Canadian Consortium for Early Intervention in Psychosis

# Trauma and Personality in First Episode Psychosis

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# Disclosures

Honoraria have been received from the following companies for participation on advisory boards.

- Sunovion
- Allergan/Abbvie
- Janssen
- Otsuka

There are no relevant ongoing financial relationships to disclose.
This presentation will be reviewing clinical data. Some medication recommendations of may be considered off-label. Other treatment recommendations are based on “ideal circumstances” and may not be readily available in your area.

# Objectives

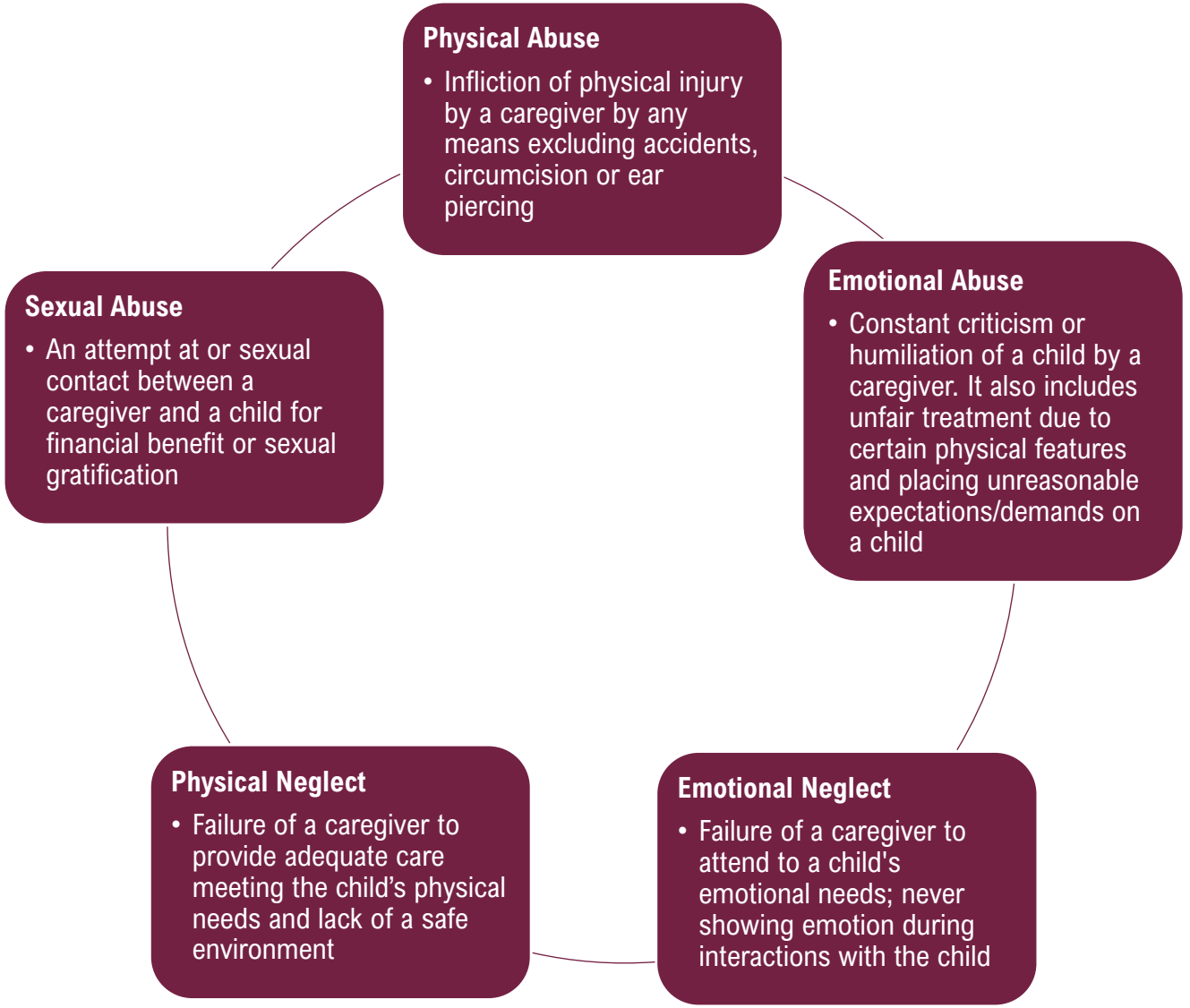
- Trauma & PTSD
- Personality Traits & Disorders
- Management
- Questions

