Interventions for Trauma: Youth, Women, Those with SMI, Forensic Populations

Chair:
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Interventions for Trauma: Youth, Women, Those with SMI, Forensic Populations

• **Presenters:**
  - Mary A. Jansen, Ph.D.
  - Erika R Carr, Ph.D.
  - Joel A Dvoskin, Ph.D.
  - Steven M Silverstein, Ph.D.
  - Martha Schmitz, Ph.D.

• **Discussant:**
  - Shirley M Glynn, Ph.D.

**APA Curriculum:** Free on APA website; Flyer handout available

*Reframing Psychology for the Emerging Health Care Environment: Recovery Curriculum for People with Serious Mental Illnesses and Behavioral Health Disorders.*

Available from: www.apa.org/pi/rtp
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APA Recovery Oriented Training Curriculum

• This symposium presents information from a new curriculum developed by the American Psychological Association (APA) with funding from the U.S. Substance Abuse and Mental Health Services Administration (SAMHSA)

• The curriculum consists of an Instruction module plus 15 chapters on a broad range of topics. Each of the chapters:
  – is fully referenced
  – contains a list of required readings
  – has a sample learning activity
  – has sample evaluation questions
  – and a power point presentation

• The curriculum and power points are available at: www.apa.org/pi/rtp
Curriculum Modules

- Instruction Module
- 1. Introduction to Recovery
- 2. Recovery, Health Reform and Psychology
- 3. Assessment
- 4. Partnership and Engagement
- 5. Person Centered Planning
- 6. Health Disparities
- 7. Interventions I
- 8. Interventions II
- 9. Interventions III
- 10. Forensic and Related Issues I
- 11. Forensic and Related Issues II
- 12. Community Inclusion
- 13. Peer Delivered Services
- 14. Systems Transformation
- 15. Scientific Foundations
Mary A. Jansen, Ph.D.
Bayview Behavioral Consulting, Inc.
Vancouver, BC

For questions about the APA Curriculum: jansenm@shaw.ca
or mjansen@bayviewbehavioral.org
Abuse and Trauma: Youth, Women, the Forensic System and Serious Mental Illness
Trauma and Serious Mental Illness

• From the APA Curriculum:
  • “The kinds of trauma experienced by persons who are or who become recipients of public mental health services are usually not associated with “single blow” traumatic events such as natural disasters, accidents, terrorist acts, or crimes occurring in adulthood such as rape and domestic violence. Rather, the traumatic experiences of adults, adolescents and children with the most serious mental health problems are interpersonal in nature, intentional, prolonged and repeated, occur in childhood and adolescence, and may extend over years of a person’s life. They include sexual abuse or incest, physical abuse, severe neglect, and serious emotional and psychological abuse…They are traumatized further by coercive interventions and unsafe psychiatric environments and at times sexual and physical abuse in inpatient or institutional settings, jails, and prisons (Jennings, 2008, p. 2).” emphasis added

Trauma and Serious Mental Illness

- **Sources of Trauma:**
  - In addition to physical, emotional and sexual abuse
  - Experiencing a psychotic episode for the first time can be highly traumatic and can lead to full PTSD or to PTSD symptoms. The trauma can be from:
    - Terror experienced as a result of the psychotic symptoms
    - Experiences encountered in the treatment system
    - or both
  - Many experience significant trauma at the hands of the mental health system itself:
    - Often abusive practices, further exacerbating the trauma experienced by people terrorized by psychosis
    - Historically, inpatient psychiatric units have utilized such measures as seclusion and restraint to manage challenging behaviors
    - Stigma, lack of respect, uncaring attitudes, sometimes dehumanizing & abusive practices used even today by some
Trauma and Women

