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Traumas, Adversities, and Psychosis: Practical Implications

John Read, PhD, Tony Morrison, DClinPsy, and Rachel Waddingham

The notion that bad things happen that can drive us crazy has been with us for centuries. The first meta-analysis of research on the topic did not appear, however, until 2012.[1] It involved the 41 most robust studies at the time, including 18 comparisons of psychotic patients with non-psychiatric controls, 10 prospective studies, and 8 general population surveys. People who had suffered one or more childhood adversities were 2.8 times more likely to develop psychosis ($P < .001$). The odds ratios for six specific adversities were: sexual abuse, 2.4; physical abuse, 2.9; emotional abuse, 3.4; neglect, 2.9; bullying, 2.4; parental death, 1.7. Dose response was seen in 9 of the 10 studies that tested for it. For example, a survey of 8580 people found that those subjected to one form of adversity were 1.7 times more likely to have a diagnosis of a psychotic disorder, compared with 18 times more likely for three adversities, and 193 times for five.[2]

The biological, social, and psychological mediators of the relationship have been explored.[3,4] The content of hallucinations and delusions is often related, directly or metaphorically, to childhood traumas (**Table 1**).[5-8] The range of childhood adversities that have been found to play a causal role, often in combination, includes sexual abuse, incest, physical abuse, neglect, poverty, loss (eg, of parents), bullying, and being fostered/adopted.[1-7,9,10] Relationships between specific traumas or adversities and specific psychosis symptoms have been investigated.[10,11] The Traumagenic Neurodevelopmental Model of psychosis maps the similarities between the brains of traumatized children and adults diagnosed with schizophrenia.[4]

Psychiatrist Robin Murray, one of the UK's leading psychosis researchers, recently acknowledged:

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In the last 2 decades, it has become obvious that child abuse, urbanization, migration, and adverse life events contribute to the etiology of schizophrenia and other psychoses. This has been a big shift for me! My preconceptions had made me blind to the influence of the social environment.[12]

[END BLOCK QUOTE]

A recent online survey explored the causal beliefs of 701 people, from 30 countries, taking antipsychotics.[13] On a scale from 1 (purely biological) to 5 (purely social), the mean score was 4.2. The most common theme emanating from a thematic analysis was "social" (50%), followed by "psychological" (12%). The words "trauma" or "traumatic" were used by 214 people (30%), abuse or neglect were reported by 146 (21%), and loss by 46 (7%). **Table 2** presents examples.

A report from a large epidemiological study concluded: "Adverse childhood experiences among people with psychosis are common. . . . Mental health professionals should routinely enquire about all types of adversities in this group and provide effective service responses."[14] Unfortunately, recent findings indicate that most users of mental health services, internationally, are never asked about trauma or abuse, that services often fail to respond therapeutically to disclosures thereof, and that people with psychosis fare particularly badly on both counts.[15,16]

Contrary to claims from some quarters, patients who have a diagnosis of schizophrenia or other psychotic disorders are no more likely to falsely allege abuse than anyone else.[17] Another

belief masking the relationship is the notion, based on backwards circular logic, that once trauma is identified in the life of someone experiencing psychosis, the diagnosis should change to PTSD.

Ideally, what is required is a “trauma-informed” approach, a strategy pioneered in the US.[18] The key components are recognition by all clinical staff that most mental health problems (including psychosis) can be conceptualized and treated through a trauma and/or adversity lens, and understanding that re-traumatization via force and compulsion is to be avoided. The first step, for many mental health professionals, is learning when and how to ask about events like childhood abuse and neglect, and how to respond therapeutically to disclosures.[15,16,19] **Table 3** presents the principles underpinning effective eliciting of information about abuse and therapeutic responding to disclosures, whether spontaneous or as a result of asking.[19]

A range of treatment models are well suited to address trauma and psychosis,[20,21] including psychodynamic psychotherapy, open dialogue, family therapy, acceptance and commitment therapy, and, of course, trauma therapy, also pioneered in the US by Judith Herman.[22] Two other approaches, both of which are particularly well established in the UK, are described next.

Cognitive behavioral therapy for psychosis

CBT for psychosis (CBTp) is a collaborative and problem-orientated approach, working towards goals identified by the patient.[23] Given the prevalence of adversity and childhood/adult trauma, it is unsurprising that a significant proportion of the work involves trauma-focused interventions. There is a recognition that CBTp should address traumatic experiences and acknowledge and validate the influence such experiences have on current mental health.[24]

CBTp must be delivered in the context of a good therapeutic relationship, and the interpersonal effectiveness of the therapist is important. Another central component of CBTp is the emphasis on normalization of psychotic experiences and provision of information regarding prevalence and causation, helping people to understand that experiences such as hearing voices and paranoid thoughts may be more common than people expect, can be understandable responses to life events such as interpersonal trauma in childhood or adulthood, bereavement and loss, and substance use. This approach helps to reduce distress and internalized stigma and can promote empowerment.