# Trauma & PTSD

# Adverse Childhood Events and Stressful Life Events

- Adverse Childhood Events (ACE)
- Episodes of abuse, neglect, and household dysfunction occurring in childhood that may have lasting consequences into adulthood.
- E.g. sexual, physical, or emotional abuse, parental conflict, emotional and physical neglect.
- Stressful Life Events
- Dangerous or life-changing events that have occurred for the individual and may alter the trajectory through adulthood.
- E.g. immigration, exposure to war, significant loss in adulthood.

# Classification of Childhood Trauma




*From Inyang et al., 2022*

# Connecting Trauma to Psychosis

- The RAISE-ETP study identified that 80% of participants reported at least one traumatic event during their lives.  5% met criteria for a lifetime diagnosis of PTSD and a further 3.7% met sub-threshold criteria.
- In a case-control analysis, the association between ACEs and emergent psychosis had an OR=2.72.
- Transitions to psychosis were associated with some environmental risk with greatest effect attributable to childhood trauma (OR = 34.4).
- Patients with PTSD are five times more likely to be diagnosed with a psychotic disorder than individuals without.
- Stressful life events in the preceding year and especially in the 3 months prior to onset also appear to play a role.

# Connecting Trauma to Psychosis

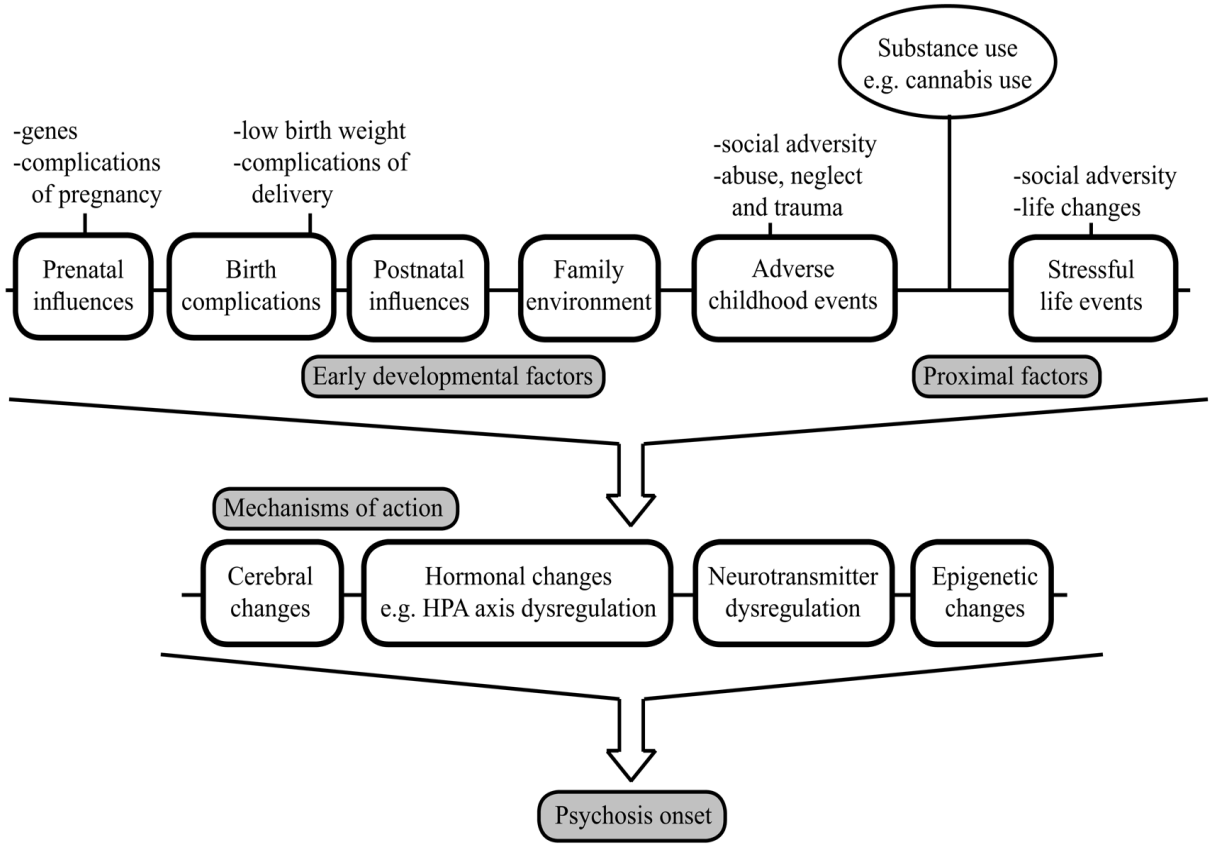
- Clinical characteristics
- Higher hospitalization rates
- Earlier onset of symptoms
- A more relentless course of psychosis and more sever episodes
- Higher rates of treatment failure and noncompliance
- Greater likelihood of mood and behavioral comorbidity
- Greater risk of suicide
- Increased prevalence of comorbid substance use disorders

