
Theses, Dissertations, and Projects

2017

Exploring clinical best practices for working with the co-occurrence of psychosis and a trauma history

Sierra Leah Black
Smith College

Follow this and additional works at: <https://scholarworks.smith.edu/theses>



Part of the [Social Work Commons](#)

Recommended Citation

Black, Sierra Leah, "Exploring clinical best practices for working with the co-occurrence of psychosis and a trauma history" (2017). Masters Thesis, Smith College, Northampton, MA.
<https://scholarworks.smith.edu/theses/1875>

This Masters Thesis has been accepted for inclusion in Theses, Dissertations, and Projects by an authorized administrator of Smith ScholarWorks. For more information, please contact scholarworks@smith.edu.

Sierra Black
Exploring Clinical Best
Practices for Working
with the Co-Occurrence
of Psychosis and a
Trauma History

ABSTRACT

This qualitative research study explored clinical practices most effective in helping people who experience co-occurring psychosis and a trauma history. The research was conducted through interviews with nine mental health professionals, who reported they created their own skill base in working with clients with a co-occurrence of psychosis and trauma. Although every respondent reported this co-occurrence as common, they all expressed a lack of confidence and expertise in treating the population. Best practices for treatment were found to be a combination of psychiatric medication, psychotherapy, and community support. Themes of treatment included the need to establish trusting relationships, appreciate client strengths, and support clients in making meaning of their experiences. Practices reported as helpful for treating psychosis were sometimes considered contraindicated for trauma. Respondents identified increased tolerance for strong emotion and an expanded capacity for self-care as positive outcomes for their clients, and treatment goals focused on quality of life.

**EXPLORING CLINICAL BEST PRACTICES FOR WORKING WITH THE
CO-OCCURRENCE OF PSYCHOSIS AND A TRAUMA HISTORY**

A project based upon an independent investigation,
submitted in partial fulfillment of the requirements
for the degree of Master of Social Work.

Sierra Black

Smith College School for Social Work
Northampton, Massachusetts 01063

2017

ACKNOWLEDGMENTS

This thesis could not have been accomplished without the assistance of many people whose contributions are gratefully acknowledged.

I wish to thank my research participants, who generously lent their time and wisdom to this study; my research advisor, Dr. Susanne Bennett, for her steadfast help; and my partner, Alison, for her patient support and skilled transcription.

TABLE OF CONTENTS

ACKNOWLEDGMENTS	ii
TABLE OF CONTENTS.....	iii
CHAPTER	
I. INTRODUCTION.....	1
II. LITERATURE REVIEW.....	7
III. METHODOLOGY.....	15
IV. FINDINGS	21
V. DISCUSSION AND CONCLUSIONS.....	47
REFERENCES	57
APPENDICES	
Appendix A: Interview Guide.....	62
Appendix B: Approval Letters.....	64
Appendix C: Recruitment Materials	66
Appendix D: Consent Forms	69
Appendix E: Transcriber Confidentiality.....	72

CHAPTER I

Introduction

The core research question of this study is, “What clinical practices are most effective in helping people who experience co-occurring psychosis and a trauma history?” Through analysis of qualitative interviews with experienced mental health counselors and clinicians, this study aims to identify practices that support recovery for this clinical population.

Trauma-focused therapies have been found to help people with post-traumatic stress disorder (PTSD) and psychotic symptoms, yet they are not widely used with this study’s target population due to widespread misconceptions that such interventions may exacerbate symptoms (van den Berg, de Bont, et al., 2016). A 2016 study found that receiving specialized training in trauma-focused therapy has a lasting effect on therapists’ views, making them more likely to offer trauma-focused treatment to patients with psychotic illnesses (van den Berg, van der Vleugel, et al., 2016).

There is a clear need for improvement to both initial training and ongoing support for helping professionals treating this population. Many patients describe unsatisfying or even re-traumatizing experiences when seeking help from mental health professionals after a traumatic experience. Mental health professionals, in turn, often describe a feeling of helplessness and confusion when attempting to address trauma symptoms in patients who also experience major mental illness.

Because a history of trauma is so common among people with psychotic disorders (Goodman et al., 2001), competent clinical practices for working with the co-occurrence of these issues are essential. The existing research in this area indicates the knowledge gap described above and offers some pointers at how the gap might be closed.

Overview of Literature

The links between trauma and psychosis have been a subject of inquiry for psychiatrists and psychotherapists since the establishment of the field in the late 19th century (Moskowitz, Schafer, & Dorahy, 2011). However, as the medical model of psychiatric care rose to prominence in the mid-20th century with the advent of effective psychoactive medications, theories focused on trauma and social context faded from focus. Since the 1980s, attention to the impact of trauma on mental health has re-emerged as a significant area of interest for social workers and other mental health providers (Chu, 2011).

Early psychoanalytic theory at first acknowledged and then colluded to deny the widespread incidence of childhood sexual abuse and the lasting disruptive impact of such abuse on children who experience it (Berzoff, Flanagan, & Hertz, 2011). The original *Diagnostic and Statistical Manual of Mental Disorders* ([DSM]; American Psychiatric Association [APA], 1952), the primary diagnostic tool for mental health professionals across disciplines in the United States, did not account for past traumatic experiences in its formulation of mental health disorders at all (Chu, 2011).

Only in the third revision of the manual, *DSM-III* (APA, 1980) was PTSD recognized. That recognition came in the wake of the Vietnam War and the undeniable needs of returning veterans. However, in the decades since, trauma theory has been widely expanded to include the

needs of survivors of experiences as disparate as sexual violence, natural disasters, and cultural oppression (Herman, 1992).

Beginning in the 1980s, work on trauma theory by Herman (1992) and others helped to highlight the symptom profiles common across different types of traumatic experiences and systematized an approach to treatment. Emerging work on intergenerational trauma within populations that have experienced genocide, emigration/immigration, or ongoing social oppression has begun to address some of these gaps (Samuels & Ross-Sheriff, 2008).

The current *DSM-5* (APA, 2013) still defines trauma as always stemming from single unusual and stressful events. However, there is growing clinical understanding that chronic abuse or fear during childhood produces a different and more complex symptom profile, commonly described as Complex Post-Traumatic Stress Disorder (Chu, 2011).

The Adverse Childhood Experiences Study provided substantial support for the theory that early trauma plays a lasting role in individual health outcomes (Felitti et al., 1998). This study collected quantitative data about early childhood stressors from over 9000 patients in the Kaiser healthcare system and showed strong correlations between exposure to childhood trauma and a wide range of health problems in adult life.

While mental health research has been building a body of literature about how and why trauma impacts mental health, nurses and other front line providers have joined with the peer recovery movement to create a body of knowledge about best practices for working with traumatized people, called “trauma-informed care” (Muskett, 2013). The shift towards trauma-informed care in mental health settings rests on a recent and rapidly growing theoretical understanding of what constitutes trauma, how it affects individuals, families, and communities, and what helps survivors heal.

This study aims to garner insight into effective trauma-informed care practices with psychotic patients through interviews with experienced providers. The literature review in Chapter II further develops the reader's understanding of trauma theory, trauma-informed care, and treatment of psychosis.

Overview of Methodology

The study was based on in-depth qualitative interviews with nine helping professionals from different theoretical backgrounds, including psychiatry, nursing, clinical social work, and case management. Interview subjects had completed their training, worked for at least one year in their field, and had worked with at least five clients who fit the target population. The target population was defined as individuals who reported both a history of trauma and experiences of psychotic symptoms. Criteria for exclusion included recent personal experience of significant trauma or loss, lack of experience, or lapsed professional credentials. A combination of availability sampling and snowball sampling was used to recruit participants (Engel & Schutt, 2017). Interviews with these professionals were analyzed using content analysis to draw out recurrent themes and identify both common practices and unique insights. More detail about the methodology will be included in Chapter III.

