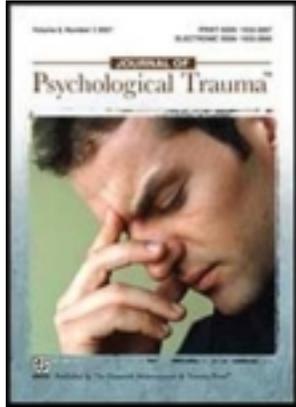


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Childhood Trauma and Psychosis: The Genie Is Out of the Bottle

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CONCEPTUAL FRAMEWORKS

Childhood Trauma and Psychosis: The Genie Is Out of the Bottle

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SUMMARY. After one hundred years of denial and ignorance, it was finally accepted 20 years ago that sexual, physical, and emotional abuse of

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children, along with neglect, was a genuine and common phenomenon with potentially devastating long term consequences for the mental health of the survivors. Until recently, there has been one exception to this rule. Sufferers of psychotic experiences were excluded. Their distress was caused predominantly by genetics or biology, or so they were told. Recent research has shown this to be a fallacy. Some of the recent studies even suggest that psychosis is the diagnostic category most likely to have experienced severe childhood trauma. This paper summarizes the historical context and offers a précis of the most important recent research findings. In keeping with the ethos of this journal we offer a case study to illustrate the effectiveness of psychotherapy for trauma survivors with psychosis. We end with an appeal to collaborate with the users movement to take this agenda forward. doi:10.1300/J513v06n02_02 [Article copies available for a fee from The Haworth Document Delivery Service: 1-800-HAWORTH. E-mail address: <docdelivery@haworthpress.com> Website: <<http://www.HaworthPress.com>> © 2007 by The Haworth Press, Inc. All rights reserved.]

KEYWORDS. Childhood trauma, schizophrenia, psychosis, therapy

After a century of denial, neglect, and inflexible dogmatic thinking from the psychiatric establishment, the crucial relationship between trauma in childhood and subsequent adult psychosis is finally being recognized. Freud's reversal of his initial observation that every single one of his patients suffering from "hysteria" had a history of premature sexual experience, led to a later theory of fantasy and childhood projection. Until comparatively recently, this set of circumstances, coupled with Western politico/medical ideology and the voracious appetite of the pharmaceutical industry, fostered the perception of sufferers of major psychotic illness not as individuals with a life narrative, but as a form of sub-species defined by misfiring synapses and aberrant genetics.

This situation has now changed permanently. Consider the following five events occurring during the last calendar year; three occurring in the United Kingdom, one in the United States, and one in Scandinavia.

1. At a recent debate at The Maudsley Institute of Psychiatry in London, two of the authors (JR and PH) proposed the motion, "This House believes that child abuse is a cause of schizophrenia," to an audience composed primarily of researchers and clinicians, with a smattering of "patients" and family members. After summaries of the relevant re-

- search and the usual genetically oriented counter arguments, followed by a full discussion, the motion was carried by 114 votes to 52.
2. In the July edition of the influential *British Medical Journal*, Professor David Kingdon from Southampton University produced an article detailing the failure of first and second-generation anti-psychotic medications and calling for an about-turn in the treatment of psychosis, “there is now evidence to support psychological targets for interventions, for instance experiences of childhood physical and mental trauma” (Kingdon, 2006, p. 212).
 3. Earlier in 2006, The Royal College of Psychiatrists in the UK commissioned an article on the subject of “When where and how” to ask individuals with serious mental illness about adverse life experiences (Read, Hammersley, & Rudegeair, 2007).
 4. In November 2005, *Acta Psychiatrica Scandinavica* published the first full literature review of more than 40 studies detailing the significant relationship between childhood trauma and psychosis. The review was described by prominent British psychologist Oliver James as “an earthquake that will rapidly change the psychiatric profession” (James, 2006)
 5. Most surprising of all were the comments made in August 2005 by the then president of the American Psychiatric Association, Steven Sharfstein.