# Connecting Trauma to Psychosis

Associations with Symptomatology

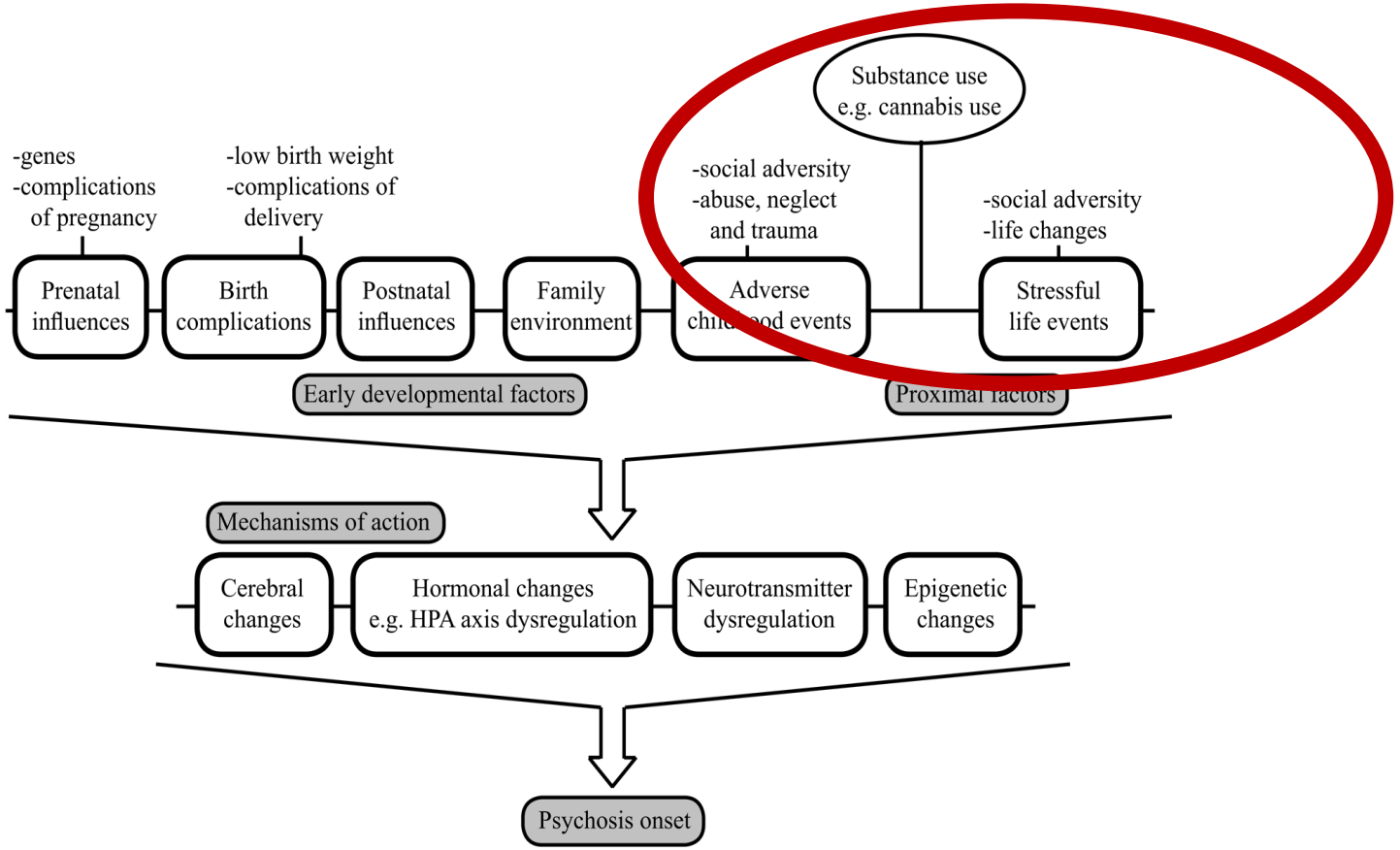
- Childhood sexual abuse associated with more severe positive symptoms
- Childhood emotional abuse associated with hallucination and delusions of mind reading
- Growing up in institutional care associated with paranoid ideations
- Life events involving loss associated with delusions of grandiosity
- Life events involving danger/life threatening with depressive delusions
- Traumatic experiences:
  - Lead individuals to have a faulty view of themselves;
  - Construct a fear-based outlook of the world;
  - This leads to suspicion, intrusive thoughts, dissociation, and paranoia as coping mechanisms.