Personal Interest

My personal interest in this topic stems from my work at the Boston Area Rape Crisis Center. Over the past four years, I have logged hundreds of hours as a rape crisis counselor, listening to survivors share their grief, fear, pain, and triumph. I have found that work deeply grounding. I am immensely grateful for the beauty and insight survivors of violence have shared with me as they have invited me into their healing journeys.

Both in my role as a hotline counselor and as a student at the Smith School for Social Work, I have had the gift of seeing emerging healers and counselors grapple with their own pain, their role as helpers, their limited skills, and the needs of the people they are trying to serve. I am frequently awed by the resilience and creativity of my classmates and colleagues.

It is this admiration for both trauma survivors and helping professionals that has led me into this research. The intersection of psychosis and trauma seems like the dragon-infested waters at the edge of a map for many clinicians. People who are otherwise skilled and sensitive seem to stumble when these two clinical concerns overlap. That gap in knowledge piqued both my intellectual curiosity and my desire to fill an unmet need in my professional community.

Contribution to Social Work

The intersection of trauma and psychosis is a particularly important area of research for social workers. Social work, with its biopsychosocial focus on the individual in their environment, is particularly well suited to exploring the links between a person's trauma history and their current psychiatric symptoms (Berzoff, 2011). Additionally, social workers now comprise a majority of mental health care providers in the United States (Heisler & Bagalman, 2015). Incorporating trauma-informed care practices into social work training, theory, and practice is essential to meeting the complex needs of this clinical population.

This study aimed to deepen understanding of best practices for helping professionals working with individuals who have experienced both trauma and psychotic symptoms. By interviewing working professionals with differing training and clinical focus, this work hoped to capture the specific skills each discipline uses. There is potential benefit to social work education and practice in cross-pollination of theory and technique between people trained primarily in treating major mental illness and people trained primarily in supporting survivors of trauma.

Summary

This study explores what clinical practices are most effective in helping people who experience co-occurring psychosis and a trauma history. Using content analysis of qualitative interviews with experienced helping professionals, this study gives insight into what helps people affected by both trauma and psychosis heal. As the existing literature shows, this is a common knowledge gap for social workers and other mental health professionals. The co-occurrence of these problems is extremely common. Learning about effective approaches to treating this clinical population is an important contribution to social work education and practice.

In Chapter II, I review the existing literature to establish an understanding of what is already known about trauma, psychosis, how the symptoms appear when these disorders overlap, and effective treatments for individuals who experience both. The literature review demonstrates the need for additional research and training on this topic. Chapter III details the methodology used to collect and analyze data for this study. Chapter IV shares the findings of this study. Chapter V offers a discussion of these findings, how they relate to the existing literature, avenues for future study, and this study's overall contribution to social work.

CHAPTER II

Literature Review

This study builds on a rich literature exploring the strengths and needs of people who have experienced both trauma and psychosis. The core question of the study is, “What clinical practices are most effective in helping people who experience co-occurring psychosis and a trauma history?”

Underlying that question is a wealth of existing knowledge about how trauma and psychosis can be defined, understood, and treated. The literature reviewed here informs the treatment modalities used by the professionals interviewed for this study, their understanding of their client’s experiences, and their view of their own role in the healing process.

This literature review will first present literature outlining the definition and prevalence of trauma, psychosis, and how the understanding of each has evolved over time. Second, this review will provide an overview of existing research on clinical training and effective treatment. Finally, this review will offer a summary of the existing literature and pose questions for further study.

Definitions and Prevalence of Trauma and Psychosis

Trauma. Traumatic experiences are characterized by overwhelming fear, powerlessness, and a sense of isolation. The feelings engendered by trauma may stay with us long after the actual danger has passed, disrupting our lives in both visible and hidden ways (Levine, 2015).

Common symptoms of traumatic stress include nightmares, flashbacks, intrusive thoughts or memories, hyperarousal or hypervigilance, high-risk or self-destructive behaviors, and a compulsion to reenact the traumatic experience (Herman, 1992).

There are individual, social, and financial costs to untreated trauma, particularly when it occurs in childhood (Harris, 2014). People who have experienced trauma are more likely than the general population to develop serious medical problems like diabetes and stroke, as well as to struggle with interpersonal relationships, mood, and affect regulation (Felitti et al., 1998).

Despite this substantial impact, attention to the lasting effects of trauma is a relatively recent theoretical turn for mental health providers. Early psychoanalytic theory at first acknowledged and then colluded to deny the widespread incidence of childhood sexual abuse and the lasting disruptive impact of such abuse on children who experience it (Berzoff, Flanagan, & Hertz, 2016). The original *DSM* (APA, 1952) did not account for past traumatic experiences in its formulation of mental health disorders at all (Chu, 2011).

The Adverse Childhood Experiences Study (ACES) provided substantial support for the theory that early trauma plays a lasting role in individual health outcomes (Felitti et al., 1998). This study collected quantitative data about early childhood stressors from over 9000 patients in the Kaiser healthcare system. The ACES study showed strong correlations between exposure to childhood trauma and a wide range of health problems in adult life. Research since then has reinforced this link, going so far as to establish a causal link between sustained abuse, neglect, or exposure to violence in childhood with the development of psychotic illnesses (Read, Os, Morrison, & Ross, 2005). One study reported that up to one third of psychotic disorders in adults could be prevented by effective prevention of child abuse and neglect (Varese et al., 2012).

Psychosis. The most familiar symptoms of psychotic illnesses are delusional beliefs and altered perceptions. In addition, psychotic illnesses often include symptoms of mood disorder, cognitive decline, and poor physical health. Early theorists and psychiatrists observing patients' experiences of disturbed reality, distorted perception, and bizarre beliefs struggled to discern the causes of these disturbances. In the 19th century, dissociative phenomena, such as split personalities or catatonia, and psychotic phenomena, such as auditory hallucinations or paranoid delusions, were much more closely linked. The 19th century diagnosis of "dementia praecox" included features of both (Maatz & Hoff, 2014).

Bleuler, a colleague of Freud, introduced the concept of schizophrenia in 1908, viewing it as distinct from trauma-induced dissociation. Modern scholarship on the history of Western psychology locates the roots of Bleuler's thinking with Janet's studies on dissociation. Moskowitz (2011) writes, "The concept of schizophrenia was nurtured and flourished, not in the ground of Freudian theory as is conventionally believed, but in the fertile soil of Janetian concepts and dissociationism" (p. 37).

Cultural and clinical understanding of psychosis has changed dramatically since the early days of psychoanalytic practice (Calabrese & Corrigan, 2005). Today, psychotic illnesses are viewed primarily as medical conditions and disorders of brain chemistry (Henderson & Bekhuis, 2016). The need for improved treatment of these disorders is clear in the health outcome data offered by the World Health Organization, which shows that people with major mental illnesses have shorter, sicker lives than their peers (YASAMY, 2014).

Co-occurrence of trauma and psychosis. Between 50% and 98% of people who experience psychotic symptoms report at least one traumatic life experience (Goodman et al., 2001). Current research shows evidence for a causal link between chronic traumatic stress in

childhood and the onset of psychotic symptoms (Read et al., 2005). A meta-analysis of research on experiences of childhood adversity in patients with psychotic disorders reported that childhood adversity appears to account for approximately 33% of all psychotic illness (Varese et al., 2012). However, while the link between early traumatic life experiences and later psychotic disorders is well established, the links are not well understood. Ongoing research is investigating what kinds of psychotic experiences are produced by childhood trauma and how they can be resolved (Freeman & Fowler, 2009).