CBTp often involves developing new coping strategies to reduce distress and increase functioning. These include trauma-focused approaches such as grounding techniques to manage trauma sequalae (eg, flashbacks, unwanted memories) and dissociative experiences. CBTp also helps people explore the meaning of traumatic events, with an emphasis on reduction of self-blame, guilt, and shame by re-evaluation, evidential analysis, and development of alternative narrative accounts. This can include contextualization of unprocessed trauma memories using reliving approaches. Clinicians are often reluctant to treat people with psychosis with exposure to trauma memories, as they fear it might make the psychotic symptoms worse or lead to destabilization. However, recent studies have shown that such trauma-focused approaches can be integrated within CBTp and be safe and helpful.[25] Another important aspect of CBTp is the emphasis on active participation by use of behavioral experiments to evaluate safety and current sense of threat, testing beliefs by changing behavior in the real world. In addition, engagement in tasks between sessions is important in relation to achieving the best outcomes.

There are over 50 clinical trials of CBTp, with recent meta-analyses finding small to moderate effect sizes. These findings have led to it being recommended as a treatment for people

who meet criteria for a diagnosis of schizophrenia and other psychoses in international guidelines.[26] Specific to trauma-focused CBTp, systematic reviews conclude that it can be safe and effective in patients who have a diagnosis of psychosis and schizophrenia.[27,28] Recent reviews and individual studies have also concluded that there is little evidence to suggest that trauma-focused CBTp leads to symptom exacerbations or adverse events; indeed, one study found a reduction in re-victimization compared to a waiting list condition.[29]

Hearing Voices Groups

Hearing Voices Groups are peer support groups for people who hear voices, see visions, or have other unusual sensory experiences. The groups are a survivor-led initiative that aims to create a safe space to talk about difficult experiences without fear of judgement or stigmatization. Originating in the Netherlands during the late 1980s, as a consequence of the work of Professor Marius Romme (social psychiatrist), Dr Sandra Escher (journalist/researcher), and Patsy Hague (voice-hearer), there are now national networks of groups in 34 countries including the USA (www.hearingvoicesusa.org), England, Serbia, Brazil, Japan, Italy, and Australia. Groups are run in inpatient wards, forensic units, prisons, immigration and removal centers, child and adolescent mental health centers, and in the community. National networks are connected through the International Hearing Voices Movement supported by the UK-registered charity, Intervoice (www.intervoiceonline.org). This organization includes online networking and an annual International Hearing Voices Congress for voice hearers, their loved ones, clinicians, and academics.

Rather than provide treatment, Hearing Voices Groups prioritize connection and exploration.[30] The role of the facilitators, therefore, is to “lead by listening,” supporting the

group's safety and development by encouraging collaborative decision-making and an ethos of mutual support.[31] Facilitators often have personal experience of hearing voices but also include mental health workers and other allies. A key tenet of these groups is a commitment to respect people's right to understand their experiences in their own way.[32] This can be a challenging aspect of the groups for clinicians who feel that unusual or delusional explanations should be challenged, especially in acute psychosis. However, given both the denial of trauma many survivors fear, and the way trauma and adversity can relate to themes within psychosis,[5-8,33] rejecting, fragmentary or confusing narratives risk also rejecting the person's truths. Just as collective sharing of trauma narratives can create "a common bond of humanity when we understand that we come to the table of dialogue with different kinds of trauma, all of which are important,"[34] the explicit pluralism of Hearing Voices Groups may provide a safe structure for members to hear and be heard. According to a survey of members of English Hearing Voices Groups, although 95% were mental health service users, the strongest results included members feeling that groups provide a safe and confidential space to discuss difficult things, and support that is unavailable elsewhere.[35]

Not considered an intervention in itself, the research around Hearing Voices Groups remains limited.[36] However, the small-scale research paints a consistent picture. The groups provide:

• A sense of belonging and connection[37-39]

• Acceptance of one's whole person[37-40]

• Increased ability to talk about the voices[37-40]

• Increased understanding of one's experience[36,38]

• An increased engagement with coping strategies[37,38]

These potential benefits complement the phased approach to recovery from trauma: safety, exploration and (re)connection.[22]

Hearing Voices Groups are not a panacea. Like all approaches, they are not universally helpful, with a small minority of participants finding that they experience “small negative shifts” after attending groups[37] and feeling certain topics can be marginalised.[39] Although 35% of the respondents to the English Hearing Voices Groups survey found groups distressing at times, the extent of the benefits endorsed in the survey suggest that groups can be helpful despite the challenges of discussing difficult material.[35] Because the discussion in the groups is often difficult (eg, trauma, adversity) and such challenges are an inherent aspect of these groups it differentiates them from other social gatherings.[41] For those who wish to attend them, Hearing Voices Groups can support people with a diagnosis indicative of psychosis and can have particular benefits for those with experience of trauma.

Conclusion

We trust this brief introduction to the various ways that a range of different traumas and adversities can contribute to psychosis, and the challenging but rewarding nature of person-centered responses, is helpful. For readers wishing to learn more, there are several books to consider,[21-23,42-44] and the International Society for Psychological and Social Approaches to Psychosis may also be of interest (www.isps.org; www.isps-us.org).

