



Trauma and Psychosis

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‘I just wish they would have said’

‘What happened to you?’

‘What happened?’

But they didn’t.”

Survey of NZ users of mental health services
(Lothian and Read, 2002)




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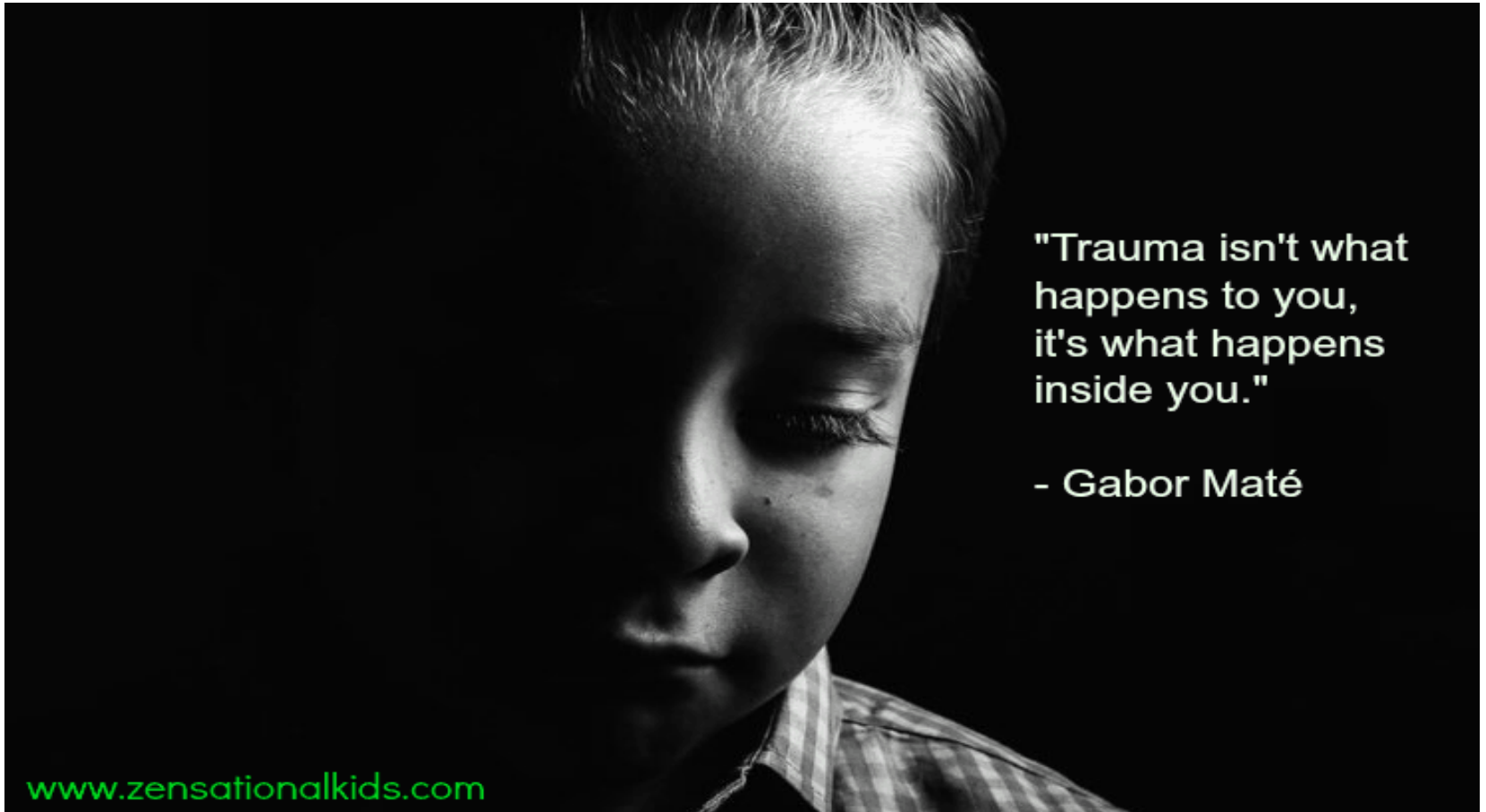
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- **What is the prevalence of trauma in general population ?**
 - **What is the prevalence of trauma in clinical populations ?**
 - **How often do your patients disclose this in clinical encounters ?**

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Experts by Experience

- ‘Something that happened to you once, or over time that you had no control over that threatened your physical safety or sanity that you did not have any means of coping with.’
- ‘An experience or circumstances where the individual perceives it to have had a damaging impact on their physical or internal safety mechanisms.’