For example, children who are verbally and sexually abused by caregivers are more likely to develop auditory hallucinations in adulthood (Read et al., 2005). Childhood trauma heightens awareness of stereotypes and social stigma in individuals whose identity is in some way targeted by the majority in their community. This heightened awareness can create increased vulnerability to the development of psychotic symptoms, particularly paranoia (van Zelst et al., 2015).

A meta-analysis of the relationship between psychosis and trauma showed that trauma alone is not necessary or sufficient to cause psychosis (Gibson, Alloy, & Ellman, 2016). Patients meeting criteria for both psychotic disorders and post-traumatic stress disorder report greater difficulty in daily functioning and more severe symptoms than those experiencing psychosis alone (Mueser, Lu, Rosenberg, & Wolfe, 2010). Severity and frequency of traumatic stress appear to affect the likelihood of developing psychotic symptoms in adulthood and the intensity of those symptoms when they occur (Russo et al., 2014).

Current Research on Effective Treatment and Clinical Training

Research into effective treatment of co-occurring PTSD and psychosis branches in two directions: (1) research into effective treatment intervention to reduce symptoms and improve functioning in these patients, and (2) research on trauma-informed mental health care practices to

reduce the risk of re-traumatization or symptom exacerbation. The following literature discusses these areas of research in more detail.

Effective strategies for treatment. A number of successful treatment modalities for addressing trauma symptoms in psychotic patients have been developed and researched. Most are rooted in modalities that already have a strong evidence base for treating trauma in the general population. These include mentalization-based therapy (Barrantes-Vidal, 2013), eye movement desensitization and repetition therapy (EMDR), and prolonged exposure therapy for patients with psychotic illnesses and PTSD (de Bont, van Minnen, & de Jongh, 2013). Prolonged exposure therapy is a therapeutic modality widely used and studied in the treatment of post-traumatic stress disorder, and it is the primary modality used in the Veteran's Affairs programs for veterans with PTSD (Rauch et al., 2009).

One of the first questions relates to whether to treat these symptoms at all. Many people have brief episodes of psychotic experiences that do not disrupt their daily functioning. For individuals who are able to maintain professional lives, independent living, and meaningful relationships, the treatment for psychotic disorders or traumatic stress may be more disruptive than the symptoms. Careful judgment should be used to mitigate the disruptive effects of treatment, including making a considered decision about the need for intervention (Oh, Devylder, & Chen, 2015).

Research has also been conducted into the role of attachment theory and how reparative experiences of interpersonal relationships can enhance the treatment of psychotic patients with PTSD (Berry, Barrowclough, & Wearden, 2007). Studies show clear links between both infant and adult attachment styles and overwhelming experiences. Additionally, research has been able to demonstrate that untreated mental illness in a caregiver can produce dissociative or psychotic

responses in an infant, along with a disorganized attachment response (Liotti, 2004). While attachment styles form early in life and tend to remain stable, there are proven techniques for repairing attachment injuries through psychotherapy, even in the presence of psychotic disorders (Allen, 2013).

Finally, medication remains critical to the treatment of most persons with co-occurring PTSD and psychosis. Beginning with the discovery of lithium's mood stabilizing effects in the mid-20th century, followed by the introduction of Thorazine for sedating violent impulses in psychotic patients, medication rapidly became the primary treatment for mental illness in the United States. Antipsychotic drugs produced 'miracles' in some patients, and played a major role in allowing people formerly confined to long-term residence in state mental hospitals to return to their home communities to live independently (van der Kolk, 1994). More recently developed psychiatric medications, including SSRIs like Prozac, have also offered immense relief to those suffering from PTSD. Yet van der Kolk (2014) warns, "The drug revolution that started out with so much promise may in the end have done as much harm as good" (loc. 852).

Importance of clinical training. Trauma-focused therapies have been found to help people with PTSD and psychotic symptoms, yet they are not widely used with this population due to widespread misconceptions that such interventions may exacerbate symptoms (van den Berg, de Bont, et al., 2016). Many therapists resist using trauma-focused treatments with psychotic patients, due to widespread beliefs that such treatment may be ineffective or harmful. A 2016 study found that receiving specialized treatment in trauma-focused therapy has a lasting effect on therapists' views regarding trauma-focused treatment of psychotic patients (van den Berg, van der Vleugel, et al., 2016). Therapists who completed the training were more likely to offer trauma-focused therapy to their patients with psychotic disorders. Many reported that they

continued using the trauma-focused therapeutic interventions with their patients one year after the study.

Mental health professionals vary widely in responding to and treating trauma. A study of crisis mental health care services in Melbourne found that the mental health clinicians responding to crisis calls had little if any training in responding to sexual assault, yet all reported they fielded disclosures about sexual violence frequently (McLindon & Harms, 2011).

Domestic violence is another traumatic experience frequently disclosed to mental health providers. A literature review on mental health workers responses to disclosures of domestic violence found that clients strongly value mental health care practices that facilitate safe disclosure of abuse, identify unnamed abuse, and enhance mental health workers' awareness of the psychosocial aspects of mental health (Trevillion et al., 2014). These practices are broadly known as "trauma-informed care" and represent a significant shift in the mode of delivery for many health care services.

Trauma-informed care. People who experience psychosis often require intensive mental health treatment throughout their lives, particularly in Western cultures (Luhmann & Marrow, 2016). Many of these treatments can themselves be traumatizing, and for people who enter the mental health system with an existing history of traumatic experiences or exposure to violence, they can be additionally damaging (Mueser et al., 2010).

There is no single systematized approach to trauma-informed care, yet there is a consensus among social work researchers and practitioners about what its core practices are. These include fostering connection between clients and staff, holding hope for recovery, training staff on the connection between childhood trauma and major mental illness in adults, and an empowering, integrative approach to care (Muskett, 2013). A 2009 qualitative study found

clients valued respect, a sense of equality or “peer relationship” between staff and clients, trust, clear communication and expectations, opportunities for self-help, and patient involvement in decision-making (Walsh & Boyle, 2009)

Summary

This review of existing literature has provided an understanding of what trauma is, what psychosis is, the prevalence of each, and the frequent intersection of the two. Reviewing empirical data and qualitative studies about this population gives an understanding of symptom profiles, the relation between the two problems, and the efficacy of common treatments. My study builds on this existing literature through interviews with experienced clinicians about what has been most effective in their work with this patient population.

CHAPTER III

Methodology

Formulation

This research study explores clinicians' perceptions about clinical practices that are most effective in work with persons who have the co-occurrence of psychosis and a trauma history. The core research question is, "What clinical practices are most effective in helping people who experience co-occurring psychosis and a trauma history?"

Research Design

This is a qualitative study based on in-depth interviews with experienced mental health professionals. I chose the qualitative interview structure to highlight the nuanced skills and insight experienced clinicians develop over time. By focusing deeply on the experiences of clinicians, I attempted to capture more of the psychosocial and relational elements of both these disorders and their treatments.

This study used content analysis of qualitative interviews with experienced professionals to gain understanding of both practice and theory to support this population. My hope is that the study will reveal both unique insight from individuals and trends among practitioners in order to offer guidance on effective practice and the need for further research.

Participants

The interview participants in this study are nine mental health professionals who have completed their training, worked for at least one year in their field, and worked with at least five

clients who have reported both psychotic symptoms and a trauma history. Criteria for exclusion included recent personal experience of significant trauma or loss, lack of experience, or lapsed professional credentials.

Recruitment efforts were made to draw participants recruited from mental health agencies, rape crisis centers, and professional organizations and networks for trauma-focused therapists, Smith School for Social Work alumni, and clinical social workers. Recruitment was done through postings on mailing lists, bulletin boards, and social media. The participants self-selected by responding to the ad, or they were approached on the recommendation of other study participants. Snowball sampling was used to spread the invitation to participate across clinicians' social and professional networks.