There is widespread concern at the over-medicalization of mental disorders and the over use of medications. Financial incentives and managed care have contributed to the notion of a “quick fix” by taking a pill and reducing the emphasis on psychotherapy and psychosocial treatments. There is much evidence that there is less psychotherapy provided by psychiatrists than 10 years ago. This is true despite the strong evidence base that many psychotherapies are effective used alone or in combination with medications. . . . If we are seen as mere pill pushers and employees of the pharmaceutical industry, our credibility as a profession is compromised. . . . As we address these Big Pharma issues, we must examine the fact that as a profession, we have allowed the bio-psycho-social model to become the bio-bio-bio model. (Sharfstein 2005, p. 3)

The battle has not been won, but the tide has certainly turned. The story of how this remarkable (and still ongoing) reversal of opinion has taken place begins with the feminist movement of the late 1970s and early 1980s. Before anyone could research the relationship between childhood abuse and psychosis, it was first necessary to establish that

child abuse was real, common, and had potentially devastating consequences for the psychological well being of the victims.

THE POLITICAL HISTORY

In her memorable book *Rocking the Cradle of Sexual Politics: What Happened When Women Said Incest*, Louise Armstrong (1994) gives an insider's view of the mainstream psychiatric, political, religious, and legal establishment responses to the explosion of revelations of childhood abuse in the early 1980s. The initial response was complete denial, The American Medical Association in 1975 estimated prevalence of incest in the USA to be one per million (Read, Van Os, Morrison, A., & Ross, 2005). Armstrong (1996) reports how attempts to publish accounts of childhood trauma would be rejected by publishers on the grounds that the problem was so incredibly rare that there would be no market for such a book.

The second response was the claim that abuse did exist, but its consequences were minimal, a position adopted by the prominent researcher of sexual behaviour Alfred Kinsey as far back as 1953. When it became clear that in fact there were serious long term physical and psychological problems associated with childhood trauma, the next stage was blaming the victims. Child victims of sexual abuse, even young children, were portrayed in the press, psychiatric/psychological journals and courts of law as prematurely sexual, provocative, 0 and partly guilty. This particular attempt at obfuscation had a relatively short life. Blaming the mothers of the children involved, however, was a more successful tactic for the "abuse deniers." Mothers of sexual abuse victims found themselves portrayed as sexually inadequate and as actively consenting to the sexualization of their own children. This led to the almost unbelievable situation where many mothers of abused children found themselves in the courts of law accused of neglect in their duty of care, and losing custody battles (Armstrong, 1996).

Evidence about the huge scale of the issue continued to grow. In a final throw of the dice, blame was shifted to one professional group: therapists. Therapists of all theoretical backgrounds were blamed for planting false memories of abuse into their clients and destroying the lives of families. False memory associations, all over the world, were given brief but very sympathetic press coverage. These Associations are now so small in membership that they are widely viewed as scientifically and politically irrelevant. (E.g., The New Zealand branch, Casual-

ties of Sexual Allegations, folded in 2002 after just a few years of unsuccessfully trying to convince the public that there was an “epidemy” of false allegations.)

At the end of this lengthy process a form of consensus was reached. Child abuse was clearly related to severity of psychiatric illness in terms of earlier first admissions, longer and more frequent hospitalizations, longer time in seclusion, more medication, higher symptom severity, more frequent self-harm, and more frequent suicide (Read, Goodman, Morrison, Ross, & Aderhold, 2004). This understanding was applied to individuals with diagnoses of depression, anxiety, substance misuse, sexual dysfunction, eating disorders, personality disorders, and PTSD.

There was one glaring exception. Psychiatry in general and biological psychiatry in particular, refused to accept the significance of trauma in the lives of individuals diagnosed with psychosis. Before and during “the decade of the brain,” adverse childhood and adult life experiences were deemed irrelevant or reduced to the roles of mere triggers of an underlying biological or genetic vulnerability (Read, Mosher, & Bentall, 2004).

THE EARLY RESEARCH

Pioneering research in the 1990s that began to loosen the cork entrapping the genie of the relationship between childhood trauma and psychosis was often hampered by a lack of resources, and sometimes suffered from methodological problems such as small sample size, inconsistency in definition, and trauma data often based on patients’ retrospective self-report, which was considered (incorrectly) by some to be a questionable source of reliable information. This research has been covered in detail elsewhere (Larkin & Morrison, 2006; Read et al., 2004; Read et al., 2005). This article will instead concentrate on some of the recent major studies that have ensured the genie’s escape from the bottle.