• **Trauma and Women:**
  - Up to 97% of homeless women with mental illness experienced severe physical and/or sexual abuse; 87% experienced this abuse both as children and as adults
  - Homeless women:
    • More vulnerable to trauma than homeless men, poorer
    • Often have additional stressors due to child care responsibilities
    • At special risk for physical and sexual violence, trauma, risky sexual encounters, and incarceration
    • More likely to be unable to control sexual situations and may be more often exposed to HIV/AIDS and other sexually transmitted diseases and have co-occurring mental health and substance abuse problems
  - 80% of female psychiatric inpatients – history of physical or sexual abuse
Trauma and Women

• Women: Very Different Treatment Needs than Men
  – Women that have been abused by men will be unable to work through those issues in a mixed group – a mixed trauma group can exacerbate their trauma
  – Pharmacotherapy can be important to reduce the anxiety, depression, & insomnia often experienced with trauma reactions & PTSD, making it possible for individuals to participate in treatment
  – Trauma interventions are specialized psychotherapeutic interventions & require specialized clinical expertise, provided in a safe environment
  – Services offered in women only groups are essential for women who have been abused both to help them recover & to avoid exacerbating their trauma
Children & Adolescents:

- Can be greatly affected by traumatic experiences:
  - Sexual abuse, physical abuse, emotional/psychological abuse, neglect, parental death, & bullying

- Children & adolescents may develop PTSD:
  - Highly prevalent in those who have experienced trauma

- Children who experience severe adversity, physical abuse - especially those who are repeatedly abused:
  - At increased likelihood for developing psychosis

- Sexual trauma may be a contributing factor in the development of psychosis for some individuals

- The more trauma a child experiences the greater the likelihood of increased severity of psychotic symptomology
Forensic & Related Issues: Homelessness, Substance Abuse, Trauma, Gender, Race, Culture

• Forensic Issues
  – For people with SMI, the prevalence of containment in prison/forensic system is high: men 15%; women 31% (U.S. & Canada)
  – For people exhibiting symptoms: 67% greater likelihood of arrest (U.S.)
  – People from minority cultures especially at risk
  – Multitude of co-occurring problems:
    • Severe trauma
    • Homelessness
    • Substance abuse
    • Victimization
    • Poor health
• Forensic Issues, cont’d
  – Criminal Justice/Forensic systems antithetical to concept of recovery:
    • Little treatment, emphasis on risk reduction
    • Respect, person centered, cultural considerations, EBPs: not the norm in criminal justice/forensic settings
    • Deplorable conditions
      – Criminal justice/forensic settings extremely re-traumatizing
  – Insufficient resources
  – Personnel receive little to no training re people with mental health disorders
  – Extremely stigmatized by dual stigma – serious mental illness & criminality
Trauma

- People with serious mental illnesses twice as likely to be victims of violence as those without illnesses
- Importance of trauma, especially for women cannot be overstated:
  - Trauma is the norm, especially for women: virtually all women in the criminal justice/forensic system have experienced severe trauma; most men have as well
- Criminal justice/forensic systems are universally re-traumatizing
- Effects of trauma so severe that mental health providers must use extreme care to avoid re-traumatizing people
Forensic & Related Issues: Homelessness, Substance Abuse, Trauma, Gender, Race, Culture

• Racial and Cultural Factors
  – Clear differences in treatment for people of color
    • Those with mental illnesses often mis-labelled as criminals
  – Immigrants, refugees and people from diverse cultural backgrounds affected by many issues
  – Cultural factors can influence:
    • The responses an individual provides
    • The way in which law enforcement personnel and mental health professionals respond to and interact with the individual
      – Language barriers
      – Fear of authoritarian systems
      – Different beliefs about mental illness
Forensic & Related Issues: Homelessness, Substance Abuse, Trauma, Gender, Race, Culture

• Cultural Factors
  • Religion
  • Different cultural values:
    – Ability of women and young people to speak for themselves, establish goals, determine skills they wish to develop
    – Acceptability of familial abuse
  • Sexual identity, LGBT
  • Language barriers:
    – Words or expressions to describe mental illness may not exist
    – Language itself
  • Beliefs about mental illness:
    – Etiology
    – Acceptability
Adaptive Behaviors Needed for Survival

Most treatment providers are unaware of the adaptive behavioral & attitudinal changes that these individuals must make to survive.