The original plan for this research study proposed a sample size of 12-15 participants, the requirement for the Smith College SSW. However, of the 17 respondents who confirmed eligibility and interest in the study, I was only able to interview 9. While there was significant initial response to the recruitment materials, scheduling interviews turned out to be a barrier to participation. To facilitate scheduling, I expanded my planned availability for interview times to include all weekday evenings, weekends both day and evening, and at least two hours each weekday during regular work hours. I conducted some interviews by phone to support flexibility around scheduling, and I traveled to private offices around the Boston area. I sought and received permission from the IRB to expand my inclusion criteria to include mental health professionals who had worked with any co-occurrence of psychotic symptoms and trauma history. Also with IRB approval, I shortened the interview guide and did away with a pre-interview survey, with the aim of easing the time commitment for participants.

This small sample size produced limitations to the study, including homogeneity of experience and training among study participants, and a small sample size. These are explored in more detail in the Discussion chapter.

Data Collection

The data for this study was collected through in-depth interviews exploring clinician's perceptions of effective clinical practices with their clients who have report both a trauma history and psychotic symptoms.

The interview questions were drafted for this study, based on my review of the existing literature and my own clinical experience working with this population. I used a semi-structured interview (Appendix A) in which the same set of open-ended questions was asked of each participant, in the tradition of qualitative research methods (Padgett, 2008).

Each interview was recorded using two separate recording devices, to ensure successful recording of all material in the event of a technical failure. The recorded interviews were then transcribed verbatim using standard notation for simple transcription. I used F5 (an academic transcription software program), and a transcription foot, as technical supports for this work. I completed some of the transcriptions myself. For the others, I relied on the assistance of an outside transcriber.

Data Analysis

The completed transcripts were analyzed using content analysis to highlight the individual voices of interview subjects and find common themes across their work. Themes were coded using Atlas TI, a qualitative data software that allows for organizing and indexing text by code, quotation, date, subject, and document to allow for an integrated and easily cross-referenced view of the complex data collected.

Although the study did not use all elements of grounded theory, I did utilize coding techniques developed and commonly used in grounded theory research. The transcripts were first analyzed through open coding, using over 140 codes to select significant quotes, themes, and topics from the transcripts. Once I had coded all transcripts, I moved on to a second stage of coding, combining codes that were similar in meaning, such as “addiction” and “substance use disorder.” At this stage, I eliminated codes that had applied to fewer than four quotations, except in a small number of cases where a code that was used only two or three times seemed especially relevant to the study findings. Throughout the coding process, I made use of Atlas TI’s memo function to jot longer notes and organize the emerging themes between clusters of related codes.

After creating and condensing the codes, I created five code groups emphasizing what had emerged as the central findings of the study: (1) treatment goals and outcomes; (2) who helps: therapists, family and other; (3) what helps: best clinical practices; (4) what hurts: barriers and challenges; and (5) why is this important: risks and needs. These five groups and their attached codes and quotations became the backbone of my findings chapter.

I also used the code mapping feature to organize connections between codes that did not fit into the code groups. For example, ‘involuntary treatment’ and ‘internal family systems’ were both identified as associated with the ‘treatment modality’ code, although one fell into the “what helps” code group and the other into the “what hurts” group.

Trustworthiness and Reliability

To assure trustworthiness, I used a semi-structured script for my interviews. I used two recorders to record the interviews. I transcribed the interviews verbatim, ensuring the language belonged to my interview subjects and was not my own invention. I made sure to include representative quotes from every subject, rather than cherry-picking the statements that

supported my existing ideas. My advisor carefully reviewed my interviews and coding and provided consultation about analysis.

Reflexivity

I worked to hold reflexivity in mind throughout the interview process. Reflexivity describes the way that the interviewer and subject influence each other during the interview. It acknowledges that what an interview subject says to me emerges in part from the subject and their own beliefs and experiences, but also in part from who I am sitting across from them.

Before the interviews began, I predicted that the most likely manifestation of reflexivity would be a dynamic of an eager student asking for lessons from a teacher. This seemed likely to me because the subjects of my study are professionals with more advanced learning and experience than I have in the field I am currently studying. To counteract the impact of that, I tried to be very thorough in my literature review and enter the interview process with some sense of mastery of the subject matter. I also nurtured that dynamic at points during the interviews, using my enthusiasm and curiosity to encourage confidence and exploratory thinking from my interview subjects.

Ethical Considerations

To maintain ethical standards in my research, I first developed and submitted a research plan to Smith's institutional review board (Appendix B). With their feedback and approval (Appendix C), I proceeded to conduct the study. I used written consent forms (Appendix D), which I reviewed with the participants at the start of each interview, to ensure participants understood what was being asked of them and how the data collected would be used. My transcriber reviewed and signed the required confidentiality forms, affirming that she understood the requirements of confidentiality and the importance of adhering to them (Appendix E).

Throughout the study, I took steps to minimize the impact of bias on my data. I first engaged with my own bias as a researcher. I remained open to changing the beliefs about psychosis, trauma, and treatment that I held at the start of my work. During my literature review process, I sought out diverse perspectives for understanding my topic, culturally diverse work on how psychosis and trauma are treated around the world, and studies that directly address the role oppression plays in mental illness.

I also made efforts to address respondent bias. In writing the interview guide and conducting the interviews, I included questions addressing issues of racism and social bias. During the interview process, I attempted to counteract reactivity bias by asking neutral, open-ended questions.

The following chapter presents an analysis of the findings obtained through interviewing the participants.

CHAPTER IV

Findings

The central question of this study was, “What clinical practices are most effective in helping people who experience co-occurring psychosis and a trauma history?” Study participants identified best clinical practices for this population, as well as some common practices in mental health care that are contraindicated for people presenting with these co-occurring disorders. Participants also addressed challenges in their work and the goals and outcomes of treatment. Each of these findings is discussed in detail in this chapter, following a presentation of the demographics of the participants.

Demographics

This study’s participants represented a relatively homogenous group of mental health professionals. The group included six clinical social workers, two psychiatrists, and one psychiatric nurse practitioner. All but two participants had current or past work experience at the same Boston-area teaching hospital. There was more diversity represented across age, with two participants identifying as early career professionals, five as mid-career, and two as late-career.

Demographic details about personal identity were not included in the interview guide, but some participants did share parts of their personal identity in the discussion of their work. All but one participant identified as female. Two study participants identified as white, one identified as a person of color, and the remaining six did not identify a racial or ethnic identity. No one

identified sexuality. Several participants shared that they are or had been married and have parented children. Two identified as Jewish; the others did not specify their religious identity.

In summary, the demographic makeup of the study sample represents a deep but narrow perspective. The individuals who participated in this study all work in the same geographic area and in the same time in history. Many share experiences of working in the same hospitals and having trained in the same schools. Their overlapping perspectives give a nuanced look at the practices common for treating individuals with psychosis and trauma in the Boston area in 2017, but do not explore the edges or alternatives. These limitations will be discussed further in Chapter V.

Professional Experience and Training

Despite their broad experience in treating psychotic disorders and post-traumatic stress disorders, none of the study participants felt they had sufficient expertise in treating patients who present with both. Every participant saw themselves as primarily an expert in either assessing and treating psychosis or assessing and treating trauma. All respondents evinced some level of helplessness and confusion when working with this study's target population, individuals who report both psychotic experiences and a trauma history. Describing this sense of helplessness, Participant 7, a mid-career psychiatrist at a large teaching hospital, said, "I can't see my way out of the cave."

