Effectiveness of trauma-focused treatment for patients with psychosis with and without the dissociative subtype of post-traumatic stress disorder

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Summary
This study presents secondary analyses of a recently published trial in which post-traumatic stress disorder (PTSD) patients with psychosis \( n = 108 \) underwent 8 sessions of trauma-focused treatment, either prolonged exposure (PE) or eye movement desensitisation and reprocessing (EMDR) therapy. 24.1\% fulfilled the criteria for the dissociative subtype, a newly introduced PTSD subtype in DSM-5. Treatment outcome was compared for patients with and without the dissociative subtype of PTSD. Patients with the dissociative subtype of PTSD showed large reductions in clinician-administered PTSD scale (CAPS) score, comparable with patients without the dissociative subtype of PTSD. It is concluded that even in a population with severe mental illness, patients with the dissociative subtype of PTSD do benefit from trauma-focused treatments without a pre-phase of emotion regulation skill training and should not be excluded from these treatments.

Declaration of interest

Method
In this brief report, we want to address this topic by comparing patients with psychosis with and without the dissociative subtype of PTSD, who underwent TFT without any pre-phase of emotion regulation skill training. We performed a secondary analysis of a large randomised clinical trial among PTSD patients with psychosis (for details, see de Bont et al\(^7\)), comparing 8 sessions of TFT – either PE \( (n = 53) \) or EMDR \( (n = 55) \) therapy – with waiting list \( (n = 47) \) for PTSD patients with psychosis. In earlier papers, we have reported that TFT was more effective than waiting list in primary (PTSD symptoms)\(^2\) and secondary (psychosis and depression)\(^6\) outcomes, and that TFT did not lead to adverse events or symptom exacerbations in this patient population.\(^9\)

To test the assumptions above, we compared effects of TFT for patients (PE and EMDR combined; \( n = 108 \)) with and without the dissociative subtype of PTSD, as established with items 29 (depersonalisation) and/or 30 (derealisation) (frequency \( \geq 1 \) and intensity \( \geq 2 \)) on the clinician-administered PTSD scale (CAPS).\(^10\)

The trial design was approved by the medical ethics committee of the VU University Medical Center and was registered at isrctn.com (ISRCTN79584912).
We found that 24.1% of our population fulfilled the criteria of the dissociative subtype, a proportion comparable with other studies. All patients fulfilled diagnostic criteria for a psychotic disorder (60.2% had schizophrenia and 29.6% schizoaffective disorder) and full diagnostic criteria for PTSD. Most patients had experienced severe childhood trauma. In the PTSD, dissociative subtype group, 7 patients dropped out (26.9%) vs. 17 patients (20.7%) in the PTSD no-dissociative subtype group ($\chi^2(1, n = 108) = 5.08, P = 0.059$). The following analyses were performed in the subgroup of completers ($n = 82$; post-treatment data were missing for 2 treatment completers). Patients with the dissociative subtype of PTSD showed a similar decrease in PTSD symptoms on the CAPS (within-group Cohen's $d = 1.63$) to that of the patients without the dissociative subtype of PTSD (within-group Cohen's $d = 1.68$), with large reductions observed in both groups (see Fig. 1). Patients with the dissociative subtype of PTSD showed significantly more severe PTSD symptoms at pre-treatment ($t(80) = -0.29, P = 0.005$), whereas at post-treatment, CAPS scores did not significantly differ ($t(80) = -1.34, P = 1.85$).

Our data showed that even in one of the most vulnerable patient populations – patients with a psychotic disorder and PTSD – individuals with the dissociative subtype of PTSD showed large improvements in PTSD symptoms and responded in a similar way to those without the dissociative subtype of PTSD. Our data are in line with several other studies in other patient populations (e.g., Wolf et al11) and thereby add to the consistent findings that patients with dissociative subtype benefit from TFTs comparably to patients without this subtype. Also, patients with the dissociative subtype of PTSD did not drop out more often than patients without the dissociative subtype of PTSD, suggesting that TFT is not intolerable for PTSD patients with dissociative subtype.

Our study needs replication in this specific patient population, especially because symptoms of psychosis and dissociation are highly related, and more sophisticated measures of dissociative subtype could be used in future studies. Despite these limitations, however, our data strongly indicate that there is no need to withhold patients with the dissociative subtype of PTSD from TFT, or to add a pre-phase of emotion regulation skills for patients with this subtype. Together with the many recent and consistent findings that patients with the dissociative subtype of PTSD respond equally well to regular TFT as do patients without the dissociative subtype of PTSD (e.g. Wolf et al11), this study showed that patients with the dissociative subtype of PTSD do not need a different treatment (see also De JONGH et al13 for a similar discussion). For clinicians, it may be valuable to know that, in contrast to their clinical view, patients with the dissociative subtype of PTSD can be effectively and safely treated with prolonged exposure therapy or EMDR therapy, using standard treatment protocols without preparatory emotion regulation skill training.

References

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