Review article

Trauma-Informed Care Promoting Recovery from Psychosis

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Abstract

Research confirms that a traumatic experience, especially during childhood, is associated with an increased risk of psychosis and that psychosis is also associated with an increased risk of PTSD. People with psychosis and a history of trauma have a poor response to medication and a worse prognosis, which adversely affects their recovery. During the psychiatric treatment of a person with psychosis, they are rarely asked about their personal experience of trauma, which results in inadequate treatment planning. The main obstacle to the optimal treatment and recovery of these people is the neglect of the bio-psycho-social approach because it is still considered that psychosis is exclusively biologically conditioned and neglects the psychological approach and psychosocial interventions. The paper presents data related to the prevalence of trauma-related psychosis and the consequences of trauma on recovery. It describes a trauma-informed recovery approach that represents a framework for the organization of treatment that helps people overcome the negative consequences of trauma and promotes recovery.

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Introduction

There is strong research evidence that experiences of trauma during a lifetime increase the risk for psychosis (1, 2). The risk of psychosis is three times higher in people who experienced trauma in childhood compared to those who did not (1, 3), but the risk is high for bullying (4, 5, 6, 7), domestic violence and other highly stressful life events (8), and involuntary treatment (9, 10). Higher rates of childhood victimization and PTSD are reported across the spectrum of psychosis compared to the general population (11–15). The prevalence rate for PTSD for people with psychosis is 20 to 30% (16) compared to 7.8% in the general population (17). People with psychosis and a history of trauma have worse clinical and functional outcomes and poor response to medication (16, 18, 19, 20). Unfortunately, trauma and PTSD in people with psychosis often remain under-detected in mental healthcare services (21–24). As a consequence, many people with psychosis and PTSD will not be treated with trauma-specific therapy (25). It is, therefore, imperative that therapists be willing and able to address trauma and its consequences when supporting recovery from distressing psychosis (26).

Although findings show that psychological trauma plays a role in developing psychosis and that these people have a poor response to medication and poor prognoses, they are less likely to be treated in the framework of trauma-informed recovery care as well as receive evidence-based psychological treatment for trauma and psychosis. Unfortunately, the biological approach to understanding psychosis and pharmacological therapy for psychosis still prevails in clinical practice. As a result, patients diagnosed with psychosis who do not respond satisfactorily to medication are often declared treatment-resistant without considering psychosocial factors such as a history of trauma as the cause of resistance (27, 28). Such disregard of trauma has severe negative consequences related to poor outcomes and recovery from psychosis (29, 30). The goal of this paper is to draw attention to the need to talk about trauma and assess its impact on mental health conditions and recovery of persons with psychosis in everyday psychiatric practice in order to develop appropriate individual treatment plans that can affect the adverse effects of trauma and promote recovery.

Method: The key terms trauma, psychosis, recovery and PTSD were used to search three databases: Medline, Embase and PsycInfo. After that, relevant papers were selected in accordance with the objectives of this paper.

The impact of trauma on mental health

As stated earlier, there is a connection between trauma and the onset of mental disorders, including psychosis. The trauma victims activate automatic fight, flight and freeze responses to minor stresses or external cues, which can lead people to become dysregulated into a hyperarousal state, in which feelings of terror and panic may trigger the use of coping strategies such as substance misuse and self-injury to reduce distress (31, 32). Trauma can impair the course of normal psychological development and put people at a high risk of developing mental health disorders. The functioning of the mother as an empathetic self-object who meets the child's needs for mirroring and protection (33) is related to the development of a healthy personality with a stabile positive sense of self and the capacity to develop trustful relationships with other people, which decreases the risk for developing the mental disorder. Early trauma interfered with the healthy empathic functioning of the mother and led to attachment difficulties (34–38) with the consequences of difficulties in emotional regulation and mentalization, negative self-perception and decreased trust in other people (39). Therefore, trauma can impact people's ability to feel safe in relationships, manage strong emotions and view themselves as worthwhile. On the social level, it causes avoidance of social contact, difficulties expressing feelings and loneliness (40). On the other hand, for some persons, there is also a possibility for posttraumatic growth and positive change following trauma (41–45). The promotion

of PTG may contribute to the treatment of people who have experienced severe mental illness (SMI) and who have endured psychotic symptoms, especially using interventions targeting the development of a positive perception of identity (46).