Clinicians treating primarily psychosis report that they feel competent to help their patients with their psychotic illnesses, but are aware that they are not addressing the underlying trauma. Participant 9, an early career psychiatrist who primarily treats psychotic disorders, said:

I think we tend to drift toward assessing and treating the things that are within our wheelhouse, and since I mainly treat people or help people with experiences of psychosis

or mood disorder or other things, it keeps me aware that people most likely have, you know, other co-occurring illnesses and likely trauma that kind of deserve awareness and attention as well.

This sentiment was echoed by Participant 7. “Even in this system which is a more thoughtful system, we tend to kind of silo patients by diagnoses,” she said. “If someone comes in with a psychiatric illness as significant as schizophrenia or schizo-affective disorder, we often stop there, and we don’t always bear in mind both their pasts.”

Clinicians treating primarily trauma survivors reported feeling a similar gap between their expertise in treating trauma and their relatively lesser ability to assess and treat psychotic symptoms. Participant 4, a social worker sitting on a trauma-focused team, said:

I have a confidence in my ability to know and assess parts and to see if someone has DID, which I do not consider a psychotic disorder. I can assess the extent of the dissociation, and I can assess a person’s capacity to ground themselves around dissociation. ...I don’t know any way to ground someone from psychotic process.

Several trauma-focused clinicians identified the emergence of psychotic symptoms during therapy as a risk factor, and they expressed concern that their work might not only fail to help, but make things worse. Participant 7 and Participant 9 expressed similar concerns about attempting to address trauma symptoms in their work with psychotic patients. “At what point, if ever, would it be more helpful than harmful to actually explore the losses that she’s had,” Participant 9 said of one of his patients.

In some cases, trauma specialists said they would refer the patient out to a different provider. Participant 2 said:

The [trauma-focused outpatient clinic] takes a programmatic stance that we don't take people into our program who have an untreated psychotic disorder. Because what we've found over the years is that doing trauma-focused work can cause patients to decompensate and become increasingly psychotic. However...if somebody has a psychotic illness that they kind of recognize and it's medicated and being treated, and the person wants to do trauma work, then yes!

Participant 4 noted that being referred out to a new provider can be devastating for people healing from trauma. She said:

Systems don't do relationships very well. I think people who feel alien in the world, whether it's because of trauma, psychosis or both, having a relationship means the world. Being understood means the world. If being understood means you can't stay here, that's a horrible, horrible message to have to give someone.

Participants from both areas of specialization expressed a desire for more collaboration between their fields. "I think kind of crosstalk would be better, but it's hard to do," Participant 7 said. She said she feels the teaching hospital she works in would benefit from having a psychiatrist from her team, which specializes in psychotic disorders, sit in on team meetings with the trauma-focused therapy team, and vice versa. Similarly, she thought it would be a benefit to have someone from the team sit in on her team's meetings.

Participants said that teamwork is valuable not only for sharing knowledge and expertise, but to mitigate the impact of their work on their own mental and emotional well-being. "One individual cannot hold this level of risk and even suffering and everything else. The team is necessary in that," Participant 9 stated.

Treatment Goals

Individuals experiencing psychosis and trauma often have complex psychiatric, medical, and social needs that require care throughout their lives. These needs stem from the severity of their symptoms, elevated risks of victimization, self-harm, and medical complications, and secondary social and health problems created by their disorders or the medications they take to treat their symptoms. Participant 7 said that in many cases, she is working to get her clients to “first principles of like basic safety and self-care.” She acknowledged that this goal may seem like “setting the bar low,” but said, “I kind of think like what else is there? I mean, there’s nothing else.”

Treatment goals often center on improving quality of life, rather than eliminating symptoms. Participant 1 addressed the primacy of safety and stability from the perspective of working with trauma, saying, “For trauma, its more establishing first safety and self-care, and helping someone even recognize when they are putting themselves into a dangerous situation, or an unfair situation.” Participant 3, who primarily treats clients diagnosed with psychotic disorders, described the goal of treatment as helping her clients get a “grip on life,” a term she picked up from her Finnish teachers in Open Dialogues training.

Every respondent mentioned the need for collaboration and transparency in setting goals and evaluating the course of treatment. “I ask them what they think better is, what they want,” Participant 4 said. Participant 1 echoed this, emphasizing the need for a client to participate in their treatment planning, “I just think motivation is always very key. What do you want? What kind of change do you want? What are you willing to go through to achieve that change?”

Best Clinical Practices

The study participants universally stated that they did not consider themselves experts at treating trauma and psychosis, though all acknowledged the co-occurrence is common in their patients. Rather than a single set of clear clinical practices, what emerged in the discussion of their work was a strong reliance on an eclectic set of tools, ranging from intuition to antipsychotic medication.

The five clinical practices described as most effective and helpful to clients with co-occurring psychosis and trauma were (1) solid clinical judgment in assessing and diagnosing these complex cases, (2) providing trauma-informed care, (3) psychotherapy, (4) fostering community support, and (5) medication.

Assessment and diagnosis. Discerning the distorted perceptions and paranoid thoughts set off by traumatic experiences from those arising organically from a psychotic disorder can be extremely difficult. The fact that such a large majority of people being treated for psychotic disorders also report traumatic experiences complicates the picture further. This is an area of confusion even for seasoned clinicians.

Participant 6, an early career clinical social worker, described her efforts to get help from her supervisors with making this distinction in the case of a young patient who believed she was being haunted by her abuser after his suicide in prison. She said:

The line between trauma and psychosis and delusion and cultural belief was a really sticky one, and no one could tell me where it was. It was really unclear, depending on whether it was psychosis, disassociation, or some kind of delusional disorder.

Participant 8, a clinical social worker specializing in work with torture survivors, described the blurry edges between the two conditions, saying, “The transient hallucinatory

effects of trauma, and particularly the more complex the trauma is, the more likely that you'll have that in some area.”

Participant 4, a clinical social worker whose primary expertise is with victims of violence, described her caution about assigning a diagnosis of a psychotic disorder to a patient she has treated in long-term psychotherapy. “For about two years we were hesitant to give her a psychotic disorder until things got more clear and she was willing to try a medication and we could see the result of the medication.”

Awareness of risk. Participants stressed the need for clear, comprehensive assessment of a person’s symptoms because a hidden delusional system or undisclosed trauma can elevate risk of suicide, self-harm, exposure to violence, substance use, and medical complications. “Managing risk can be challenging, when there are [risks], or being aware of risk, assessing risk, when there are a number of factors that interfere with assessing thought processes,” Participant 2 said.

Participant 1 stressed the safety risks of a missed psychotic disorder. She said she had been an expert witness in several wrongful death cases that centered on a person having completed suicide shortly after being discharged from a hospital where their symptoms were not appropriately treated. “I just want to underscore the whole thing of command auditory hallucinations and how important it is to know about them. How it’s such a major factor in safety that I think is underestimated a lot of times,” she said.

Prioritizing needs. Another frequently cited reason to be thorough in assessment was a need to prioritize needs in these complex cases. As discussed elsewhere, the appropriate treatments for psychosis and the best treatments for trauma recovery can be in conflict, and it can be difficult to address both at the same time. Participants consistently agreed that active

symptoms of psychosis must be successfully addressed before engaging in any trauma-focused therapy. “I believe that psychotic illness needs to be well-managed first before someone would do any trauma work,” Participant 5 said.

Participant 8 likened active psychosis to the initial crisis following a traumatic event. “If someone is floridly psychotic, it’s more important to attend to that,” she said. “So many people who are psychotic in that manner are pretty terrified, and so in many ways, they’re very much like a trauma survivor who is acutely injured.”

Trauma-informed care. Several participants noted the importance of practicing trauma-informed care. Trauma-informed care, as discussed in the literature review, is a set of practices designed to provide safe and effective care to individuals who may be coping with post-traumatic stress, whether or not they are known to have a trauma history. Participant 9 highlighted this as the most significant tool he has for working with this clinical population. “The one thing that I picked up along the way is just I guess the principles of trauma-informed care,” he said. “...to assume from the get-go with anybody I meet with that they may have had a traumatic experience in their life.”