1. Bebbington and Colleagues (2004)

This was a huge general population study conducted in the UK. A sample of 8,580 British adults was assessed for psychiatric disorders using structured assessments by neutral researchers, separate from the research team, drawn from the Office of Population Census and Surveys. The interviewees were asked to state whether they had ever experienced any of nine “victimization experiences” clearly defined and displayed

on cards. The nine victimization experiences were: sexual abuse, bullying, running away from home, time in local authority care, time in a childhood institution, expulsion from school, homelessness, violence at work, serious injury, or assault.

Significant associations were found between all but one of the victimization experiences (expulsion from school) and subsequent psychosis. The strongest association was between sexual abuse and psychosis. Those in the psychosis group were 15 times more likely to have experienced sexual abuse than those without psychiatric problems. In addition, contrary to popular opinion, childhood trauma was three times more strongly associated with psychosis than with adult neurosis or with drug or alcohol misuse. The authors concluded that this excess of “victimization experiences” in the lives of psychotic patients was suggestive of a social contribution to the cause of psychosis.

2. Janssen and Colleagues (2004)

This study conducted in Holland is arguably the most significant study to date in the psychosis/trauma research agenda. Like in the previous study, the sample size was large. The research team attempted to eradicate the issue of self-report of childhood abuse from psychotic individuals by initially interviewing a sample of 4,045 individuals who were “psychosis free” at initial interview about their childhood experiences. The participants were then re-assessed after three years to see who had made the transition into psychosis. In this study, psychosis was rated by four clinicians according to three levels of severity: 1. Any psychosis, 2. Pathology level psychosis, and 3. Needs level psychosis (intervention required). The results were unequivocal. Participants who had been abused were 3, 13, and 11.5 times (respectively) more likely than the non-abused to develop psychosis during the study period.

This study was able to demonstrate much more. The researchers controlled for possible confounding variables in their analysis. After controlling for age, sex, educational level, employment status, urbanicity, ethnicity, marital status, presence of previous psychiatric diagnosis, psychosis in a first degree relative and drug use, the significant relationship was maintained. Those in the abused sub-group were 2.5, 9, and 7 times more likely to have developed the various levels of psychosis. Note that controlling for a family history of psychosis and still finding a significant relationship demonstrates that adverse events can increase one’s chances of becoming psychotic without a genetic predisposition.

One final aspect of the Janssen study warrants attention. The researchers were able to assess severity of abuse in addition to occurrence of abuse. The results demand attention. People who had experienced child abuse of mild severity were twice as likely as non-abused participants to have “pathology level” psychosis, compared to 10 and 48 times for those who had suffered moderate and high severity of abuse respectively. This is the clearest evidence to date of both the “dose-response effect” and of actual causality.

3. Spataro, Mullen, Burgess, Wells, and Moss (2004)

This is the most controversial of the three studies, and our interpretation of the data is certainly at odds with that of the authors. In this study, 1,612 individuals, who had formally documented histories of severe abuse, were identified from the records of the Victoria Institute of Forensic Medicine in Victoria Australia. The participants were then followed up as adults for analysis of treatment in the public mental health system. The traumatized group was then compared with a general population group. The great strength of this study is that it completely negates concerns about the accuracy of self-report and is able to control for some confounding variables. Unlike the two previous studies, the relationship between childhood trauma and schizophrenia was non-significant. In addition, no relationship was found between childhood trauma and subsequent adult substance or alcohol misuse. Both findings are highly unusual in that they contradict a large body of previous research, suggesting problems with both the methodology of the study and the sample.

There were indeed a number of major methodological problems associated with the study. First, the certain presence of a proportion of individuals in the general population group who would have experienced abuse in their childhoods introduces a systematic bias into the results. Second and more important is the issue of age. The average age of the subjects was early twenties. This is simply too young to determine whether or not an individual will become psychotic. For example, in twin studies of schizophrenia, the cut-off age for establishing concordance is usually 40 years (twice the age of this study) and statistics are adjusted accordingly. In addition, the general population sample was significantly older than the abused sample and as such had a greater chance of developing psychosis. These and other failings were identified by the authors themselves.

Finally and most importantly, a key point was missed by the original researchers. The fact that all the individuals in the traumatized group had been identified by the authorities at the time of their abuse means that all the children had told someone and, moreover, had been believed (appropriately), and that a large proportion would have been removed from the abusive situation. In addition, some would have received support and even therapy. Such scenarios are rare and predict good outcome. We would argue that, far from demonstrating that child abuse is not associated with adult psychosis, the Spataro study actually may be construed as providing evidence that removing children from abusive situations may actually be highly protective of onset of psychosis in adulthood (Read & Hammersley, 2006).