The link between psychosis and trauma is complex and multifactorial. According to Morrison et al. (47), an integrative model of the spectrum of trauma reactions, trauma may lead to psychosis and related experiences can themselves give rise to PTSD, and both psychosis and PTSD may lie on a spectrum of shared reactions to emotional trauma.

The influence of particular traumatic experiences on specific psychotic symptoms such as auditory verbal hallucinations and paranoia has been studied in research (48). Thus, it has been found that childhood rape was associated with hallucinations and institutional care was associated with paranoid beliefs. Physical abuse was associated with both kinds of psychotic experiences (48). For many people with psychosis and a history of trauma, a relationship between their life events and the content of their psychotic experiences has been found, such as hearing distressing voices, which were a direct repetition of a past traumatic event (48–52).

Comparisons made with the type of trauma about the risk for psychosis have found that emotional neglect and interpersonal violence compared with parental loss, unintentional injury or economic adversity are strongly associated with the risk of developing psychotic symptoms (4), and the risk is more significant for abuse compared with neglect (53).

The research on the relationship between life-threatening events such as accidents and natural disasters and the risk for psychosis is conflicting. However, most studies did not find an increased risk for psychosis (54, 55), but exposure to multiple types of trauma and a longer duration of trauma has been associated with a greater risk of developing psychosis (48, 56, 57).

The mechanisms involved in pathways from trauma to psychosis

Multiple models have been proposed to explain the link between trauma and psychosis (34). The stress vulnerability model suggests that following trauma exposure, individuals with a genetic risk for developing psychosis are at an increased risk of developing the disorder (58). The socio developmental hypothesis suggests that multiple stressors interact at various stages of development to cumulatively increase the risk of developing psychosis through gene environment interactions (59). The theory of social defeat explains the link between childhood trauma and psychosis, whereby prolonged or chronic exposure to victimization may lead to negative evaluations of the self and other individuals, leading to hostile interpretations of ambiguous social situations and the intentions of other individuals (60). According to Alameda et al. (61), these findings suggest that the extreme experiences of threat, hostility and violence in childhood and adolescence may mediate the development of psychotic symptoms in individuals with underlying genetic susceptibility and neuro-developmental adversity through cognitive processes such as negative beliefs about the self, world and others, leading to distressing interpretations of everyday events or cognitive appraisal biases that could eventually result in paranoid delusion. Affective pathways such as anxiety, depression and emotional dysregulation, leading to dissociation, could eventually evoke hallucinations (61). Hardy (62), in her model of posttraumatic stress in psychosis, describes the central role of autobiographical memory and trauma-related emotion regulation strategies in shaping the phenomenology of intrusive imagery, subsequent appraisals and coping responses.

Mayo et al. (34) conceptualize a cyclical relationship between trauma and psychosis; the emergence of psychosis creates a string of increased vulnerability to future traumatic experiences and poor prognosis. Therefore, trauma interventions are needed to break this cycle of expected poor prognosis.

Recovery is facilitated by trauma-informed care

Healthcare services themselves can unintentionally traumatize or re-traumatize people (63), mainly when the biomedical approach dominates interventions and fails to acknowledge the value of healthy and meaningful relationships, which mitigate the destructive impact of trauma (64). Therefore, to reduce traumatization in mental health care, the provider should make organizational changes aiming to create environments and relationships that promote recovery and resilience and prevent traumatization. The recovery approach is based on the assumption that people have the capacity for growth, change and recovery (65), empowering individuals to regain control over their lives, develop coping strategies, build social support networks and pursue personal goals (66). Trauma-informed care incorporated the principle of recovery and resilience in the organization's care framework.

Trauma-informed care (TIC) is a process of organizational change that creates recovery environments for staff, survivors, their friends and allies, with implications for relationships (71). TIC mental health service assumes that any client admitted to mental health service could have a trauma history, fosters safety and trust and actively resists re-traumatization (67). TIC enables the creation of organizational settings that reflect the exact opposite conditions a person may experience during a traumatic event, and the creation of such conditions will facilitate growth and engagement (68). TIC responds in a way that supports recovery, does no harm, and recognizes and supports people's resilience (69). To do that, all of the interactions with clients should be based on safety, trustworthiness, choice, collaboration and empowerment (67, 68).