Participant 5 also described her efforts to respect patients’ autonomy and independence, an important element of trauma-informed care. “In my work with people I try to be non-coercive and to give them as much control as possible,” she said.

The value of trauma-informed care was most often referenced by the prescribers who participated in the study. They each said that they consistently hold in mind the risk of harming their patients through unnecessary intervention or control. Participant 9 said, “If I’m only aware of ‘let’s treat the symptoms of psychosis’ without any attention to trauma, they may not come back again.”

Psychotherapy. All respondents spoke to the value of psychotherapy as part of the treatment for this clinical population. Participant 5, a psychiatric nurse practitioner specializing in psychopharmacology for trauma survivors, said, “For the trauma piece, psychotherapy really is the treatment for trauma, not psychopharm. So I conceive of the role of psychopharm as being to dial down acute symptoms so that the person can do the therapy.”

No one modality for psychotherapy emerged as a clear gold standard for working with this clinical population. Several participants described themselves as ‘eclectic’ in their approach. Participant 4 simply said, “I work in a practical direction.”

Participants did mention at least one specific theoretical stance or therapeutic modality they find particularly helpful in their work. These included couples therapy (P1), family therapy (P1, P3), group therapy (P2, P4, P5), the use of genograms to track family relationships (P1), psychodynamic formulation (P4), internal family systems (P1, P2, P4), cognitive behavioral therapy (P8), Open Dialogues (P3), contextual therapy (P1), grounding techniques (P4), and community-based flexible supports, which offer team-based wraparound medical and mental health services (P7, P9).

Regardless of their preferred modality, all participants emphasized the importance of a few key benefits of psychotherapy: (1) the development of trusting relationships, (2) positive regard for their clients’ strengths, and (3) supporting a person’s efforts at meaning-making around their struggles.

Trusting relationships. Every participant in the study cited the development of stable trusting relationships as the primary benefit of a therapeutic relationship, either in psychotherapy or psychopharmacology. “When you don’t trust anyone, you’ll have certain behaviors that will

not be conducive to daily life if you continue to have them. So that's my focus," Participant 5 said.

Trust can be difficult for people who have survived traumatic relationships or been victims of violence. Persistence and tolerance of mistrust emerged as important traits for building trust with patients in this target population. "You just have to be willing to go over and over and over how someone doesn't trust you and why that is and work through each occurrence of this," Participant 1 said.

This clinical population can be especially challenging to develop trusting relationships, because the need to address safety risks that emerge in psychotic disorders can sometimes be at odds with the needs of trauma survivors for transparency and trust. Participant 9 addressed this tension in his work as a psychiatrist:

It's extremely difficult to really treat the illness and to build an alliance because of the kind of prominent psychiatric illness, and that our hand is forced sometimes to ensure her safety, and that further undermines the trust and slow relationship building that she probably really needs in order to have the right kind of support.

Trusting relationships emerged over and over as a significant stabilizing force in creating safety, keeping someone engaged in care, diminishing symptoms, and supporting people in tolerating internal distress and external stressors. "Creating a network of safety and support and consistent self-care routines and breaking through isolation is huge in healing," Participant 2 said. "That's true for major mental illness, it's true for trauma, it's true for addiction."

The healing power of simply remaining present emerged as a frequent theme. Every participant had extensive clinical training, but they all noted the value of simply being a stable, trustworthy presence in their clients' lives.

“I think just being there, sitting with it in a way, and you know, probably the strongest thing is no matter what’s happened and how risky things get, we have not abandoned her,” Participant 9 said, describing the benefits of a trusting relationship he feels he’s built with one of his patients. Participant 9 said that he has been his patient’s longest standing care provider, and while she is sometimes hostile towards him and his colleagues, their persistence in caring for her has begun to ease the burden of her distress in her family and peer relationships.

Participant 7 reported that relationship-building is her primary strength as a clinician. “I’m always respectful of the need to establish a relationship and keep that as a primary goal, so that involves of course being respectful and patient.”

Appreciating strengths. Providing insight into and support for a clients’ strengths was often mentioned as a benefit of psychotherapy. Participant 3 identified this as an important change in focus of treatment over the past generation of mental health care, brought about through the efforts of the mental health recovery movement, peer support organizations like the Hearing Voices Network (a peer support group for individuals who hear voices), and the development of a professional peer workforce in the mental health system, whose expertise rests on lived experience rather than education. “I think they’ve helped clinical professionals to redefine that there are many paths to recovery, and that experiencing psychosis, and even having a diagnosis of schizophrenia, is oftentimes only as limiting as you allow it to be,” she said.

Participant 2 described how she had come to view psychotic thought processes as a strength, based on her work with a client who joined her trauma recovery group after stabilizing her psychotic illness through psychiatric care:

I’m pretty sure that she explained to us, to the group, that it was a choice of psychosis or survival, you know, at a very early age. So, many of our patients who are abused,

particularly abused by caregivers at really early ages, have very few psychological choices.

Other participants also noted their high regard for the insight and resilience displayed by the people they work with. Participant 7 described the strengths of one of her patients, “That sort of ferocity in her, of being like, I’m going to be okay, and her ability to take care of herself, is a real strength.” Additional descriptions of patients’ strengths included appreciation for their strong motivation, kindness, commitment to recovery, and creativity.

Meaning making. Several participants talked about the value of meaning-making in psychotherapy for people with psychotic disorders and trauma histories. Having a listening space that integrates people’s past life experiences with their current mental health symptoms and future hopes and goals was often cited as important to the patient’s recovery process. “One of the big things I do with psychosis is that I show the person that I see what part of their hallucinations or delusions are embedded in their context and their historical reality,” Participant 1 said.

Participant 3 saw this meaning making role as essential to her work, and in contrast to the medical model of psychiatric illness as primarily biological in origin. “We’re trying to weave together a story of what’s gone on, not that this is a chemical imbalance,” she said. She described the way her team approaches clients’ disclosures of delusions or hallucinations:

When we hear a hallucination, when we hear this clinical jargon, that’s not where we stop. We’re saying, tell me more about that, help me understand how you came to know that, help me understand how this experience has affected where you are today.

Participant 3 said she tries to create a space where people are free to share the “weirdest ideas that have ever occurred to them.” Participant 3 said that the Open Dialogues approach sees

value in any communication and thought process, and encourages sharing one's fears and strange thoughts without shame or judgment.

Participant 8 described how she uses delusional content shared by a client to address psychodynamic themes in their life, rather than focusing on what is real or not real:

It's been an interesting mix of trying to help him use the metaphor of the aliens as a way of ...play therapy, of giving voice to the pain that he's experienced... and his need to feel powerful, you know, "what does it feel like to feel like your anger could kill someone?"

While meaning making was seen by many participants as an important benefit of therapy, most participants also discussed risks associated with engaging their clients' efforts at meaning-making around delusions or traumatic memories. These concerns are discussed below in the section on contraindicated practices.

Community supports. In many cases, a person's only social and emotional support system might be the professional supports they access through the mental health system.

Participants 1, 2, 4 and 7 described the value of community outreach programs, day treatment centers, and drop-in spaces for peer support. "I think it's helpful for people to have community-based resources, and opportunities to be with people who may have experienced life similarly to how they have, just people to be around when the tendency is towards isolation," Participant 4 said.

These community outreach programs and spaces were originally designed as temporary supports for people in the process of recovery, in the hope that they will over time become more independent. For some people, though, the day programs and recovery centers are places where they form lasting connections. "For some people they are the network," Participant 4 said. "They

stay the network. They're very real connections and very real social supports and may not be a bridge at all. It may be like home."