- Providers see such behaviors as resistance, lack of motivation, pathology, or symptoms of the person’s mental illness.
- This makes communication & establishment of trust difficult, impeding treatment provision & transition to successful community life.
- Mental health providers must understand life in correctional facilities & need to recognize the reasons why people adopt the attitudes & behaviors they need to survive in these frequently abusive situations.
- The effects of trauma are so severe that extreme care must be taken to avoid re-traumatizing individuals.
Forensic & Related Issues: Interventions, Transition Planning, Follow Up

- **Transition Planning and Follow up - Essential & Usually Lacking**
  - Inadequate transition planning puts people with co-occurring disorders who enter jail in a state of crisis back on the streets in the middle of the same crisis.
  - The period *immediately* after release is critical – the first hour, day or week can determine success or failure - high intensity interventions that support the person during this time are *essential*.
  - Without immediate monitoring and follow up many miss the first crucial health and social service appointments:
    - Do not have medications
    - End up on the street
    - Quickly return to the criminal justice/forensic system
Forensic & Related Issues: Interventions, Transition Planning, Follow Up

• If People with Serious Mental Illness in the Criminal Justice & Forensic Systems are to Succeed

• WE MUST PROVIDE:
  – Complete range of clinical interventions (including specialized & gender specific trauma services) aimed at ensuring best psychological treatment, proper housing, and successful employment for those who can work
  – PLUS
    – Mental Health Courts
    – Superior transition planning
    – Help with medical and mental health follow up
    – Community integration that diminishes stigmatization
Trauma Informed Care: Positive Behavioral Supports in Inpatient Treatment

Erika Carr, PhD
APA Annual Conference 2015
Toronto, CA
Historical Practices

- Historically, inpatient units have over utilized coercive measures to manage challenging behaviors such as seclusion and restraints (Craig & Bracken, 1995; Donat, 2005)

- Use of seclusion and restraints contributes to trauma for staff and individuals receiving services (Frueh et al., 2005)

- Poor empirical support for the effectiveness of seclusion/restraints as a treatment intervention (Bonner, Lowe, Rawcliffe, & Wellman, 2004)

- No randomized controlled trials, little empirical support
Literature on S/R

• Research indicates heavy reliance on such measures as seclusion and restraints facilitates negative opinions by individuals who are receiving care

• Literature indicates the use of seclusion/restraint can cause negative impact on further course of illness and impact the likelihood of the development of PTSD (Langle et al., 2003; Meyer et al., 1999; Priebe et al., 1998; Robins et al., 2005)

• Generates concerns about quality of care (Ray, Rapaport, 1995; Blanch & Parrish, 1990; Donat, 2005)
Need for Alternatives

• Researchers suggest these interventions be minimized as an intervention for those who experience serious mental illness in congruence with ethical practice (Sailas & Fenton, 2000)

• Due to noteworthy concerns related to trauma and quality of care the literature is calling for alternatives to manage challenging behaviors on inpatient units (Donat, 2005)

• Alternatives should be consistent with trauma-informed care
Trauma-Informed Care

- Trauma-informed care works to understand the role of violence and victimization in those who experience psychiatric hospitalization and seeks to conceptualize the experience of individuals from this perspective.

- This relates to an individual’s presenting challenges or symptoms, life experiences, and culture (including their experiences of trauma).

- Includes education of staff on effect of trauma on lives of individuals and its effect on functioning.

