

Chapter 12

Trauma & Psychosis

This module is presented as a companion to the core treatment modules already described. While it is found as a web-companion chapter to the therapist guide due to space constraints, we advocate taking a trauma-informed approach from initial assessment through each stage of intervention, given both the prevalence of trauma in the histories of individuals struggling with psychosis, and the overlap of symptoms, compensatory behaviours, and treatment strategies for these difficulties.

Materials

-Reference exercises in chapters and handouts

Goals and Outline of Module

This module will focus on the development of such a trauma-informed approach by providing you with an understanding of the interaction between trauma and psychosis, and a discussion of trauma-sensitive issues pertinent to assessment, conceptualization, and treatment.

Overview of Treatment Area for Therapist

Rationale for a Trauma-Informed Approach

Environmental influences on psychosis have been underestimated until recently. We now know that genes and environment interact in the etiology of many illnesses and conditions, and that experience can literally shape the structures of the brain (Bentall, 2006). Known environmental influences on the development of psychosis include: 1) family relationships, with factors such as insecure attachment, vague and inconsistent communication in parenting style, and highly expressed emotion (i.e., the tendency to be critical and overcontrolling); 2) trauma, especially sexual abuse (Bentall, 2003; Goodman, Rosenberg, Mueser, & Drake, 1997); and 3) the experience of discrimination, victimization, and social marginalization linked to socio-economic circumstances associated with powerlessness (e.g., poverty, lack of education) (Bentall, 2006). Being knowledgeable about such environmental factors will guide us in obtaining a thorough assessment of our clients' experiences, which will in turn enable us to develop a trauma-informed case formulation collaboratively with our clients.

Increasingly, researchers and clinicians are recognizing the relationship between childhood trauma and psychosis (Mueser, Rosenberg, Goodman, & Trumbetta, 2002; Mueser, Rosenberg, Jankowski, Hamblen, & Monica, 2004; Larkin & Morrison, 2006). Research suggests that 40-50% of individuals with psychosis report either childhood sexual abuse (CSA) or childhood physical abuse (CPA), with 11-46% meeting criteria for a diagnosis of posttraumatic stress disorder (PTSD; Schäfer & Fisher, 2011). A recent longitudinal study using prospective measures of trauma during childhood demonstrated that trauma characterized by the intention to harm, including emotional abuse and bullying, has been associated with children's reports of psychotic symptoms (Arsenault et al., 2011).

Those individuals with psychosis and a history of childhood trauma, with or without PTSD, tend to present with a more complex clinical profile compared with those without these experiences, including more severe and chronic psychotic symptoms (especially hallucinations; Mueser et al., 2002). Kingdon and Turkington (1999) described the clinical characteristics of what they termed traumatic psychosis, a subgroup of those diagnosed with schizophrenia, in detail. They noted the abusive content of hallucinations, prevalence of command hallucinations (e.g., kill yourself, kill your children), a high frequency of comorbid depression linked to suicidality, symptoms perpetuated by increased arousal and avoidance, and a decreased response to antipsychotic medication, often resulting in high-dose treatment and polypharmacy. Others have underscored common comorbid difficulties, including more current and lifetime substance abuse (Conus, Cotton, Schimmelmann, McGorry, & Lambert, 2010b; Garo, Goldberg, Ramirez & Ritzler, 2005), higher levels of depression and anxiety (Lysaker & Salyers, 2007; Schenkel, Spaulding, DiLillo, & Silverstein, 2005), and more dissociative symptoms than patients with psychosis without a history of childhood trauma (Sar et al., 2010; Schäfer et al., 2012). Additional special considerations for those with a history of childhood abuse include the robust finding that early victimization predicts victimization later in life (Dean et al., 2007), higher levels of suicidal ideation, and more frequent suicide attempts (Conus et al., 2010a; Romero et al., 2009). Those with a history of abuse have difficulty sustaining intimacy in interpersonal relationships (Lysaker, Nees, Lancaster, & Davis, 2004), which impacts their social support network, a critical element in recovery from both trauma and psychosis. Overall, a history of abuse is related to worse social functioning (Gil et al., 2009; Hodgins, Lincoln, & Mak, 2009), involvement in the legal system (Conus et al., 2010a), and poorer quality of life (Fan et al., 2008); suggesting that it is imperative that we recognize this subgroup of our clients with psychosis who are particularly vulnerable.