For others, mental health treatment is a support in becoming or remaining engaged in relationships with family and community. Participant 1 said that she assesses someone's support network as part of every initial assessment. "I always look for who else in someone's life growing up was instrumental in helping them feel either safe or nurtured or valued," she said.

For people with involved family and social supports, referred to collectively as 'natural supports' by the mental health profession, a focus of treatment may be strengthening those existing relationships. In her community outreach work, Participant 3 uses Open Dialogues, a Finnish model of care for people with psychotic experiences that relies strongly on family and community supports rather than institutional care. She talked about the centrality of family relationships to the work she does:

I think that for families that we work with, they would say that they are just so thankful to be included. They're so thankful to be given the chance to get it. Because a lot of times, the young person assumes no one could ever understand what I'm feeling, and oftentimes parents don't even get a chance to say, "You're right, I don't. AND I'm still here for you."

Medication. Medications are an essential support for many people experiencing psychosis. They can also provide significant relief to those experiencing a traumatic stress response. Participants spoke of both direct and indirect benefits to the use of psychiatric medications. Participant 7, a mid-career psychiatrist, noted that while a few medications may effectively manage or even eliminate psychotic symptoms, most work only to mitigate discomfort through decreasing anxiety, helping with insomnia, and other palliative effects. A

medication or treatment that does not eliminate the primary symptoms can still be helpful because it supports stability and eases some of the “burden of disease” created by the symptoms, Participant 7 reported. She added that, “Medications can...decrease anxiety. They can help modulate the intensity of the affect that in and of itself is overwhelming and destabilizing. They can quiet the voices so they’re not as tormenting.”

Participant 7 stated that Clozaril and lithium remain the two medications that most often seem to profoundly improve someone’s baseline psychotic features. She felt these two stand apart from other psychiatric medications in their direct and significant benefits to patients. “I think that in the case of Clozaril or Lithium, they can actually decrease suicidality,” Participant 7 said. “So you know, they’re life-saving.”

Participant 1 echoed Participant 7’s experiences with Clozaril, stating, “The only medication that I’ve seen help is Clozaril, and it’s such a hard medication for people to tolerate, either because of the blood draws or because of other side effects.” Participant 7 also spoke highly of electro-convulsive therapy, saying, “And ECT! You know, I often will recommend ECT, which is really effective.”

While all participants acknowledged the value of psychiatric medication in alleviating symptoms, their beliefs and when and how medications are best used varied considerably. Some clinical social workers and the two psychiatrists endorsed ongoing use of antipsychotic medication for people who report psychotic experiences. These participants are all individuals accustomed to working in a hospital setting where the medical model of mental illness holds sway both theoretically and structurally in terms of institutional policy.

Participant 5 spoke about her cautious and limited approach to prescribing, but closed by saying that in cases where she perceives a substantial risk of harm to self or others, she is much

more assertive with prescribing antipsychotics and antianxiety medications. She discussed her approach in high risk cases:

There are some cases where you know there's really incredible risk involved, and where it's like I kind of say like ... the gloves are off, so to speak. And what I mean by that is if I have someone who's having like—you know, like a patient I had in the past who's very memorable, who used to have these like, whether they were flashbacks or visual hallucinations or vivid fantasies it's really unclear, but she used to, she was ... really a very high-risk in terms of suicide. And she would get these mental images of herself with like, scars on herself, like looking like she had had an autopsy done. And like when you have patients reporting things like that AND they're suicidal—or if they're reporting they're having aggressive impulses, which is something that we probably under-recognize a little bit—those kind of people I'm going to be much more likely to give an anti-psychotic to earlier.

While Participant 5 views psychiatric medications as safe and beneficial, other participants described a more problematized view of medications, highlighting potential medical risks and side effects, including weight gain, tics, loss of interest in pleasurable activities, and dependency. Participant 1, as noted above, said that psychiatric medications often don't seem to help her clients. Even in the case of Clozaril, which she felt was an exception due its efficacy at treating psychosis, the illness continued to trouble her patient. She described meeting with him after their work together had ended:

He's like the only person I've ever really seen dramatically improve with Clozaril. The last time I ran into him—this was way after the therapy—he couldn't take the Clozaril anymore because of metabolic things and aging. I asked him, had the delusions returned

and he said yes, they had. Which was so sad to hear. But I think his functioning was much improved.

Participant 3, a social worker doing community outreach for young adults with psychotic disorders, had a clear metric for reducing or avoiding the use of psychiatric medications. She said, “We believe that using the smallest amount of medication for the shortest amount of time possible is really how to get people to be in the driver’s seat on their recovery, because if we force something on someone, 75% of the time they’re going to come off of it and they’re going to feel worse afterwards.” Participant 3 views the widespread use of medication with this target population as a barrier to care, since people who don’t wish to take psychiatric medications often have trouble accessing other kinds of help. She said, “We really want to create a space where people can say, “I do not want to take medication, and I’m not GOING to, so how else can you help me?””

This approach works well for her as a community outreach provider working in the Open Dialogues model. Open Dialogues was first developed in Finland about 30 years ago. It relies on transparency, peer support, and family involvement. In this model, psychiatric medications tend to be used only to manage crises.

Contraindicated Practices

A few therapeutic modalities commonly used to treat traumatic stress in the general population emerged as risky or ineffective with individuals with psychotic disorders. These included (1) trauma-focused psychotherapy, (2) a “detective” approach towards engaging with a person’s past, and (3) involuntary treatment.

Participants stressed the risks involved in the practices described in this section. Several mentioned an elevated risk of death by suicide, substance use, or violence. Participant 2

described her work with a client who came to her for psychotherapy in the trauma-focused clinic where she works, but who also had an undiagnosed psychotic disorder. The woman completed suicide after their treatment had ended. “I think [the treatment] undid her a little bit, actually,” she said. “I don’t... KNOW if treatment could have gone otherwise. If treatment exacerbated her psychosis. It’s not impossible that it did, although she seemed to do pretty well.”

Trauma-focused psychotherapy. Trauma-focused psychotherapy was identified by many participants as a risky, but sometimes valuable, approach to treatment with these patients. “What we’ve found over the years is that doing trauma-focused work can cause patients to decompensate and become increasingly psychotic,” Participant 2 said.

Participants who work primarily with psychotic disorders expressed significant caution about addressing trauma symptoms in their patients, for fear of exacerbating symptoms. The study participants with expertise in trauma treatment were similarly cautious about directly engaging a patient’s trauma history, but identified a clear distinction between using interventions associated with the first stage of Judy Herman’s trauma treatment model, discussed above in the literature review, and using interventions associated with stage two or three of that model. The first stage interventions of trauma treatment focus on stabilization and safety. All participants identified these as appropriate for this clinical population, whether they named them as related to trauma-treatment or not.

Stage two trauma-treatment interventions involve meaning making and direct work with the traumatic past. These were reported as counter-indicated and risky by all respondents, though the respondents working primarily with psychosis did not name them as part of a staged model of trauma treatment.

Participant 2 said, “I think the more open-ended free-associated kinds of treatment that are like, especially body-based, because that’s my experience, I would not recommend for an actively psychotic person.” She described a time she had treated a woman with a psychotic disorder in group therapy, and seen her struggle with body-based interventions:

I have developed a body-based group, trauma and the body, which uses sensorimotor psychotherapy to help people resolve PTSD symptoms, and ...I remember this one particular patient who was lovely, who joined the group, who became increasingly psychotic over the course of the group until she kind of just lay down in the middle of the floor in the middle of the group, and I don’t really quite know where she was... Those loose associations, those loosely focused... body-oriented techniques, I would not recommend them.