# A Model of Risk Factors for Psychosis




*From Roper et al., 2015*

# A Model of Risk Factors for Psychosis




*From Roper et al., 2015*

# Underlying Mechanisms: HPA Axis, Neurodevelopment and Epigenetics

- Early stressors dampen the cortisol response, leading to poor stress coping later on in life.
- Alterations in the axis may be associated more directly with psychosis, with a higher baseline of circulating cortisol, therefore leaving less room for a response in a stressful event.
- There appears to be increased metabolic turnover of cortisol and a blunted cortisol response.
- “Normal” emotional circuits develop in the context support from a caregiver, and without such support, these circuits develop faster and become more stable leading to poor emotional functioning in the long term.
- Increased pituitary volumes in individuals with FEP, UHR and family members.  Lower hippocampal volumes in individuals with PTSD and psychosis.
- Animal models suggests disrupted gene transcription via epigenetic changes to the glucocorticoid receptor gene promoter leading to disrupted negative feedback system in a later stressful event.  It should be noted that these changes can be heritable.
- In people, higher levels of peripheral FKBP5 expression have been observed.
  - FKBP5 is directly involved in modulated HPA activity and appears to be related to both PTSD and psychosis.
- BDNF Val66Met carriers have increased positive psychotic symptoms when exposed to childhood trauma

# The First Episode as a Traumatic Event

- Psychosis often involves severe perceptions of threat (e.g. paranoia, delusions of control) and are often accompanied by negative emotions such as anger, fear, and distress, and may therefore constitute a traumatic event.
- Social exclusion and stigma may also be experienced as a trauma.
- Involuntary hospitalization, and the experience of coercive treatments including involvement with law enforcement, seclusion, restraints and possible forced treatment.
- The institutional experience of being on an acute psychiatric unit and interactions with co-patients may play a role.
- Post acute symptoms can include re-experiencing of the event (memories), avoidance of related stimuli, hyperarousal and can include commonly associated symptoms such as suicidal ideation, loss, entrapment, humiliation, defeat, hopelessness, and anxiety.
- A 2017 meta-analysis reported that 42% of people with FEP displayed clinically relevant PTSD symptoms up to 2.5 years following first episode.  30% of individuals were diagnosed with full PTSD within 2 years of their first episode and in a sub-analysis the authors found higher rates in individuals with affective psychosis and in those admitted to restricted units.