Understanding the association between trauma and psychosis

There are numerous and complex relationships between childhood trauma and psychosis (Morrison, 2009), and many studies demonstrate a dose-response relationship, with greater numbers of traumatic events conferring greater risk for psychosis (Janssen et al., 2004; Scott, Chant, Andrews, Martin & McGrath, 2007; Whitfield, Dube, Felitti, & Anda, 2005). Psychosis can be a reaction to traumatic childhood experiences for some. Specific links have been found between childhood trauma and both delusions (Scott et al., 2007) and hallucinations (Whitfield et al., 2005) in large population-based studies. There may be a connection to earlier traumatic experiences in the form and content of one's psychotic experiences (Read, van Os, Morrison, & Ross, 2005); for example, CSA has consistently been found to be associated with the development of critical or commanding voices in adulthood (Read, Goodman, Morrison, Ross, & Aderhold, 2004).

Fowler et al. (2006) have argued that even more common are the indirect pathways between childhood abuse and psychosis. They present a series of "catastrophic interactions" between normal processes associated with the emotional reaction to stress and trauma, and information-processing abnormalities found in psychosis; which together may increase one's vulnerability to acute psychotic states.

Despite some debate on the topic, recognition that one's experience of psychosis (and of hospitalization) can also be considered traumatic has grown (Bendall, McGorry,

& Krstev, 2006). This is supported by research indicating that the subjective experience of threat to physical integrity is a better predictor of distress than is the objective experience (Alvarez-Conrad, Zoellner, & Foa, 2001; Bernat, Ronfeldt, Calhoun, & Arias, 1998; Girelli, Resick, Marhoefer-Dvorak, & Hutter, 1986). Predictors of the development of PTSD include “mental defeat” (Herman, 1992a) and the response of others to the victim (Briere, 1997). Certainly these factors are salient in the context of a psychotic episode, wherein many experience a sense of defeat in the face of symptoms, hospitalization, medications, and other treatment experiences. Similarly, given that social support is a crucial risk factor for PTSD, the societal exclusion and stigma that persists towards individuals with mental illness, particularly psychosis, may have a role in the development of post-psychotic PTSD (Bendall et al., 2006). Research has demonstrated that positive psychotic symptoms such as persecutory delusions, passivity phenomena, and visual hallucinations, as well as unusual thought content and suspiciousness, are related to the development of PTSD secondary to psychotic experience (Frame & Morrison, 2001). Given that the general course of PTSD following psychotic experience is similar to that for other traumas and the finding that many people experience symptoms of PTSD in the aftermath of an acute episode of psychosis (Bendall et al., 2006), it is important to assess for this possibility when working with our clients. It is also important to be aware that, unlike discrete trauma events, the experience of psychosis may be conceptualized as an ongoing trauma, similar to ongoing experiences such as childhood abuse and domestic violence (Bendall et al., 2006). This impacts the recovery process and must be taken into consideration during treatment planning.

Assessment

Unfortunately, heightened awareness of the extent of trauma in the lives of patients with psychosis does not always translate into the provision of trauma-informed care. Despite recommendations that clinicians routinely assess trauma and PTSD among individuals with psychosis (c.f., Read et al., 2005), many clients have never been asked about lifetime trauma, and only approximately 2% of those with psychosis and other severe mental illness obtain a diagnosis of PTSD (Brady, Rierdan, Penk, Losardo, & Meschede, 2003). Moreover, clients are rarely offered treatment with a trauma focus, the current evidence-based standard for trauma and PTSD treatment (Bisson & Andrew, 2007). We have witnessed patient charts containing various diagnoses (e.g., schizophrenia, schizotypal personality disorder) with a lack of diagnostic clarity spanning a period of years, when a more parsimonious explanation of the individuals’ troubles involved a sequelae of symptoms stemming from a history of prolonged childhood abuse, undisclosed until assessment for individual therapy with one of the authors. It is clear that lack of inquiry about childhood trauma can result in suboptimal or inappropriate care and can prolong distress (Morrison, 2009).