Trauma-informed and recovery promotion care and practice (66) are based on a strengths-based framework emphasizing physical and psychological safety, creating opportunities for people with lived experience to rebuild a sense of control and empowerment. Focusing on what makes individuals strong rather than what makes them weak may help us understand what helps them maintain their mental health. No intervention that takes power away from the survivor can foster their recovery, no matter how much it appears to be in their immediate best interest (70).

The fundamental shift in providing support using a trauma-informed recovery approach is to move from thinking 'What is wrong with you?' to considering 'What happened to you?' (71), and promoting resilience (72). Asking people about what happened to them rather than what is wrong with them can facilitate engagement. Trauma disempowers people and hinders recovery; therefore, it is necessary to create an environment that will allow people to feel safe to speak freely about the experience of trauma in their lives. The first and most vital step of trauma-informed practice is to establish a therapeutic relationship with clients, which promotes a feeling of safety. (70). When clients feel a sense of internal safety, they have the capacity to manage strong affect without becoming overwhelmed, engaging in self-destructive behavior or shutting down (70). A significant protective factor against mental health disorders and recovery from trauma is developing meaningful relationships (70, 73). Through relationships, trauma survivors can learn to feel safe, trust others, learn new ways of relating to people, develop self-compassion, improving self-regulation and attachment (32). The perception of social support has been found to be an influential factor in the effects of traumatic events on the individual and the community (74). Therefore, helping people find social support is an integral part of the recovery and trauma-informed care approach.

TIC differs from trauma-specific practice (75, 76), which was created to treat clients diagnosed with PTSD. However, trauma-informed practice is not used to treat a particular trauma or stressor-related disorder. Instead, it provides mental health professionals with a framework to conceptualize their practice. Different treatments are available that target traumatic symptoms in people who experience psychosis (77), such as trauma-focused cognitive behavioral therapy for psychosis, eye

movement desensitization and reprocessing (EMDR), and trauma exposure therapy. These interventions are safe (78) for people with PTSD and psychoses and should be available for those who are needed. Evaluation of TIC (79) has shown increased staff levels of safety and satisfaction, trustworthiness, choice, collaboration and empowerment, including trusting each other, ability to work collaboratively, influencing their workplace, being encouraged to innovate or feeling fulfilled. Health services also (80) demonstrated a significant reduction in seclusions and restraints. The evaluation also shows that staff training and other forms of workforce development could be the most effective strategy to promote organizational change by creating shared trauma-related language, knowledge and skills (69).

Does talking about trauma harm people with psychosis?

A systematic review found that most people who use mental health services are never asked about traumatic experiences such as childhood abuse and neglect, and that people diagnosed with psychotic disorders are asked even less than other service users (83). The reasons may be related to client-related barriers, including symptoms interfering with treatment, client unwillingness, cognitive impairment and communication difficulties (81). Clinician-related barriers to treatment included clinician anxiety (82), lack of knowledge and experience as well as staff perceptions regarding their competence and confidence in delivering interventions, the usefulness of interventions and agency support (81). A descriptive study investigating victimization found that 11% of participants with experience of psychosis would not report any victimization to anyone and that in 57% of the cases, patients would not report any victimization even when the psychiatrists thought that their patients had been victimized, which may be related to the dissociation of the traumatic experience (84).

The reluctance of practitioners to enquire about trauma has been attributed to concerns about offending or distressing the clients (83, 85). This is contrary to evidence from research that trauma disclosure is beneficial for recovery (86, 87). Patients with trauma history welcomed the idea of a professional asking them about their experiences as long as they felt safe and not judged (84, 87). Talking about the trauma was a liberating experience; the people felt as if a weight had been lifted off their chests (40). Not being able to discuss traumas resulted in being cautious around other people and keeping their distance for fear of being hurt or losing someone they cared about, leading to increasing isolation; therefore, clinicians should be encouraged to discuss traumatic experiences with patients. Not being able to recognize and discuss traumatic stress in people with psychosis is a cause of great concern, as traumatic life events and their consequences can lead to more severe clinical profiles, worse overall functioning and lower remission rates when compared to patients who did not experience such events (88).