4. Whitfield, Dube, Felitti, and Anda (2005)

This retrospective survey of 17,337 Californians found, for both men and women, that childhood physical abuse, childhood sexual abuse, childhood emotional abuse, neglect, and several other adverse childhood events, including witnessing your mother being battered, significantly increased the risk of experiencing adult hallucinations. After controlling for substance abuse, gender, race, and education, those who had experienced the greatest number of types of adverse events in childhood were 4.7 times more likely to have experienced hallucinations. We concur with the researchers' conclusions that:

Our data and those of others suggest that a history of child maltreatment should be obtained by health care providers with patients who have a current or past history of hallucinations. This is important because the effects of childhood and adulthood trauma are treatable and preventable. . . . Finding such a trauma-symptom or trauma-illness association may be an important factor in making a diagnosis, treatment plan, and referral and may help patients by lessening their fear, guilt or shame about their possibly having a mental illness. (Whitfield et al., 2005, p. 810)

PSYCHOTIC MOOD DISORDER

The schizophrenia spectrum disorders are not the only major mental health problems in which psychotic symptoms such as hallucinations and delusions are a feature. Major mood disorders such as bipolar disorder and unipolar psychotic depression may also have psychotic features. The life experiences of individuals with psychotic mood

disorders have not been the subject of systematic investigation. This is a serious omission. If a correlation between childhood trauma and psychosis could be established in the major mood disorders, this would suggest a genuine, consistent cross-diagnostic effect.

Hammersley, Dias, Todd, Bowen Jones, Reiley, and Bentall (2002) found that in a group of bipolar disordered patients with doubly ratified diagnosis, drawn from a national research trial, there was a highly significant association between childhood trauma and psychotic symptoms. This association was strongest in relation to sexual trauma and adult auditory hallucinations. This finding has been replicated by Fox and Reid (in preparation). In addition we have found an almost identical pattern in unipolar psychotic depression (Hammersley & Fox, 2006).

Moving Forward

We will never be able to improve the care offered to service users experiencing the symptoms of psychosis until we have the courage to ask them about their life experiences. Service users want and expect us to do so (Lothian & Read, 2002). A training programme developed in New Zealand (Cavanagh, Read, & New, 2004) that equips mental health workers to ask about and respond appropriately to disclosures of trauma is to commence in the UK and possibly Canada, in the near future.

Recovery is possible, and lives can be reclaimed. To illustrate this we offer the case study of a cognitive behavioural “trauma informed” intervention delivered by one of the authors (SW) to an individual diagnosed with schizophrenia that resulted in full symptom remission and discharge from mental health services. The user’s name and identifying information have been altered to protect her anonymity.

Veronica

Psychiatric History. Veronica has been involved with psychiatric services with a diagnosis of schizophrenia since the death of her father, when she was 28 years old. She has had three psychiatric admissions to hospital in the last three years following thoughts of self-harm. Veronica has been told that the cause of the problem is a brain abnormality.

Personal History. Veronica’s personal history was characterized by familial violence, bullied severely at school, parental separation, death of father by suicide, raped as an adult.

Description of Presenting Problems. Veronica described hearing a male voice, which she interpreted as telling her to kill herself, by saying

“come and get it done,” “hurt yourself,” and “you are useless.” She viewed the experience as being of a highly critical and bullying nature, possibly perpetrated by a ghostly spirit (a friend of her ex-partner). Veronica described “hearing voices” mainly when in a highly aroused state, often in public areas, or when alone in her flat. Thoughts focused upon impending danger, and fears of going mad or committing self-harm. These thoughts maintained high levels of anxiety. She reacted by scanning the environment to check for danger, which heightened anxiety further and led to thoughts of loss of control. Eventually she would leave the situation.

Goals. To not harm herself or carry out the voice’s instructions.

1. To manage/cope better with her voice experience.
2. To attempt to understand her experience and seek a diagnosis.
3. To not self harm or responding to the voices

Precipitants to Psychotic Phenomena.

1. Social situations/crowds whereby her hypervigilant cognitions were activated, resulting in high levels of arousal, and making her believe she was in danger.
2. Being alone in her flat, whereby her cognitions related to personal safety were activated.
3. Any mood changes influencing her arousal and voice activation.
4. Images/memories being activated (e.g. father’s death) which resulted in high arousal and changes in cognitions and voice activation.
5. Beliefs of danger, failure, worthlessness, could activate the voice.