The most common diagnosis related to a history of trauma is PTSD, which is comprised of reexperiencing, hyperarousal, and avoidance symptoms. Instruments assessing PTSD and posttraumatic stress symptoms developed for the general population, such as the Clinician Administered PTSD Scale (CAPS), PTSD Checklist (PCL), and Impact of Events Scale (IES), have also demonstrated reliability for use with people with psychosis (Mueser et al., 2001; Schäfer et al., 2011). These tools are beneficial in addition to a comprehensive clinical interview.

Differential diagnosis in the context of more complex childhood trauma and psychosis can be more difficult. Complex trauma involves harm and/or neglect, is chronic, and occurs during developmentally sensitive periods such as childhood, by adults who are in a position of responsibility (Ford & Courtois, 2009). Because the child’s development occurs in the context of abuse, thus affecting neurological, biological, emotional, and cognitive systems, the sequelae of such trauma have been shown to be pervasive and multifaceted (cf. Cook et al., 2005; Courtois & Ford, 2009; Herman, 1992a, 1992b). A comprehensive review of the literature on complex trauma postulates that its impact occurs in the domains of attachment, biology, affect regulation, dissociation, behavioural control, cognition, and self-concept (van der Kolk, Roth, Pelcovitz, Sunday, & Spinazzola, 2005).

There are also important questions pertaining to the differential diagnosis of psychosis and dissociative disorders related to trauma (cf. Moskowitz, Schäfer, & Dorahy, 2008), which are beyond the scope of this chapter, but important to consider in treatment (see below) particularly if your client appears to be highly dissociative.

1. Asking and responding

If asking about a history of traumatic events is new to you, or you are unsure about how to sensitively ask about or respond to a disclosure of abuse, it may be helpful to seek additional training or supervision. Dr. John Read, a Clinical Psychologist at the University of Auckland in New Zealand, has conducted training and research on this topic. See Table 1 for a summary of his training guidelines for abuse inquiry and response (see Read, 2006).

Table 1: Principles important in abuse inquiry and response

Principle	Description/ rationale
1. All clients must be asked	Due to high prevalence of abuse in patients with psychosis. Men and those with psychosis are less likely to be asked. Routine inquiry is necessary because spontaneous disclosure is rare.
2. Ask specific/ objective/behavioural questions	Begin with general questions about childhood experiences, e.g., ‘Tell me about your childhood.’ More specific questions may proceed naturally from here. Many clients may not conceptualize their early experiences as “abuse,” or may find the term threatening. Therefore, ask specific questions about acts and behaviours, such as: ‘As a child, did an adult ever hurt or punish you in a way that left a bruise, cut, or scratches?’ ‘As a child, did anyone ever do something sexual that made you feel uncomfortable?’ And then ask similar questions about experiences during adulthood.
3. Ask at initial assessment	... because when this does not occur, it is seldom asked in subsequent meetings (Read & Fraser 1998)
4. Be aware of types and prevalence of abuse	In addition to this chapter, see recommended reading list.

5. Be knowledgeable about effects of abuse	Trauma and abuse have multiple sequelae that span diagnostic boundaries. Even sub-clinical posttraumatic stress symptoms related to abuse cause significant distress, problems in functioning, and negative consequences (Maikovich, Koenen, & Jaffee, 2009; Stein, Walker, Hazen, & Forde, 1997). See recommended reading list at end of this chapter.
6. Be aware of current clinical practice	To build motivation and dedication to work in a trauma-informed manner.
7. Know how to respond to disclosures	Not necessary to ask for lots of detailed information. Affirm that it was a positive thing that your client told you; honour the disclosure. Acknowledge how the client is reacting (there may be a wide range). Offer support. Check current safety, i.e., ask about any ongoing abuse, and possible risk to others from the same perpetrator. Check emotional state at end of session. Offer immediate follow-up/ check-in, and assist clients to identify their own support systems. Be knowledgeable about resources in your community and procedures re: notetaking, need to breach confidentiality due to risk.
8. Be aware of vicarious traumatization	Be aware of your own emotional response to hearing about others' abuse histories, particularly if you have a personal history of trauma. Seek support, supervision, and individual therapy if necessary.