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Table 1

Published examples of trauma-related psychotic experiences[5-8]

Trauma/adversity	Psychotic experiences
Incest	Believes that her body was covered with ejaculate[5]
Incest	Believes that she had had sexual relations with public figures[5]
A man who had been raped several times by an uncle at age seven	Heard voices telling him he was "sleazy" and should kill himself[5]
A woman who had been sexually assaulted by her father from a very young age, and raped as a teenager	Had the delusion that people were watching her as they thought she was "a sexual pervert" and had auditory hallucinations accusing her of doing "dirty sexy things"[5]
Sexual abuse from an early age; raped several times by strangers and violent partner	Believes that he is being tortured by people getting into body, e.g. the Devil, and had bleeding secondary to inserting a hose into self, stating "wanting to wash self as people are trying to put aliens into my body"[6]
Child physical and sexual abuse, multiple rapes	Believes he has never been a child but is an old man who had his penis gauged out[6]
Child sexual abuse	Olfactory hallucinations—smells sperm[6]
Ongoing sexual abuse by a violent relative	Hears voice of the relative telling to jump off a bridge and kill self; has already tried to commit suicide several times[6]
Sexually abused by her father from age 5	Command hallucinations to kill self; male voices outside her head, screaming children's voices inside her head[7]
Physically abused by father as a child	"Paranoid delusions of persecution" with fears of being killed, and 'ideas of reference' that violence on television is related to him[7]
Physically and emotionally abused by mother as a child	Command hallucinations of mother telling her to commit suicide[7]
Sexually molested by old man as a child	"Persecutory delusions" that men are out to harm her and sexually harass her[7]
Childhood sexual abuse	Shame about the abuse, causing pervasive belief that she is inadvertently contaminating others by existing[8]

Table 2

Examples of causes reported by people with a psychosis diagnosis[13]

• Being raised in a house with a dad with anger issues led me to live in constant fear as a child; I didn't understand that fear so instead it changed to paranoid thinking like monsters or demons were coming to kill me; I developed protective delusions (such as me being a werewolf or God)
• Abusive childhood
• Abusos sexuales en la infancia
• Bad experiences, no proper positive attachments growing up; did not know how to deal with distressing stuff; grew up in a hostile environment: belittled by my mother and ignored by my father; did not like myself; I think the voices are a reaction to that
• Being an anxious child, then being in abusive relationships, undue stress in life
• Inherited vulnerability and serious environmental trauma (parental loss among other things)
• Physical and sexual abuse and denial of that; in psychiatry for many years
• Bad treatment when an infant; followed by stress exacerbated by social and societal factors, accompanied by family conflicts and dis-satisfactions
• My psychosis was a natural transition from the physical and mental abuse experienced as a child/teenager . . . as a child if you don't have at least one adult that you know you can depend on to be there for you then what do you have? Paranoia, seclusion and hallucinations are a natural consequence of this abuse
• In an abusive relationship and had unresolved childhood trauma
• Extreme ongoing child sexual assault and being the victim of a paedophile network and not being believed and supported
• The passing of both parents 5 months apart
• Trauma, stress, burnout, death of a parent while still a child, abusive and neglectful parenting, social isolation, bullying
• Psychological abuse stemming from my mom's own abuse
• Past trauma and environment, isolation, father's suicide, holocaust 1st generation German Jew, seeing my mom pass away from a heart attack

Table 3

Principles for eliciting and responding to abuse histories[19]

Principles for eliciting history	**Comments**
Explain confidentiality boundaries	This must be done at beginning of contact, not just before asking about abuse
Ask all patients	Don't just ask patients that you guess might have been abused, (eg, patient with PTSD)
Ask at initial assessment as part of a general psycho-social history	Unless the patient is acutely suicidal or psychotic, in which case document that inquiry has not occurred
Preface with brief normalizing statement	"We ask everyone, because it is fairly common among the people who come here"
Ask specific questions rather than "were you abused?" (about 50% is missed when using just "abused"); ask about recent/ongoing abuse as well as childhood	"Did anyone do anything to you sexually as a child that you didn't want or made you uncomfortable?" "Did anyone hurt or punish you in a way that left bruises or cuts or required medical treatment?"
Principles for responding	
Affirm that it was a good thing to tell you	"I really appreciate you trusting me enough to share that with me; some people find that very hard to do"
Do not try to gather all the details	This is not necessary, stay focused on the here and now, and the relationship between you and your patient
Ask if he or she has told anyone before, and ask how that went	Many patients will not have disclosed before; the response to those that have disclosed is important
Ask if he or she thinks about whether the event(s) is linked to current difficulties	Useful to know the patient's thinking about this; may not be relevant
Offer support	Inform your patient of the range of treatments/support available, but do not seek a decision there and then
Check current safety from possible ongoing abuse	People abused as children have relatively high rates of abuse as adults
Check emotional state at end of session	"How are you feeling about telling me about xxxxx earlier in our session"
Offer follow-up/check in	Either offer to phone later or provide a support/crisis center number