Discussion

Interpersonal trauma, especially in childhood and adolescence, is a significant risk factor for psychosis and can hinder the process of recovery. It can have lasting adverse effects on psychological and social individual functioning in many life areas. If not treated, persons become imprisoned with negative emotions such as helplessness, guilt, anger, fear and shame. It has consequences of increasing difficulties in trusting self and others, which has resulted in various difficulties in emotional control, low self-esteem, mentalization difficulties, trust in others and social exclusion, which puts a person at risk for poor prognoses, frequent hospitalizations and recurrent psychotic episodes.

Based on the evidence on the link between trauma and psychosis, there is the importance of comprehensive screening for trauma in all patients presenting with psychotic-like symptoms or a psychotic disorder (89) and offering trauma-informed treatment to address trauma and its consequences (77, 89) and supporting recovery from psychosis (29, 30).

Trauma experiences and associated clinical consequences can be identified through a variety of methods, and clinicians should be able to determine whether trauma is a significant centerpiece of the presenting problem or a complicating factor that aggravates the individual's psychosis symptoms (34). Trauma-informed mental healthcare offers opportunities to improve service users' experiences, improve working environments for staff, increase job satisfaction and reduce stress levels by improving the relationships between staff and patients through greater understanding, respect and trust (30, 79). Recovery and trauma-informed approaches emphasize creating safe and supportive environments based on trust and collaboration, validating a person's traumatic experiences, promoting empowerment and addressing the underlying trauma-related issues that may contribute to psychotic symptoms. Acknowledging and addressing trauma can also open the door for posttraumatic growth. Integrating trauma-informed and recovery promote care principles into mental health services can enhance engagement, empower people, promote resilience, improve treatment outcomes and facilitate recovery for individuals with psychosis who have a history of trauma.

Conclusion

Our paper reveals enough evidence that the experience of trauma, especially in early childhood and adolescence, is associated with the risk of psychosis, developing PTSD and a worse prognosis. Also, people with psychosis are rarely asked about their traumatic experiences. The most common reasons for this behavior are attitudes about the biological cause of psychosis and neglecting the psychosocial interventions, which becomes the main obstacle to recovery, putting people at risk of being declared treatment-resistant, which seriously jeopardizes the possibility of recovery. Other reasons include a lack of trauma screening within routine services or minimization of trauma impact on psychosis by the individuals themselves. Our findings support the need to change current practices and implement trauma-informed care to promote the recovery process.

Our paper highlights the importance of discussing trauma and looking at psychosis through a "trauma lens". Therefore, there is a need to systematically assess trauma history and traumatic symptoms in psychosis and overcome the clinicians' worries about discussing trauma with service users.

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Skrb utemeljena na traumi koja promiče oporavak od psihoze

Sažetak

Istraživanja potvrđuju da je traumatsko iskustvo, osobito tijekom djetinjstva, povezano s povećanim rizikom od psihoze te da je psihoza također povezana s povećanim rizikom od PTSP-a. Osobe s psihozom i poviješću traume imaju slabiji odgovor na lijekove i lošiju prognozu, što negativno utječe na njihov oporavak. Tijekom psihijatrijskog liječenja osobe s psihozom, rijetko se postavljaju pitanja o njihovim osobnim traumatskim iskustvima, što rezultira neodgovarajućim planiranjem liječenja. Glavna prepreka optimalnom liječenju i oporavku tih osoba je zanemarivanje bio-psiho-socijalnog pristupa, jer se i dalje smatra da je psihoza isključivo biološki uvjetovana, uz zanemarivanje psihološkog pristupa i psiho-socijalnih intervencija. Rad prikazuje podatke vezane uz prevalenciju psihoze povezane s traumom i posljedice traume na oporavak. Opisuje se pristup oporavka temeljen na razumijevanju traume, koji predstavlja okvir za organizaciju liječenja, pomažući ljudima da prevladaju negativne posljedice traume i potiče oporavak.