Adapted and summarized from Read, 2006, p.208-215

2. Feedback and explanation of symptoms

We have found it pertinent to share an explanation of the diagnosis with clients as part of our feedback and formulation following the assessment. This provides transparency and an opportunity to make meaningful connections between your client's individualized formulation (which is discussed in more depth below) and the symptoms that comprise PTSD (or other relevant diagnosis/es). In explaining PTSD, it is helpful to explain the symptom clusters, with paper and pen, using examples taken from the client's own experience. If we begin with an explanation of reexperiencing symptoms (i.e., intrusive memories; distressing dreams; feeling and acting as though the traumatic event is recurring, as in flashbacks; distress and/or physiological reactivity at exposure to internal or external cues reminiscent of the trauma), and hyperarousal symptoms (i.e., difficulties with sleep; irritability/ angry outbursts; difficulty concentrating; hypervigilance; and exaggerated startle response), it can be very validating to next examine how avoidance and numbing symptoms have evolved for the client as attempts to "solve" the problem of intrusive distressing symptoms and a body stuck in "fight or flight." It can be useful to point out that avoidance takes the form of both active choice (efforts to avoid thoughts, feelings, conversations; or activities, people or places that remind one of the trauma) to both internal and external reminders of the trauma, as well

as “system shut-down”-type numbing symptoms (e.g., inability to recall parts of the traumatic event; decreased interest in formerly enjoyable activities; feelings of social detachment; restricted range of affect; and the sense of a foreshortened future) which are less voluntary responses by a system on overdrive.

It is important to highlight how avoidance plays a key role in maintaining symptoms of PTSD by: preventing integration and contextualization of the traumatic memories; generalizing to more and more situations, thereby narrowing the client’s life and resulting in isolation and a disconnection from one’s valued goals; and by depriving the client of opportunities to experience their anxiety and distress and to learn that their worst fears (e.g., “I won’t be able to handle it,” “I’ll go crazy”) will likely not come true, and that their anxiety may dissipate with time (i.e., thereby developing distress tolerance and a more accepting attitude towards symptoms). It may be highlighted how reexperiencing and hyperarousal symptoms on the one hand and avoidance and numbing symptoms on the other ultimately appear to pull the client in two very opposite directions – the former towards “too much” or flooding of sensations/ feelings/ thoughts/ memories; and the latter towards “too little,” such that clients are often caught in a perpetual cycle of extremes.

For clients with psychosis, avoidance of psychotic symptoms via “safety” or “maintaining” behaviours serves the same purpose as avoidance strategies that are central to a diagnosis of PTSD. Recognizing this as a means of trying to cope with or control one’s symptoms of both PTSD and psychosis helps to integrate what might otherwise seem to be disparate problems. We use the ACT term “experiential avoidance” to refer to avoidance in general, as it nicely represents the avoidance of both internal and external experiences (cf Walser & Westrup, 2007 for a discussion of experiential avoidance in the context of PTSD).

Treatment

1. Individualized clinical conceptualization

Many clinicians providing CBT for psychosis advocate an individualized conceptualization-based approach, and this approach is consistent with our integrative model. It is particularly important that the formulation is trauma-informed, and the collaborative development of such a formulation with your client will form a shared understanding and contextualization of her/his symptoms (both psychotic and trauma-related) and current difficulties (see Figure 5.1 on p. 47 of *Treating Psychosis*). This process is often experienced by clients as incredibly therapeutic, and has been in our experience an exercise serving to normalize and destigmatize; as well as one that begins the process of cognitively organizing and contextualizing your client’s trauma experiences within memory and his/her life narrative. From here, interventions derived from evidence-based psychological therapies for trauma and PTSD may be appropriate (examples of these will be discussed further below).