- Is an approach to increasing safety, reducing likelihood of retraumatization, empower positive coping. (Chandler, 2008; Huckshorn, 2004)
Positive Behavioral Support

• Empirical evidence indicates that strategies which are based on trauma-informed and strengths based care can decrease seclusion and restraints (Azeem et al., 2011)

• Positive behavioral support is a method of behavioral analysis that has been used with adults with serious mental illness and shows efficacy for increasing positive behavior and decreasing challenging behaviors from a non-coercive & strengths-based perspective (Carr et al., 2002)
Positive Behavioral Support

• Congruent with recovery-oriented care (Baez et al., 1997; Carr et al., 2002; LeBel et al., 2004)
  – Focuses on strengths of individuals in recovery
  – Is person-centered
  – Focuses on skill development
  – Honors and empowers personal goals/dreams/preferences
  – Promotes ecological changes to inpatient units to support individuals in their environment
  – Teaches new skills to staff
  – Avoids coercive methods such as seclusion and restraints
Positive Behavioral Support

• Involves functional analysis of target behaviors

• Looks at behavior of concern in context and includes assessment of reinforcing factors; antecedents and consequent variables, motivating factors, situational variables, that might decrease/increase behaviors

• Plan involves many things; teaches more appropriate alternative behaviors, examines interactional styles, communication styles, ecological factors, teaches new skills needed for staff (Donellan et al., 1998)
PBS in practice

• Recognizing times of day when someone gets irritated; offering a schedule that involves preferred activities at that time and interaction with staff that individual works well with

• Teaching positive ways of handling emotions and more positive interpersonal interaction; emotion regulation and interpersonal effectiveness

• Outlets such as going to comfort room, preferred hobbies (art), going to exercise, walks; getting off the unit

• Communication strategies; expressed validation of feelings + offering of positive activities, tone of voice, how to set boundaries effectively
PBS in practice

• Teaching staff to deal with countertransference
• Staff trainings on recognizing cues
• Offering choices, a feeling of control, and options
• Development of valued roles
• Value of music
• Personalized self-soothing options
• Daily phone call check-ins with son
Impact of PBS

• These alternatives such as positive behavioral support have been shown to have a positive impact on reduction of seclusion and restraint (Donat, 2005)

• Researchers indicate that if individuals with serious mental illness experience inpatient care as less aversive they may be more likely to access inpatient hospitalization earlier when they need it in case of an ensuing crisis, rather than involuntarily (Kidd et al., 2014)
References

People with SMI in the Forensic MH System: Trauma before, during, and after they arrive.

Joel A. Dvoskin, Ph.D., AoM
Univ. of Arizona College of Medicine
Chair, Governor’s Advisory Council on Behavioral Health and Wellness for the State of Nevada
Trauma and Violence

• Understanding a person’s history of trauma can teach you:
  • Triggers to violent behavior
  • How to avoid forcing them to relive their worst nightmare
  • The meaning of violence and violation in their lives
  • Why they choose such costly ways of meeting their needs
Therapeutic Milieu of Inpatient Units

- We must strike a difficult balance between over-control and under-control
- When the ward is over-controlled, hostility and fear build and eventually erupt
- When the ward is under-controlled, everyone is scared, and scared people hurt each other.
- Scared patients
- Scared staff
- Scared people get angry, and scared and angry people hurt each other way too often.
The Recovery Model

• What the recovery model is
  – Restoration of hope
  – Strength based
  – Respectful

• What the recovery model is NOT
  – License to hurt other people
  – A gift certificate to life
  – The absence of natural consequences
The Recovery Model

• Decisions, choices, responsibility
• The pretense of coercive control – You can’t punish people into responsible behavior
• Obedience is almost useless as a life skill
• Punishment does not teach pro-social skills
• OTOH, rewarding bad behavior or protecting people from its natural consequences prevents the acquisition of pro-social skills.
• Recovery is essential to public safety, because it recognizes rights and responsibilities.
Autonomy and Choice

- The dilemma: If I allow patients to make choices, and they get hurt, I’ll get blamed for not protecting them
- But if I don’t allow patients to make choices, I’ll get criticized for providing bad treatment
- Answer: You can teach people to make better, safer choices
- When every staff member is a teacher...
What about Reducing the Use of Restraint and Seclusion?