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Trauma

- A traumatic event is often described as an experience which causes psychological distress and produces extreme fear, helplessness or horror as a response (American Psychiatric Association, 1994)
- 'Trauma is a response to a **discreet** or **prolonged** circumstance which at some point is **perceived** by the person to be an **uncontrollable serious threat** to **physical or psychological integrity** and which **overwhelms** emotional resources or capacity to function.' (TEWV, 2017).
- What counts as trauma may vary in different social worlds (Kohrt & Hruschka 2010)



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Experts by experience

- A reaction to an event which may be brief or over an extended period. The event will have resulted in a sense of hopelessness, worthlessness, fear or other negative emotion which is persistent.'
- Any circumstance a person perceives to be a threat to self which they have found overwhelming.' · 'One or many damaging occurrences interfering with a person's life significantly.

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Examples

- Events which provoke intense fear can be traumatising sometimes even if the threat is not to own safety but to someone else's. - illness, childbirth, accidents, war, natural disasters, being restrained. .
- Experiences which exclude one from society through shame, alienation or stigma. - refugee, bullying, stalking, diagnosis. .
- Relationships which deliberately inflict harm on others. - Sexual violence and abuse (including trafficking), physical assault, domestic violence, torture, .

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Examples

- Witnessing violence or abuse happening to other people
- Preventing the positive well-being and growth of another person. - neglect (the persistent failure to meet a dependent's basic physical and/or psychological needs), emotional abuse (ongoing intimidation, criticism or manipulation).

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Trauma and the brain

- https://www.youtube.com/watch?v=ZLF_SEy6sdc
- <https://www.youtube.com/watch?v=RTp5OHtuAec>

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Trauma and mental health

- Morrison et al 2003 34% and 53% of patients with severe mental illness report childhood sexual or physical abuse,
- Morrison et al 2003 - 56% of patients admitted with first episode psychosis report childhood sexual abuse²⁶
- Whitfield et al 2005 ;Early trauma exposure effectively doubled the risk of hallucination (with odds ratios between 1.2 and 2.5 for different categories of trauma;
- Bebington et al 2004 ; patient with psychotic symptoms are 3 times more likely to have been sexually abused than those with other mental health problems and 15 times more likely to have been sexually abused than those with no disorder

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Voice Hearing

- 2 – 4 % of adult population experience hallucinations at any one time.
- 15% of adults will experience voice hearing in their lifetime
- Only 1/3rd will need intervention mental health services
- Patients who present to services report experiencing distress from their voice hearing experiences

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Trauma and mental health

- People who had experienced three types of trauma (sexual abuse, bullying, violence in home etc.) were 18 times more likely to be psychotic than non-abused people. whereas those experiencing five types of trauma were 193 more likely to become psychotic (Shevlin et al. 2007).
- Experiences considered 'psychotic' include voice hearing, visions and unusual beliefs ('delusions').



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CHILDHOOD TRAUMA AND PSYCHOSIS



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Trauma and Voice hearing

- Voices can be dissociated or disowned components of self (or self–other relationships) that result from trauma, loss, or other interpersonal stressors.
- The interpretation of a voice hearing experience determines the emotional reaction. Making sense of a voice as malevolent, omniscient and powerful is associated with distress.
- Psychological approaches can be used to integrate life events as precipitating and/or maintaining factors for distressing voices.



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Trauma and voice hearing

- Evidence suggests that trauma is a significant risk factor for psychosis and for voice-hearing in particular.
- Co-occurrence of other events can constitute a parallel risk factor for the development of hallucinations after trauma:- concussion and brain injury in intimate partner violence, malnutrition and neglect in childhood trauma, and drug-facilitated sexual abuse

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Trauma and voice hearing

- (Ross & Joshi 1992, Falmularo et al. 1992) have highlighted a correlation between childhood abuse and the experience of hearing voices
- (Kilcommons & Morrison (2005) found a significant relationship between the incidence of traumatic life events and the experience of hearing voices. (strong relationship between lifetime incidence of sexual abuse and hearing voices.)



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Trauma and voice hearing

- Read and colleagues detected a significant relationship between auditory hallucinations and abuse, in both childhood and adulthood, in a sample of over 200 individuals attending a community mental health centre. (Read et al 2003)
- They also noted that those who had been abused were significantly more likely to experience command hallucinations to harm or kill themselves than the group that did not report abuse.



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Trauma and other perceptual abnormalities

- Hallucinations (visual, auditory and tactile) can be explained in the context of trauma flashbacks (Read et al., 2005) which are created in an attempt to integrate trauma memories (Briere, 2002).
- Childhood rape, as well as physical abuse have been found to be related not only to auditory but also to tactile hallucinations by Whitfield et al. (2005).
- Childhood neglect reported to be significantly related to visual hallucinations (Shevlin et al., 2007).
- Experiencing multiple types of trauma (more than one) also increases the likelihood of expressing each of the three types of hallucinatory experiences (auditory, visual and tactile) (Whitfield et al., 2005).

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Proposed theoretical models

- Trauma impacts hallucinations on 3 levels;
 - Biological, biopsychosocial, and/or psychological stressor or trigger
 - Influence voice content: what voices say may reflect elements of the original event.
 - Trauma-related dissociation may create or maintain hallucinations.