The top portion of our Integrated Treatment Model (Figure 5.1 on p. 47 of *Treating Psychosis*) is an example of a CBT framework for clinical formulation that we have found very helpful. ‘History’ may encapsulate any relevant experiences that have shaped your client’s life, including abuse, traumatic events, and family environment, the experience of psychosis and hospitalization(s), etc. Time should be taken to develop connections between these experiences and their influence on your client’s worldview,

including elucidation of core beliefs/ “stories”/ interpretations about self, others, and the world. These core beliefs may include compensatory assumptions, rules stemming from family, beliefs in relation to one’s abuse experiences (including those which came about through indoctrination by one’s perpetrator), etc. Next, we highlight the relationships between these core beliefs and rules and your client’s daily thoughts, feelings, and actions (beginning with whichever is easiest to identify), and use a typical CBT framework to examine how these are interconnected.

Given the role of experiential avoidance in both PTSD/ trauma and psychosis, this is an important opportunity to explore the role of avoidance with your client and how it ties into your client’s current difficulties/ self-identified problem list. The clinical formulation ties in nicely to a general discussion of values and goals, which will be picked up again later.

The beliefs that people develop in response to their traumatic experiences have a large impact on recovery from PTSD (Brewin & Holmes, 2003); and the significance of beliefs has also been implicated in differential levels of distress experienced by those with psychosis (e.g., distress caused by auditory hallucinations depends on whether the voices are perceived as benevolent or malevolent; Chadwick & Birchwood, 1995). Here, we are using the case conceptualization to explore these beliefs. Future interventions may include: a) cognitive reappraisal of these beliefs; or b) cultivation of a new attitude or relationship towards these beliefs or old interpretations via cognitive defusion, mindfulness and self-compassion strategies (e.g., to see them as only one interpretation, as a story not a truth, as an understandable interpretation for a child in that situation, etc.).

2. Evidence-based trauma treatment

An entire trauma and psychosis treatment protocol is beyond the scope of this chapter. Our aim is to provide some suggestions for using the treatment modules already provided in this manual in a way that is trauma-sensitive, and to provide some awareness about evidence-based trauma treatments that may benefit your clients.

In their meta-analysis, Bisson and Andrew (2007) concluded that trauma-focused therapies are more effective in the treatment of PTSD than are those without a trauma focus (Bisson & Andrew, 2007). Thus, if your client meets criteria for PTSD, an evidence-based, trauma-focused treatment should be considered once he/she is not in an acute psychotic episode and is relatively stable in functioning (e.g., has a stable living situation, is not using substances excessively).

Many clinicians and/or caseworkers are hesitant to conduct or refer their clients to trauma-focused therapy, often due to concerns that it will have a destabilizing effect or exacerbate existing psychotic symptoms. However, the evidence that psychosocial stressors precipitate the onset and relapse of psychotic episodes in individuals with psychosis-related disorders suggests that untreated anxiety and trauma-related symptoms may precipitate relapses or increases in symptoms in their own right (Rosenberg, Lu, Mueser, Jankowski, & Cournos, 2007). Turkington and colleagues (Turkington, Dudley, Warman, & Beck, 2004) noted that the high levels of arousal in PTSD can maintain and perpetuate psychotic symptoms and recommended combining CBT approaches to PTSD and CBT approaches to psychosis for the most effective treatment.

Therapies for PTSD which are empirically supported include:

