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# Post-traumatic reactions to psychosis in people with multiple psychotic episodes

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ABSTRACT

Psychotic symptoms, coercive interventions, and other negative treatment experiences have been found to lead to posttraumatic stress disorder (PTSD) symptoms. However, prior research has not examined the importance of the DSM-IV A1 (perception of threat) and A2 (negative emotion at time of event) criteria for a traumatic event due to a psychotic episode. To address this question, 50 clients with a history of multiple episodes of psychosis were interviewed to identify distressing experiences related to past episodes, with PTSD assessed (including A1/A2 criteria) related to those events, and other psychiatric symptoms, psychosocial functioning, and coping style. Participants reported intense distress related to psychotic symptoms (66%), treatment experiences (25%), and their combination (8%), with 69% meeting symptom criteria for PTSD (excluding A1/A2 criteria), and 31% meeting full diagnostic criteria for PTSD (including A1/A2 criteria). Clients meeting symptom criteria for PTSD, as well as those meeting full diagnostic criteria for PTSD were similar, with both groups reporting more severe symptoms and distress, and more problems in daily functioning, than clients with fewer or no PTSD symptoms. The results are similar to a previous study of PTSD in persons with recent onset of psychosis (Mueser et al., 2010), and suggest that individuals with PTSD symptoms related to psychosis and coercive treatment may benefit from interventions designed to help them integrate their experiences into their lives and reduce PTSD symptoms, regardless of whether the triggering event(s) meet DSM-IV A1/A2 criteria for a traumatic event.



## 1. Introduction

The development of a psychotic illness can be a devastating event with major impact on an individual's perception of self, self-esteem, and the ability to get on with life (Davidson, 2003). Furthermore, the experience of psychotic symptoms, such as derogatory hallucinations or paranoid delusions, can be a frightening, traumatic one (Boevink, 2006; Cohen, 1994). In addition, coercive interventions for schizophrenia and other severe mental illnesses, such as involuntary hospitalization, seclusion and restraint, or being forced to take medication, can be upsetting, traumatizing events (Frueh et al., 2005; Gallop et al., 1999; Ray et al., 1996). A range of other traumatic aspects of inpatient psychiatric treatment has also been reported, such as being around sick or frightening patients, witnessing/experiencing physical assaults, and experiencing

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unwanted sexual advances (Frueh et al., 2005, 2000; Cohen, 1994; Cusack et al., 2003).

Over 20 years ago, Shaner and Eth (1989) observed that the trauma associated with developing schizophrenia could lead to symptoms consistent with posttraumatic stress disorder (PTSD), including re-experiencing the traumatic event(s), avoidance of trauma-related stimuli, and over-arousal. Since their seminal paper, over ten studies have reported high rates of PTSD symptoms due to either psychotic symptoms, treatment experiences, or their combination (Chisholm et al., 2006; Cusack et al., 2006; Frame and Morrison, 2001; Jackson et al., 2004; Meyer et al., 1999; McGorry et al., 1991; Morrison et al., 1999; Mueser et al., 2010; Priebe et al., 1998; Shaw et al., 2002; Tarrier et al., 2007; White and Gumley, 2009). There are conflicting data in regards to which is more traumatic, the psychotic experience itself, or the treatment used in the hospital to control the psychotic symptoms. Although involuntary hospitalization is associated with post-psychosis PTSD symptoms in people with a first episode of psychosis (Tarrier et al., 2007), the preponderance of studies report that the psychotic symptoms are more distressing than coercive treatments (Mueser et al., 2010; Meyer et al., 1999; McGorry et al., 1991; Priebe et al., 1998; Shaner and Eth, 1989). Recent research indicates that fear of psychosis recurring, low intolerance for uncertainty, and negative appraisals of psychotic experiences may increase an individual's vulnerability to developing traumatic reactions from psychotic symptoms and coercive treatments (White and Gumley, 2009).