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- Traumatized individuals also tend to blame other people rather than interpersonal circumstances for all the negative events happening to them- external locus of control . External locus of control has a strong positive association with psychotic symptoms such as hallucinations or delusions . Bental and Kaney, 1996).
 - Personality traits may influence the association between childhood adverse experiences and adult's mental health (Bak et al., 2005).
 - Experiencing childhood trauma is strongly associated with emotional distress (Levendosky et al., 2002) which negatively affects one's integrity and sense of security (Nijenhuis et al., 2004).

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Clinical implications

- Individuals with a diagnosis of 'schizophrenia' are less likely to be asked about abuse (Read & Fraser, 1998a) or to receive an adequate response when abuse is disclosed (Agar & Read, 2002).
- Very few individuals with a diagnosis of 'schizophrenia' were referred for abuse counselling (Read & Fraser, 1998b).
- The high prevalence of childhood sexual abuse in patients with psychosis suggests that this may be an important factor to consider in the assessment, formulation and care planning (Read et al. 2007).
- In individuals with trauma histories, beliefs about voices may be at least partially understood in the context of trauma, (nature of the trauma, meaning of the trauma to the individual, and the extent to which the trauma has been resolved).

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Assessment of risk

- Risk to others- is there evidence of paranoia ? Inadvertent risk to others due to paranoia .
- Voice hearing – content ; command, derogatory ? Are they combined with a low level of resistance, or self-esteem?
- Risk to self- Suicidality , self harm
- Protective factors
- Social support / network
- Comorbidity – substance misuse including alcohol
- Impact on socio occupational functioning

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Management

- Safety planning
- Medication
- Psychoeducation
- Trauma screening
- Formulation
- Recovery work
- Well being /Staying well plan

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Formulation -

- Trauma has a role in the development and maintenance of voice hearing.
- A formulation-based approach to psychosis would aim to integrate, where appropriate, trauma potentially either as a vulnerability, precipitating or maintaining factor in the distress associated with psychosis. (see Larkin & Morrison, 2006)
- Provides a hypothesis about someone's difficulties,(linking past trauma with current experiences) and what interventions may be useful in reducing stress and alleviating difficulties.

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Exploring alternative strategies – Self harm

- **Feeling**

Anger, frustration, restlessness

- **Reason for Self Harm**

- Overwhelming feelings that are difficult to express
- An alternative to emotional pain

- **Alternative**

- Slash an empty plastic bottle, a piece of heavy cardboard or an old piece of clothing
- Rip up newspaper or an old phonebook
- Write down why you are angry then rip the paper up
- Use a pillow to hit the wall



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Crisis Intervention

- Proactive care planning
- Patient centred –focus is on using the patient’s resources and strategies
- Structured plan – triggers , coping strategies , staff / services involved and agreed actions for staff and patient
- Positive risk taking is encouraged where possible (Saakvitne et al. 2000; as cited in Elliott et al. 2005).

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Phased Model of Recovery (based on Herman, 1997)

- **Stabilisation** is a CORE task of mental health services and may be necessary at least to some degree over the whole period of care but is essential to establish at the outset.
- **Trauma processing** may be PERIODIC but clustered in the middle phase of the treatment when the patient is sufficiently able to address the memories without being overwhelmed.
- **Reconnection and rehabilitation** INCREASES towards the end of care and begins only after the impact of the trauma and the potential outcomes of therapy are glimpsed. The period of care may take many years or it could last for a few months depending on the level of trauma encountered.



CBTp

- ACE's can shape the development of core beliefs about oneself and the world, these thoughts determine emotions, and the behaviour maintains beliefs (Beck, 1979).
- These premises underlie the development of cognitive behavioural therapy for psychosis (CBTp).
- Freeman and Garety(2014) demonstrated that CBTp had positive effect within interventions for the socially disabling experience of paranoia where paranoid beliefs can be formulated as threat beliefs which arise within the context of adverse/ traumatic life events.

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Trauma informed approach to clinical encounters

- <https://www.youtube.com/watch?v=SMijltOM2Z8>

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“Recognizing the impact of trauma on health and patient engagement is a critical step that health care organizations can take in pursuit of achieving better outcomes.”

Kuruma T (2016)

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Screening

- “Have you experienced physical, sexual, or emotional abuse at any time in your life?”
- Always record any disclosures quoting the person’s own words.
- Department of Health and National Institute for Mental Health in England recommendations for dealing with trauma disclosure

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What GPs should do

- Refer to secondary care mental health services.
- Urgency determined by level of immediate risk
- Please do not prescribe anti-psychotics for FEP or ARMS.
- Ask about coping strategies and social support - Is there anything the patient can build on before they are seen in secondary care?

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Trauma-informed services don't just ask about symptoms.

They ask, “What happened to you?”

Bloom, S (1994)

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