- **Prolonged Exposure** (PE; Foa, Hembree, & Rothbaum, 2007) is a manualized treatment protocol that relies on: 1) breathing retraining; 2) repeated in vivo exposure to avoided activities or situations; and 3) repeated prolonged imaginal exposure to traumatic memories. It is a well-established treatment for PTSD, and particularly useful when avoidance is a central problem.
- **Cognitive Processing Therapy** (CPT; Resick, Monson, & Chard, 2007) is a manualized treatment targeting PTSD and depression, with more emphasis on trauma-related cognitions, and less on exposure. The client is taught to recognize the relationship between thoughts, feelings, and behaviours; and “stuck points,” or problem areas in their thinking about the trauma event are identified. The client provides an Impact Statement, a written account of the worst traumatic incident and associated thoughts and feelings, which is read to the therapist in the session. Socratic questioning is used to challenge distorted thinking, particularly self-blame, hindsight bias, and guilt cognitions. Additional topics discussed include those potentially affected by the traumatic experience: safety, trust, power/control, esteem, and intimacy.
- **Eye Movement Desensitization and Reprocessing** (EMDR; Shapiro, 2001) uses brief, interrupted exposure to traumatic memory while simultaneously focusing on external stimuli (e.g., therapist directed lateral eye movements), and free association, to process information associated with past distressing events.

A phase-based approach to treatment is recommended for complex trauma related to childhood abuse (Courtois & Ford, 2009, Herman, 1992a). Typically, the initial phase involves stabilization, psychoeducation, and skills building. Clients learn grounding and affect regulation skills, which will help to manage symptoms and provide skills to support further trauma-focused treatment. The second phase involves treatment focused on processing the past trauma, typically a variation of exposure work (as in PE). A good example of an evidence-based phased approach to working with complex PTSD for childhood trauma is Cloitre and colleagues’ Skills Training in Affect Regulation (STAIR) model (Cloitre, Cohen, & Koenen, 2006). This model has demonstrated preliminary evidence for its effectiveness with clients diagnosed with both a psychotic disorder and PTSD (Trappler & Newville, 2007).

Preliminary studies of treatments combining CBT and exposure to treat PTSD in individuals with severe mental illness have been found to be effective (e.g., Frueh et al., 2009; Mueser, Rosenberg, Jankowski, Hamblen, & Monica, 2004). One article suggested that EMDR provided benefit in a case study of an individual with psychosis (Van Der Vleugel, Van Den Berg, & Staring, 2012). We did not find any published evidence for the use of CPT with individuals with psychosis. Consistent with our treatment approach, ACT has proven beneficial for those with PTSD (see Walser & Westrup, 2007), and has equally been shown to benefit those with psychosis (Bach & Hayes, 2002; Pankey & Hayes, 2003). Unfortunately, those with psychotic disorders are often excluded from

studies of treatment for PTSD; obviously this is an area where further research is required.

3. Suggestions for addressing trauma-related symptoms via an integrative model of treatment for psychosis

Our underlying theory draws from approaches such as mindfulness, compassion-focused therapy, and ACT, which have been incorporated into therapies for psychosis and trauma. Modules discussed elsewhere in this manual address symptoms common to both trauma and psychosis:

- Chapter 4 discusses the importance of developing a safe, trusting, and collaborative therapeutic alliance. This is also central to trauma work, and is further cultivated by asking about your client's history of traumatic experiences, responding with respect and compassion, incorporating these experiences when communicating the clinical formulation, involving your client in a collaborative treatment planning process and/or facilitating treatment referral if appropriate.
- Chapter 5 discusses strengths, resources, values, and goals, important underpinnings of our model that serve to motivate clients through difficult moments in treatment. Common to psychosis and trauma-related symptoms is emotional distress and the tendency towards avoidance that results in estrangement from others and a narrow life. The aims of this chapter are consistent with an integrated, transdiagnostic theory of the treatment of suffering via cultivation of a different attitude and relationship towards one's symptoms, and the thoughts, feelings, and behaviours that may be maintaining them and exacerbating our suffering.
- Chapters 6 and 7 on emotion regulation and valued action provide strategies consistent with the central aims of the initial phase of trauma treatment, i.e., stabilization, pacing, emotion regulation, and building coping skills. Grounding and mindfulness exercises help clients reorient to the present moment when triggered by traumatic material, including intrusive memories and flashbacks. It is important to recognize that psychotic symptoms are often distorted flashback phenomena, especially visual hallucinations.
- Self-harm, self-criticism, critical voices, and shame are all prominent with psychosis and for those with a history of childhood abuse. The self-compassion exercises described in chapter 6 address these features, and can decrease depression and increase a sense of self-worth. Without addressing this extreme self-criticism, outcomes in treatment are limited. See also Gilbert's (2009) highly useful comments on the forms and functions of criticism and his techniques (e.g., engaging the self critic, compassionate letter writing). It should be noted that compassion-focused work is extremely difficult for individuals with psychosis and a history of trauma. It may take pacing, a number of sessions, and a great deal of practice for clients to be able to "let in" compassion and positive emotions.
- Chapter 7 addresses negative symptoms in psychosis, which are consistent with the avoidance and numbing symptoms experienced by individuals with PTSD. If you client is willing and able to complete behavioural activation, with motivation anchored in his/her valued goals, you might use this approach to increase your client's activity level. Depending on the level of anxiety experienced by your

