CEDAR Clinical Brief

Center for Early Detection, Assessment, and Response to Risk

Considerations for Trauma-Informed Early Psychosis Care

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Traumatic Events in Relation to Psychosis

Trauma exposure is more common than many people realize. About 70% of Americans are exposed to at least one potentially traumatic event by age 18[i]. According to the DSM-5, a traumatic event involves "actual or threatened death, serious injury, or sexual violence" and can be direct or indirect (i.e., witnessed or learned about in personal or professional contexts). Common traumatic events include abuse (e.g., physical, emotional, or sexual), neglect, violence (e.g., domestic, school, community, or political), accidents, and natural disasters[ii]. Scary or painful medical procedures and sudden or violent deaths of loved ones can also be traumatic events. **While not considered traumatic events according to the DSM-5, many individuals describe experiences of psychosis itself and involuntary psychiatric hospitalizations as traumatic.** Imagine how terrifying it might be to believe that aliens have replaced your loved ones with imposters or to feel strangers raping you with their eyes, or to be locked up, restrained, or forced to take medication when you truly believe such thoughts or experiences are real!

Trauma-Related Disorders and Early Psychosis

In the month following exposure to a traumatic event, posttraumatic stress (PTS) symptoms are common. A diagnosis of Acute Stress Disorder may be appropriate if PTS symptoms result in clinically significant distress or impairment in those first 30 days, whereas a diagnosis of Posttraumatic Stress Disorder (PTSD) may be appropriate if this pattern continues after 30 days. About 30% of individuals exposed to a traumatic event go on to develop PTSD[iii]. **PTSD is about twice as prevalent in people with chronic psychosis[iv] and about four times as prevalent in people with first-episode psychosis[v] compared to the general population.**

Some theories[vi,vii] suggest that people with a history of PTSD may be more vulnerable to psychosis due to common maintenance factors. For example, intrusive thoughts and images are common in both problems: in PTSD, these intrusions might include having thoughts or images about a traumatic event in the days or weeks following a traumatic event, whereas, in psychosis, these intrusions might include thinking others are thinking negatively about you, hearing your name being called when no one is there, or seeing something out of the corner of your eye. People who go on to develop PTSD, and possibly psychosis, may interpret these intrusions as evidence of current or future threats (i.e., rather than as a normal reaction to a past threat) to their wellbeing or as evidence of permanent, negative changes. As a result, they may respond to these intrusions with strong, negative emotions or unhelpful behaviors (e.g., paying too much attention to them, or trying to avoid people, places, or situations they associate with them).

Treating Trauma-Related Disorders and Early Psychosis

While we know that PTSD and psychosis commonly co-occur, we are just beginning to understand how best to treat them together. Providers are often confused about how to tease apart trauma and psychosis and anxious about how to treat them when they co-occur[viii]. Because individuals with past or current psychosis have historically been excluded from most PTSD treatment studies, research hasn't yet helped to clarify and calm these confusions and anxieties[ix,x]. Sadly, this can lead to one or both problems being undertreated or untreated[xi]. **Promising new research, however, suggests that evidence-based treatments for PTSD are safe and effective for addressing PTS symptoms and psychotic symptoms in individuals with PTSD and chronic psychosis[xii,xiii,xiv,xv].** In addition, interventions geared toward preparing clients for exposure treatments for PTSD are highly compatible with common cognitive-behavioral treatments used to treat mood, anxiety, and psychosis spectrum symptoms.

Preparing Clients with Early Psychosis for Exposure Treatment for PTSD

- ***Psychoeducation:*** *Provide accurate information about trauma, PTS symptoms, and psychosis spectrum symptoms*
- ***Relaxation Skills:*** *Develop 1-3 relaxation skills to effectively reduce physical tension*
- ***Affect Recognition and Regulation Skills****: Learn to accurately identify affective states, rate their intensity using a subjective units of distress (i.e., SUDs) scale, and develop 1-3 skills to decrease negative emotions and/or increase positive emotions*
- ***Cognitive Skills:*** *Learn about the difference between and changeability of thoughts, feelings, and behaviors, as well as about how they influence each other*
- ***Relapse Prevention Planning:*** *Develop a clear plan for monitoring and responding to possible symptom exacerbations*

The **Center for Early Detection, Assessment, and Response to Risk (CEDAR)** provides assessment and treatment services for young people showing clinical signs of risk for psychosis and their families, including those with comorbid conditions like PTSD.

For more information about CEDAR, please contact Megan Graham, LMHC, at 617-754-1223 or mgraham1@bidmc.harvard.edu.

Additional resources, including a list of statewide first-episode psychosis programs, are available through the Massachusetts Psychosis Network for Early Treatment (MAPNET) at https://www.mapnet.online/.

Do you have questions that you would like us to address in future clinical briefs?
Contact: Emma Parrish at eparrish@bidmc.harvard.edu

[i] Finkelhor et al., 2003
[ii] APA, 2013, p. 217
[iii] Kessler et al., 1995
[iv] Achim et al., 2011

[v] Strakowski et al., 199
[vi] Ehlers & Clark, 2000
[vii] Morrison et al., 2003
[viii] Cragin et al., 2017
[ix] Becker et al., 2004
[x] Litz et al., 1990
[xi] Ronconi et al., 2014
[xii] de Bont et al., 2015
[xiii] Frueh et al., 2009
[xiv] Mueser et al., 2008
[xv] van den Berg & van der Gaag, 2012

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