• Costs and benefits of using seclusion and restraint
• Costs and benefits of banning the use of seclusion and restraint
• Benefits of reducing the NEED for seclusion and restraint
Involuntary Medication

• **When all else fails**
  • How much time was spent talking with the patient about the benefits of taking medication and listening to the patient about reasons for refusing?
  • Were the patient’s objections truly heard?
  • Were alternatives seriously considered?
  • Costs and benefits of using medication to control people.
  • Justified to prevent emergent, serious harm
  • May be justified when it allows other, more collaborative treatment to occur – take the long view.
  • Justified only when the benefits outweigh the costs.
Risk-Based Treatment Planning

• Ideally, violence risk assessments and treatment plans should bear some resemblance to each other, but...
• …they usually don’t.
• Ideally, treatment plans should include real, meaningful assessment of strengths, but...
• …they usually don’t.
Risk-Based Treatment Planning

• Ideally, treatment plans should represent teamwork between the treatment team and the person being treated, but…
• …they usually don’t.
• Improving the quality of treatment plans
• Plans must be simple enough to be understood by the patient and the staff at all levels
Preventing Violence

• Whether a person has a mental illness or not, violence is typically born of four things:
  – Greed
  – Fear
  – Anger
  – Despair

• If you want to reduce violence, you have to reduce despair.
Faith, Hope, and Charity

• “Believe in my possibilities; believe that I can recover.”
• “Restore my hope for a better future; help me to dream.”
• “Allow me to make choices and to fail, and help me to my feet when I stumble.”
• “My despair is our enemy, and the only cure for despair is HOPE.”
CBT vs. Brief Treatment for PTSD in People with SMI: A Randomized Controlled Trial

Steven Silverstein
Rutgers University
TRAUMA IN SEVERE MENTAL ILLNESS

- Trauma and other adverse events in childhood increase risk of developing SMI
- Victimization common after onset of SMI
- Multiple traumatization is common
- History of trauma associated with more severe symptoms, distress, functional impairment, acute care treatment
- Service users report traumatic experiences are important but neglected in treatment
- High rates of trauma and PTSD in SMI population
TRAUMA IN SMI (N=779)

Source: Goodman et al. (2001)
RATES OF PTSD IN CLIENTS WITH SMI

Percent with PTSD

- Czaja 1988 (N=225)
- Combs-Callard 1996 (N=275)
- Menas 1999 (N=131)
- McFarlane 2001 (N=141)
- Neria 2002 (N=425)
- Remick 2003 (N=782)
- Muner 2004 (N=782)
- Strauss 2006 (N=155)
THE COGNITIVE RESTRUCTURING PROGRAM

- 12-16 week manualized individual CBT program
- Treatment provided at local CMHCs, integrated with other services
- Minimal exclusion criteria to enhance application to broad population
- Flexible model that can adapt to wide range of severe symptoms and other challenges
THERAPY MODULES

1. Overview
2. Crisis plan
3. Breathing retraining
4. Education I [Trauma and PTSD Symptoms]
5. Education II [Associated problems: mood, relationships, etc.]
6. Cognitive restructuring I [Common Styles]
7. Cognitive restructuring II [5 steps of CR]
   1. ID situation
   2. ID negative feeling
   3. State associated thought/belief
   4. Evaluate evidence for/against thought
   5. Change thought if inaccurate; action plan if accurate
8. Generalization Training & Termination
CBT FOR PTSD STUDY

- Collaboration between medical schools at Dartmouth and Rutgers universities
- RCT Conducted at 5 sites in urban settings
- CBT for PTSD delivered by frontline clinicians
- Clients randomized to CBT vs. Brief Treatment (3 sessions)
- Assessments at Baseline, Post-treatment, 6 month and 1 year follow-up
- N = 201
ELIGIBILITY CRITERIA

• SMI according to state of NJ
• Axis I diagnosis of schizophrenia, schizoaffective, bipolar, or major depression (borderline PD accepted)
• Current diagnosis of severe PTSD (CAPS Total 65 or higher)
• No hospitalization or suicide attempt past 3 months
• Not dependent on substances
• Receiving mental health services
• Willing and able provide informed consent
BRIEF TREATMENT INTERVENTION