# Personality Traits and Disorders

# Comorbidity of Personality Disorders

- Rates of comorbidity vary from 17% to 85% depending on study demographics such as location and sample size.
  - In two studies looking at a FEP population, rates of 8.6% (amongst a hospital sample) and 9.5% (in a community sample) were reported.
  - Most common comorbid diagnosis was “borderline personality disorder” or “emotionally unstable personality” at 53% and 75% of the respective study population.
  - ~3:1 ratio of F:M.

# Personality and Psychosis

- Poorer prognosis with risk of re-hospitalization as high as 73% within one year.
- 38% of individuals with a premorbid personality diagnosis had engaged in suicide attempts and/or severe self harm.
- Following discharge from an early psychosis intervention program, there is an risk of relapse in individuals with a personality diagnosis with HR=2.96.

# Personality And Psychosis

- Sociopathic and Schizoid personality traits have been associated with poor insight and a lack of change in degree of insight over a 6 month period.
- Schizotypal traits appeared to be associated with poor medication adherence.
- Schizoids traits were associated with negative symptoms of psychosis.
- Sociopathic and passive-dependent traits were associated with increased hostility and suspiciousness.
- Obsessional traits appeared to be associated with manic and grandiose features of psychosis.

# Borderline Personality & Psychosis

- Adds complexity to the diagnostic process and management
  - May present with more severe hallucinations but not be considered to be part of a primary psychotic disorder and delay diagnosis.
  - Higher prevalence of comorbid substance use.
  - Poorer social supports and increased relational difficulties.
  - More likely to experience depression and engage in self-harm throughout follow-up.
  - Will often have a “longer” journey before engaging with an early intervention program.
  - Will often experience delays in accessing first-line antipsychotic treatment (which would be inconsistent with most EIP guidelines).

# Management

# Psychotherapy

- When stable, EMDR has been reported to be a safe intervention.
  - Some protocols have been adapted to avoid direct exposure to trauma related stimuli, but there is evidence that unmodified protocols can be safe as well.
  - Benefits include improvement in symptoms of PTSD, auditory and visual hallucinations, delusions, anxiety, and depression. In one study, paranoid ideations and feelings of hopelessness did not appear to improve.
- A modified form of CBTp referred to as Trauma-Informed CBTp integrates CBTp, Trauma-Focused CBT, prolonged exposure therapy and Cognitive Processing therapy to process traumatic psychotic experiences by focusing on the experienced distress rather than on the validity of the experience.

# Psychotherapy

- Emotional regulation and Dialectical-Behaviour Therapy remain the treatment of choice for comorbid borderline personality disorder.
- Insight oriented therapies can be more challenging depending on severity of the primary psychotic presentation.
- Therapeutic rapport/alliance remains an integral part of any psychotherapeutic approach.
  - A study reporting on 1st person patient perspectives of treatment highlighted that participants were often reluctant to recount traumatic memories and that being in control of how these memories are shared and taking the time to build a therapeutic relationship enhanced readiness.

# Pharmacotherapy

- Antidepressants have a role in the management of mood and anxiety symptoms of PTSD and personality disorders
  - Antidepressants have been associated with neurogenesis in the hippocampus.
- Antipsychotics and mood stabilisers have been shown to have a role in the management of borderline personality disorder by targeting symptoms of affective instability, impulsiveness, and cognitive-perceptual distortions
  - Antipsychotics remain the foundational treatment for the management of psychosis and so its benefit overlaps here.
  - Sodium valproate has shown some potential to reverse epigenetic modifications by inhibition of histone deacetylase (which can impact genetic expression).
- The use of benzodiazepines is discouraged as they may worsen PTSD symptoms.

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# Q & A

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