client, and the degree to which he/she avoids situations, you may decide to instead begin with exposure work, which is described in our online supplemental chapter on anxiety disorders. The exposure hierarchy ladder described here is virtually identical to that used in PE, with avoided situations often related to trauma triggers. Time may be spent first identifying triggers.

- As discussed above, hallucinations and delusions have been associated with a history of childhood trauma. Chapters 8 and 9 deal with the treatment of these psychotic symptoms. In working with your clients with a history of trauma, it is important to recognize that themes of abuse, control, and humiliation may be related to this history, and it can sometimes be validating and illuminating for clients to make this connection. Although it is more rare that clients will hear the exact content of things said by their abuser(s), it is common that voices provide a present-focused source of highly critical commentary that is nevertheless related to abuse experiences and internalized extremely negative evaluations of self and others (Fowler et al., 2006). From here, once these patterns are recognized, the work of developing a meta-cognitive and non-judgmental stance towards one's thoughts, and a compassionate stance towards oneself, remains the same.

4. Special considerations for those with psychosis and a history of trauma

- Substance abuse. Given high rates of concurrent substance use for both individuals with psychosis and those with PTSD, substance use should be assessed. This must be done sensitively, using a motivational interviewing stance (see Chapter 1). If substance use is an important concern, and an agreed-upon target for treatment, you may consider implementation of strategies from *Seeking Safety* (Najavits, 2002), a treatment targeting both substance use and PTSD symptoms.
- Self-harm. Similarly, many clients have developed coping strategies involving self-harm or risk-taking behaviours. It is important to explore and validate the functional significance of these (managing affect, avoidance, etc.), to present a compassionate and nonjudgmental attitude towards the client's behaviours, while nevertheless encouraging more adaptive, life-affirming coping choices. See Chapters 6 and 7.
- Group therapy. Individual and group approaches to working with trauma and psychosis appear to be beneficial. Your client may have a preference, and individual work with the goal of working towards group participation may be appropriate for an extremely anxious client. For very vulnerable clients, individual support concurrent to group therapy may be warranted.
- Processing/ exposure. A cautious approach should be taken towards processing/ exposure work, with the decision to proceed made on an individual basis. Some clinicians suggest that more important for those with a history of childhood abuse, is to address interpersonal schemas related to themes of abuse and distrust (Smucker & Dancu, 1999). One such approach to trauma work involves rescripting, whereby prolonged exposure is paired with imaginal rescripting, such

that the course of traumatic events goes in a more desired direction. By creating a different emotional experience, or a new way of understanding the event, a more adaptive schema can emerge (see Smucker & Dancu, 1999).

- Veracity of the trauma account. While the retrospective accounts of CSA and CPA by psychosis patients have been shown to be reliable (Fisher et al., 2011), we have encountered clients for whom the accounts of their past traumatic experiences have become entangled in their delusional symptoms. Clinicians can become confused, uncomfortable, and unsure of how to respond when clients tell them traumatic stories that seem outright unbelievable (e.g., being raped hundreds of times). The best approach is to identify the theme(s) (i.e., violation) without getting into a challenging or confrontational stance towards your client, which will inevitably be perceived as invalidating. It is helpful in these instances to mindfully attend to our own emotional reactions and to seek peer consultation/ team support as necessary.

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