• 3 weekly individual sessions
• 2 main components:
  1) Breathing retraining skill
  2) Education about PTSD
• Use of manual, client worksheets, plus a DVD for education piece
Demographic and Clinical Characteristics of Sample by Treatment Group

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PRIMARY (PTSD) OUTCOMES

• Significant differences favoring CBT over Brief found in:
  – PTSD symptom severity (CAPS Total & subscales)
  – PTSD diagnosis
  – Knowledge of PTSD
  – Social functioning affected by PTSD
SECONDARY OUTCOMES

• Significant differences favoring CBT over Brief for global functioning (GAF)
• Significant group X time interactions for social functioning and BDI
  – More rapid improvement for CBT than Brief
• No group differences in:
  – Depression or other symptoms
  – Post-traumatic cognitions
  – Overall quality of life
CONCLUSIONS

• CBT for PTSD program effective in treating PTSD and related outcomes in people with SMI

• Study showed:
  – Predominantly minority clients living in poor, urban areas benefit from CBT for PTSD program
  – Frontline clinicians can implement program with good fidelity
  – Effects sustained for 1 year
  – Cognitive restructuring component of CBT program most critical to improving PTSD in SMI
  – Brief program appeared to produce benefit in PTSD and other symptoms

• First and only intervention shown to improve PTSD in SMI in 2 RCTs
NEW QUESTIONS AND NEXT STEPS

• Apparent effectiveness of Brief program raises question: should treatment of PTSD in SMI be provided in a stepped fashion, with Brief first?
• Can treatment of PTSD in SMI be provided more efficiently in group format?
• Prior pilot research suggests group treatment in closed-format is feasible (21 sessions)
• However, closed-group format has limitations in terms of clients having to wait for new group
• Stepped care approach: combine Brief program with open-enrollment group program for clients with persistent PTSD
STUDY TEAM

• Kim T. Mueser, CPR/BU, PI
• Stanley D. Rosenberg, Dartmouth, Co-PI
• Jennifer Gottlieb, CPR/BU, Project Manager
• Steve Silverstein, Rutgers, Site PI
• Weili Lu, Rutgers, Site Project Manager
• Phillip Yanos, Rutgers, Clinical Supervisor
• Stephanie Marcello, Rutgers, Clinical Supervisor
• Haiyi Xie, Statistician, Dartmouth
• Gregory McHugo, Statistician, Dartmouth
• Eric Slade, Health Economist, U. Maryland
• Rosemarie Wolfe, Data Manager
### Engagement and Exposure to Brief or CBT Interventions.

<table>
<thead>
<tr>
<th></th>
<th>Brief (N=97)</th>
<th></th>
<th>CBT (N=104)</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N</td>
<td>%</td>
<td>N</td>
<td>%</td>
</tr>
<tr>
<td>Engaged (&gt;1 session)</td>
<td>88</td>
<td>90.7%</td>
<td>92</td>
<td>88.5%</td>
</tr>
<tr>
<td>Exposed (&gt;2 sessions for Brief; &gt;6 sessions for CBT)</td>
<td>84</td>
<td>86.6%</td>
<td>66</td>
<td>63.5%</td>
</tr>
</tbody>
</table>

### Significant Differences between Exposed and Non-Exposed Clients at Baseline in Clients Randomized to CBT Program.

<table>
<thead>
<tr>
<th>Treatment Site</th>
<th>Exposed</th>
<th></th>
<th>Non-Exposed</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N</td>
<td>%</td>
<td>Mean</td>
<td>%</td>
</tr>
<tr>
<td>Newark Outpatient</td>
<td>20</td>
<td>48.8%</td>
<td>21</td>
<td>51.2%</td>
</tr>
<tr>
<td>Newark Partial Hospital</td>
<td>11</td>
<td>84.6%</td>
<td>2</td>
<td>15.4%</td>
</tr>
<tr>
<td>New Brunswick Partial Hospital</td>
<td>13</td>
<td>100.0%</td>
<td>0</td>
<td>0.0%</td>
</tr>
<tr>
<td>New Brunswick Outpatient</td>
<td>7</td>
<td>46.7%</td>
<td>8</td>
<td>53.3%</td>
</tr>
<tr>
<td>Monmouth Partial Hospital</td>
<td>15</td>
<td>68.2%</td>
<td>7</td>
<td>31.8%</td>
</tr>
</tbody>
</table>
TREATMENT OF PTSD IN GENERAL POPULATION