Although research has shown that PTSD symptoms often occur following treatment for a psychotic episode, it is less clear how often psychotic symptoms or coercive treatment experiences meet the required A1 and A2 DSM-IV criteria for a traumatic event. Specifically, the A1 criterion states, "The person has experienced, witnessed, or been confronted with an event or events that involve actual or threatened death or serious injury, or a threat to the physical integrity of oneself or others," and the A2 criterion states, "The person's response involved intense fear, helplessness, or horror" (American Psychiatric Association, 1994, pages 427–428). A related question is whether meeting diagnostic criteria for *full PTSD* related to psychotic symptoms or treatment experiences, including both the A1/A2 criteria and symptom criteria, is associated with more distress or functional impairment than meeting the symptom criteria for PTSD regardless of the A1/A2 criteria (i.e., including clients who meet A1/A2 criteria as well as those who do not), which we refer to here as the *PTSD syndrome*. This question is of relevance to the DSM-IV diagnostic criteria for PTSD, as there has been active debate about whether the A1/A2 criteria for a traumatic event are necessary and important qualifiers for a diagnosis of PTSD (Kilpatrick et al., 1998; Long et al., 2009; Spitzer et al., 2007; Brewin et al., 2009).

Only one prior study of PTSD secondary to psychotic symptoms or treatment has examined whether those experiences met the DSM-IV A1/A2 criteria for a traumatic event (Mueser et al., 2010). In that study, 66% of clients with a recent onset of psychosis met symptom criteria for the PTSD syndrome (i.e., irrespective of A1/A2 criteria), whereas 39% met criteria for full PTSD (i.e., including A1/A2 criteria). Clients with full PTSD and those with the PTSD syndrome reported similarly higher levels of distress and more problems functioning than those without PTSD symptoms, suggesting that requiring the DSM-IV definition of a traumatic event did not identify a group of clients who were more disturbed or impaired by their traumatic psychosis-related experiences than those identified by PTSD symptoms alone. However, that study examined posttraumatic reactions following treatment of either the first or second episode of psychosis, leaving open the question of the importance of the DSM-IV definition of traumatic event in persons with multiple episodes of psychosis and psychiatric hospitalization.

Mueser and Rosenberg (2003) speculated that PTSD reactions might be especially marked in persons recovering from their first episode psychosis, given the novelty of the experience. However, Chisholm et al. (2006) presented data showing that PTSD symptoms were actually more marked in people with multiple previous episodes of psychosis than a single episode, although they did not examine the A1/A2 criteria for a traumatic event. The present study was conducted to evaluate the prevalence of both the PTSD syndrome and full PTSD diagnosis related to psychotic symptoms and coercive treatments in clients with multiple psychotic episodes. Following the same procedures as Mueser et al. (2010) in their study of persons with a recent onset of psychosis, it explores whether PTSD symptoms occurring after experiences meeting the DSM-IV A1/A2 criteria for a traumatic event are associated with more distress or functional impairment than PTSD symptoms occurring after events that do not meet those criteria.

## 2. Methods

The study took place at a university medical center and at a state psychiatric hospital in New Jersey. All of the study procedures were approved by the appropriate university and hospital Institutional Review Boards.

### 2.1. Participants

Inclusion criteria for participation in the study were:

a) age 18 and above;
b) chart or clinician diagnosis of schizophrenia, schizoaffective disorder, schizophreniform disorder, bipolar disorder with psychotic features, major depression with psychotic features, brief reactive psychosis, or unspecified psychosis;
c) presentation for treatment of a psychotic episode within the past 6 weeks;
d) psychotic symptoms of moderate severity or greater on any item on the Brief Psychiatric Rating Scale (Lukoff et al., 1986) thought disturbance subscale (hallucinatory behavior, unusual thought content, grandiosity, suspiciousness) (Mueser et al., 1997), that had persisted for at least 2 days in the absence of substance use;
e) history of treatment for at least three psychotic episodes including the current episode; a psychotic episode was defined as an episode in which there was the presence of one (or more) of the following symptoms: delusions, hallucinations , disorganized speech, and grossly disorganized or catatonic behavior for at least one week; and
f) voluntary signed informed consent to participate in the study.

The only exclusion criterion was substance induced psychotic disorders. Fifty individuals met eligibility criteria