiential avoidance may improve both traumatic and psychotic symptoms. Moreover, there are considerable overlaps when trying to conceptualize and understand symptoms of PTSD and psychotic disorders. For example: some hallucinations and delusions may be variants of posttraumatic flashbacks (Morrison et al., 2003); dissociative experiences, which are a prominent complication seen in complex trauma, and psychosis may be difficult to disentangle (Moskowitz, Schäfer, & Dorahy, 2008); and finally, voices and intrusive thoughts share a range of common phenomenological aspects, such as being repetitive, powerful, and often negative or critical (Morris et al., 2014; Morrison & Baker, 2000).

Studies have found ACT to be effective in managing a number of disorders, including depression, anxiety, stress, psychosis, epilepsy, and pain (Hayes, Luoma, Bond, Masuda, & Lillis, 2006; Ost, 2008; Powers, Zum Vorde Sive Vording, & Emmelkamp, 2009). While ACT has demonstrated safety and potential efficacy for PTSD in uncontrolled studies (Batten & Hayes, 2005; Orsillo & Batten, 2005; Twohig, 2009), larger controlled studies are still under way (e.g., Lang et al., 2012). The aim of the current study was to examine the feasibility and effectiveness of an ACT intervention in reducing PTSD symptoms in persons with early psychosis.

Method

Participants

Participants were three persons consecutively referred to outpatient psychotherapy from a specialized early psychosis treatment service, after having been screened