Onset. Veronica described having begun to hear voices following a violent assault (rape) approximately three years ago by her boyfriend at the time. She did not press charges and the relationship ended. She continued to have fears of his return to harm her, the worst imagined outcome being murder.

Cognition. Thoughts were concerned with her fears of “going mad” and carrying out the act of self-harm. However, she reported being able to resist instructions and has some control.

Affect. Veronica described feelings of low mood and depression and high levels of anxiety, including palpitations, breathlessness, and restlessness. These experiences occurred most often when she feels vulnerable (e.g., being alone in her flat at night, large social gatherings or crowded places).

Maintenance. The cycle was maintained by safety behaviours, including anger, swearing, shouting at the voices, thought suppression,

avoidance of situations, and high levels of arousal. In addition, beliefs such as “I am in danger, a failure, not good enough,” “I’m different,” “the world is unsafe,” served to maintain the anxiety. Eventually she would leave the situation and avoid the perceived impending disaster. She was unable to disconfirm her beliefs of “danger and fears” of going mad and harming herself.

Intervention. The main emphasis of the intervention was to enable Veronica to talk about her story and develop a warm and trusting relationship, before any direct therapeutic work could occur. Then, the initial aspect of the work focused upon coping strategy enhancement in the attempt to reduce her arousal levels as Veronica was struggling to cope on a daily basis and had limited social functioning. This entailed utilizing Veronica’s own resources to reduce her arousal levels; interestingly, this enabled her to gain some control over her symptoms and maximised some early success.

Sharing the formulation and introducing the PTSD model had an empowering effect as Veronica began to make sense of her experiences and made connections between past events and present distress. She was also able to cluster her problems, which helped to reduce the hopeless feelings she had about her problems being insurmountable. As she became more confident to manage some of her distress, Veronica gradually began to drop some of her safety behaviours which seemed to maintain her distress. An educational approach was selected to work on her hypervigilance in social settings and the impact upon her arousal levels and cognitions. This prepared her for the behavioural experiments to follow.

A hierarchy of situations was identified whereby Veronica could gradually introduce herself to test out her predictions of “going mad” without using safety behaviours and from not avoiding the situation. If she did have voice activation, she utilised self-statements to de-arouse herself before entering the feared situation and occasionally throughout. She eventually had repeated successes but retained some doubt about the possibility that under certain situations she may still go mad. A lot of emphasis was placed on normalizing and humanising her experiences. She began to realize that she could cope during difficult circumstances. This raised her self-esteem and enhanced her social functioning.

Veronica has continued using these skills and managing her anxiety and depression effectively. As a result of this de-arousal, she is in control of her voices. Social networks have improved and she has begun to

acknowledge her own resilience. She has had no further hospital admissions.

CONCLUSION

We have made good progress but there is still much to do. Much of the credit for this progress must be attributed to the users movements from all over the world who continue to provide support and inspiration to the fast growing number of professionals, who are determined, now that the genie is out of the bottle, to never let it be forced back in. The last word, therefore, goes to Jacqui Dillon, the National Chair of the UK “Hearing Voices” network, who issued this press release on the day of the debate at The Institute of Psychiatry (Dillon, 2006).

In our experience, gained through more than 15 years running a national network, listening to people who hear voices, many of them living with a diagnosis of schizophrenia; it is clear that there is a definite link between traumatic life events and psychosis.

On a daily basis, we hear terrible stories of sexual, emotional and physical abuse, and the impact of racism, poverty and stigma on people’s lives.

We do not seek to reduce people to a set of symptoms that we wish to suppress and control with medication. We show respect for the reality of the trauma they have endured, and bear witness to the suffering they have experienced.

We honour people’s resilience and capacity to survive often against the odds.

The reduction of people’s distressing life experiences into a diagnosis of schizophrenia means that they are condemned to lives dulled by drugs and blighted by stigma, and offered no opportunity to make sense of their experiences. Their routes to recovery are hindered.

Rather than pathologizing individuals, we have a collective responsibility to people who have experienced abuse, to acknowledge the reality and impact of those experiences and support them to get the help they need.

Abuse thrives in secrecy. We must expose the truth and not perpetuate injustice further. Otherwise today’s child abuse victims will become tomorrow’s psychiatric patients[s10].

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