• CBT is most widely studied & replicated intervention, with primary support for:
  – **Exposure therapy (ET):** Prolonged exposure to safe but anxiety-provoking, trauma-related stimuli (imaginal & in vivo) leads to emotional processing of event & habituation of fear
  – **Cognitive restructuring (CR):** Identifying, challenging, & changing upsetting, inaccurate trauma-related thoughts & beliefs underlying PTSD facilitates incorporation of trauma experiences into self

• ET & CR equally effective, as is combination of ET + CR

• Most studies employ exclusion criteria that rule most or all people with SMI & PTSD: psychosis, suicidal ideation, cognitive impairment, recent medication changes, & severe medical problems
PROBLEM OF EXCLUSION
CRITERIA IN TREATMENT
RESEARCH ON PTSD

• Consensus statement by leaders in trauma research:
  – Simple or “pure” PTSD is unrepresentative of the typical presentation of treatment seeking individuals with trauma histories
• Spinazzola et al. (2005): “True advancement of the field will require a deliberate process of evaluation and adaptation of efficacious treatments with less restricted, more clinically representative PTSD samples.” (p. 427)
• Need for treatment programs for PTSD tailored to accommodate common problems in people with SMI and other vulnerable populations
RCT OF CBT FOR PTSD IN NH
(Mueser et al., 2008)

- RCT of CBT vs. TAU (N = 108)
- Exposure to CBT: 81%
- Conducted at 4 local CMHCs in NH & VT
- CBT provided by 6 Ph.D. & 1 M.A. clinician
- Assessments conducted at baseline, post-treatment, 3-months, 6-months
- Primary focus on PTSD knowledge, trauma-related beliefs, PTSD, other symptoms
COMPARISON OF NH & NJ STUDIES

• Is Brief intervention delivering a treatment benefit?
• Focus on NH sample with severe PTSD (75% of total sample)
• Examination of CAPS Total, PTSD Knowledge, BDI, and PTCI
• CAPS change:
  – CBT in NH = 20 points
  – CBT in NJ = 23 points
  – TAU in NH = 9 points
  – Brief in NJ = 15 points
Mean capss_m scores for both cbt and tau groups
DISCUSSION

• First RCT of intervention for PTSD in SMI; positive effects on PTSD and related outcomes

Limitations:
• Lack of ethnic/racial heterogeneity
• Rural setting
• Most clinicians academically trained
• Only 15% schizophrenia-spectrum disorders
• CBT compared to TAU, not active control
TREATMENT OF
Posttraumatic Stress Disorder
in Special Populations

A COGNITIVE
RESTRUCTURING
PROGRAM

Kim T. Mueser, Stanley D. Rosenberg,
and Harriet J. Rosenberg
Seeking Safety Therapy: Implementation for People with SMI, PTSD/Trauma, and Substance Abuse

Martha Schmitz, PhD, ABPP
SFVA/UCSF School of Medicine

Lisa M. Najavits, PhD
Boston University School of Medicine
Harvard Medical School
Seeking Safety Book

Seeking SAFETY
A Treatment Manual for PTSD and Substance Abuse
Lisa M. Najavits
Interventions for Trauma: Youth, Women, Those with SMI, Forensic Populations

Discussant:

Shirley Glynn, PhD
VA Greater Los Angeles Healthcare System
Chair, Div., 18 Section on Serious Mental Illness/Severe Emotional Disturbance