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COMMENTARY

Schizophrenia is not a kind of PTSD

COMMENTARY ON... DOES CHILDHOOD TRAUMA PLAY A ROLE IN THE AETIOLOGY OF PSYCHOSIS?†

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†See pp. 307–315 and 316–317, this issue.

SUMMARY

Coughlan & Cannon's article provides a helpful review of the current state of evidence regarding the connection between childhood trauma and psychotic-like symptoms. This commentary focuses on the clinical implications by noting that much of the data comes from studies in non-patient populations and to some extent depends on the underlying assumption of the continuum model of psychosis. I reconsider the presented data focusing purely on clinical diagnoses of psychosis, and consider the implications of the association between trauma and psychosis by looking at the evidence base for specific trauma-focused therapies in psychosis.

DECLARATION OF INTEREST

None

Coughlan & Cannon (2017, this issue) discuss a series of recent meta-analyses that suggest a connection between childhood trauma and the experience of psychotic symptoms. They highlight the evidence that childhood sexual abuse appears to be the most consistently associated form of trauma. Although this is interesting for the practising psychiatrist, much of the evidence they present is derived from surveys conducted in the general population rather than in patients with confirmed psychotic illness. The clinical significance of these findings is therefore dependent on the assumption that there is a continuum between psychotic-like experiences and frank psychosis, such that the voice-hearing commonly found in the general population does not differ qualitatively from the distressing auditory verbal hallucinations of schizophrenia. The authors describe a particular version of this model where it is not the psychotic symptoms themselves but their persistence and transition to impairment that characterises psychotic illness (e.g. van Os 2009). While this approach is undoubtedly useful for epidemiological studies, it is unclear how it relates to clinical practice, where the detection and discrimination of psychotic symptoms remains at the core of diagnosing psychotic illness (David 2010; Lawrie 2010). Many studies comparing partially treated psychosis patients and non-psychotic voice-hearers have downplayed any qualitative differences in phenomenology, but there is a large difference in emotional valence and distress between the experiences of psychotic and non-psychotic individuals (e.g. Daalman 2012) and it seems more likely that the crude instruments used in research fail to adequately capture the phenomenology of true psychotic symptoms (Upthegrove 2016a), as is suggested by cognitive (e.g. Garrison 2017) and neurobiological studies (e.g. Howes 2013).

If we consider only those meta-analyses looking at the association between childhood trauma and the development of clinically diagnosed psychotic illness there are actually only two of relevance. Varese *et al* (2012) found a link between childhood trauma and psychosis in case–control and prospective studies. Focusing specifically on schizophrenia, Matheson *et al* (2013) looked at cohort, case–control and cross-sectional studies to show an increased rate of childhood trauma compared with healthy controls. However, this association was not specific and they found significantly greater rates of childhood trauma in dissociative disorders and post-traumatic stress disorder (PTSD) than in schizophrenia and no difference from depression or personality disorders. The rate in schizophrenia was greater than that in anxiety disorders (although there was not a greater rate of sexual abuse).

Looking specifically at the studies of childhood sexual abuse, which Coughlan & Cannon consider to be one of the most potent traumas associated with psychosis, there are few focusing purely on the risk of developing a clinical diagnosis of psychosis. Daalman *et al* (2012) in a case–control study found increased rates of childhood sexual abuse in patients with psychosis and auditory hallucinations compared with healthy controls, but not compared with healthy voice-hearers. Similarly, Sheffield *et al* (2013) in a case–control study found increased scores on the Childhood Trauma Questionnaire (CTQ) sexual abuse subscale (but not increased overall trauma scores) in those with psychosis compared with healthy

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controls. In patients at 'ultra high risk' of psychosis there are two studies looking at whether a higher rate of childhood sexual abuse predicts transition to a first episode of psychosis. Thompson *et al* (2014) found that total score on the CTQ did not predict transition to psychosis but the score on the sexual abuse subscale did. Bechdolf *et al* (2010) measured a history of trauma (primarily in childhood, given that the average age of their sample was 18 years) and found no statistically significant effect of sexual trauma or all trauma unless they made a questionable adjustment for the number of ultra-high-risk categories a patient fulfilled. Both these studies used the Comprehensive Assessment of At-Risk Mental States (CAARMS) interview to determine transition to first-episode psychosis, but this may well not be equivalent to a clinical diagnosis of a psychotic illness (Yung 2010).

Causal associations

Overall there is some limited evidence of an association between childhood trauma, particularly sexual trauma, and psychosis, but this is an inconsistent and non-specific effect seen across other mental illnesses and in the voice-hearing general population. As Davies (2017, this issue) points out in his commentary, the potential mechanisms mediating a connection between childhood trauma and the development of psychotic illness are myriad and not necessarily causal: for example, parental mental illness during childhood and prodromal developmental anomalies might increase vulnerability to childhood trauma. Coughlan & Cannon discuss a model where psychotic experiences are triggered and then maintained by traumatic experiences, and in their discussion of psychodynamic perspectives they are led to the suggestion that auditory hallucinations in psychosis could be considered a dissociative phenomenon with a traumatic aetiology, although this is only one of many potential cognitive neurobiological models discussed in the literature (Upthegrove 2016b).

Trauma-focused therapies in psychosis

Coughlan & Cannon recommend that psychotic symptoms and traumatic experiences are elicited in all those presenting to mental health services. Rates of childhood trauma are high in patients with psychosis, with estimates of childhood sexual abuse around 30% (e.g. Daalman 2012) and rates of diagnosable PTSD in patients with first-episode psychosis estimated to be around 30% (Rodrigues 2017). Therefore it is clearly good clinical practice to elicit a history of trauma or to screen for psychotic symptoms in all patients.

They also suggest that trauma-focused therapies are offered to patients with psychosis and imply that this should include all those with psychosis, not just those with diagnosable traumatic disorders such as PTSD, and this appears at least partly motivated by the suggestion that psychotic symptoms might be considered dissociative in nature. Without needing to criticise the foundations for such a claim there is an existing evidence base for the treatment of PTSD in psychosis with trauma-focused cognitive–behavioural therapy (CBT) or eye-movement desensitisation and reprocessing (EMDR). A recent Cochrane review has considered this and found little current evidence to support benefits on either post-traumatic or psychotic symptoms, including considering hallucinations specifically (Sin 2017). Perhaps the most promising study, and the one cited by Coughlan & Cannon, looked at EMDR, finding a greater response rate in PTSD compared with treatment as usual, but not an increased rate of recovery, and it did not report on psychotic symptoms.

There is therefore, perhaps, some limited support for patients with psychosis being offered EMDR for the treatment of comorbid PTSD. But in these times of limited resources focused on mental health services, and given the consequent difficulties in delivering even those therapies with a robust evidence base for the treatment of psychosis (such as CBT for psychosis or family interventions), it seems not only premature but actively unhelpful to advocate the delivery of trauma-focused therapies to the wider population of patients with psychosis, given the distinct lack of evidence for any benefit.

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