Becoming a detective. Within the theme of approaching trauma-focused work with caution, participants specifically warned against slipping into a forensic role, becoming more detective than therapist. As discussed above, meaning making was reported as an important positive function of mental health treatment for this population, but several participants cautioned strongly against becoming preoccupied with determining “the truth.” Participant 4 explained that with people experiencing both psychosis and trauma, it is important to “not get hung up on my external experiences of truth and reality and, unless there’s risk involved, to be able to work without having to be the determiner of truth or reality too rigidly.”

The concerns were that focusing on determining what was real or delusional, or piecing together a precise factual narrative of past trauma, can collude with a person’s symptoms of mental illness and detract from their healing process. Participant 7 discussed her emphasis on staying in the present, saying:

It hasn't seemed to me to be fruitful to go back and try and pick apart the history as much as it is to say, "You know...when we have terrible experiences, how it gets filtered through our minds can show up in a number of ways. Our job is to help your mind be as healthy as possible."

The risk of slipping into a detective mode was cited as a reason for avoiding trauma-focused therapy altogether, and a specific risk in cases where a therapist had chosen to engage the trauma history with their client.

Participant 7 described her strategy for containing and limiting the 'trauma detective' aspect in her work. "I listen for the traumatic content when the person talks to me about their auditory hallucinations, but I don't necessarily treat it... I try to be, I guess, thoughtful about where it's coming from when it might get triggered, but I don't say okay, well, that's true and that's not true."

Involuntary treatment. Aspects of the mental health system developed to contain and treat acute psychotic episodes can be triggering for trauma survivors. Several participants described the risk of harm involuntary treatment and inpatient hospitalization pose to their psychotic patients who report a prior trauma history.

Participant 3 said that many of her patients who report symptoms of traumatic stress identify involuntary mental health treatment as the primary trauma they have experienced. "People will come to us because they've had awful hospitalizations that were forced on them, or they've had someone force them to take medication, [but] they weren't informed of the risks."

Participants who use involuntary treatments, including inpatient hospitalization, as part of their work with these patients, all said their patients are made aware of the risks, and the clinicians work to be sensitive to the patients. Participant 9 spoke about the tension between a

patient's need for autonomy and need for safety. He described an incident in which a patient with a trauma history became acutely psychotic and suicidal:

We had no choice but to section her involuntarily to the hospital. And that led to a further kind of mistrust and rift in that, you know, we didn't care for her and that she experienced that as— and she further avoided the clinic for that reason.

Participant 3 said that one of the goals of her program is to keep people out of “the mental health system,” and particularly out of inpatient hospitalization. She said her team has learned from the people they serve that they do not get better in hospital settings. They report feeling isolated and taken away from community. “Just because someone's experiencing psychosis, that's not a reason for us that they should be in a hospital,” she said. “It's more about, are you able to be safe, what do you need tonight to be safe, what do you need just to get through till tomorrow?”

Treatment Outcomes

Progress in the treatment of these co-occurring disorders is often gradual and largely internal, best assessed through self-reports by the clients. Participant 9 said it often takes three to five years of treatment before someone trusts him and his team enough to fully take advantage of the services they offer. Participant 3 said one of the core benefits of the Open Dialogues model is its slow, collaborative approach to diagnosis and treatment.

Participant 8 described how she can tell if a client is improving:

Sometimes it's that people set the limits for themselves, and you know, the symptoms are better, and a lot of times they're using less medication. The connection is better, you know, when they're having trouble they stay connected. I mean there's a hundred thousand ways.

She described the slow progress she's seen with one psychotherapy client, who she has been treating with cognitive behavioral therapy in conjunction with medication. She said, "I've worked with him now for about maybe five or six years, and slowly, what he's been able to do is occasionally just kind of note that it really does comfort [him] when [he] has these thoughts."

Participant 1 also described the shifts in internal experiences as a key feature of recovery in treating this clinical population. "It's how they talk about their lives, whether it's a reduction in anxiety or a reduction in loneliness or a feeling of more well-being, a feeling that they can name their emotions and feel like they are surviving them."

Observing a growing ability to tolerate increasingly strong emotions was a common theme among respondents. Participant 8 said, "I notice a willingness to tolerate more strong emotion without having to retreat into, you know, the fantasies or whatever might be going on." Participant 5 echoed this sentiment, saying that she knows her clients are doing well when "they feel like they can control their feelings instead of their feelings controlling them."

Several participants discussed the difference in treatment outcomes between primary psychotic disorders and psychotic symptoms resulting from traumatic stress. Everyone who addressed this stressed that it can be difficult to determine whether a person struggling with distorted perceptions and paranoid thought processes is suffering from a psychotic disorder or traumatic stress. Participant 5 said, "I tend to see people whose psychotic symptoms are more wrapped up in the trauma so that you know, they could actually remit."

Participant 1 described a case in which she had seen psychosis abate as a person worked through their trauma history:

It's hard to know whether to attribute that to he became somewhat more compliant with medication and stabilized his sleeping a little bit (not as much as what you would want).

And I think he just generally matured and did a graduate program that had potential for employability and that was important to him too.

While participants were in broad agreement that people in this clinical population have long-term care needs, they did note a significant difference in treatment outcomes between people with people with psychotic symptoms stemming from traumatic experiences and those with primary psychotic disorders like schizophrenia. “What I’ve often found is that if you can get to the trauma, a lot of the psychotic kind of stuff fades,” Participant 8 said.

The consensus of the group was that people whose psychotic symptoms stem from traumatic stress may see the psychosis resolve as they recover from the trauma. However, participants reported that people with primary psychotic illnesses are likely to continue to have psychotic experiences even when helped to establish safety and stability.

Participant 2 said, “We have had patients in the [trauma-focused clinic] who start out with a lot of paranoid ideation. That resolves, over time. As they feel safer in their lives. And continue in treatment. Or it gets more amenable.” She said a sense of agency helps to resolve the symptoms, and a growing capacity to control how one responds to distressing internal stimuli. Participant 5 also said she has seen people’s psychotic symptoms fade as their trauma recovery progresses. “I see people who when they receive trauma treatment, their psychotic symptoms essentially remit, and I see people who have more of a primary psychotic illness that never remits,” she said.

Conversely, when someone has a primary psychotic disorder, symptoms tend to worsen over time, as Participant 7 noted in discussing a case of a woman with a significant trauma history and a lifelong psychotic disorder. Her patient had recovered substantial capacity to lead a meaningful, self-directed life during middle age, and had a period in which she was able to

maintain employment and a healthy marriage. As she has aged, her mental health has declined again.

She's just so sick as she's getting older and older and it's harder and harder for her to keep her mind together. And she's getting really overwhelmed. Like, she's had to fight a lot to hold on to enough threads to keep a life outside of the hospital. And she has been less successful. The kind of burden of disease has mounted.

Because progress in these cases can be difficult to assess and the problems that brought someone in to therapy may not be resolved through the treatment, a long-term perspective helps to maintain hope for both the clinician and the client. "We are constantly in the vein of, what can we celebrate today? It's really important that we hold that in all of the meetings and that as facilitators you're holding the hope," Participant 3 said.

Participants 1, 3, and 6 all talked about the long-term needs of clients in psychotherapy, and Participants 7 and 9 addressed this theme as well. Participant 4 captured the sentiments of several respondents when she described the benefits of therapy for people with psychotic disorders and trauma histories:

It's not towards the goal that there is this whole being that you will become and when you've reached it then you're all better. For people who have trauma, for people who have psychotic disorders, for people who have whatever life experiences they have, those are always going to be there. There are always going to be factors. Maybe psychosis isn't always going to be there, but having had psychosis is going to be there.

In contrast to that perspective, Participant 3 said that she recognizes that the people she serves may have lifelong mental health needs, but she also holds in mind that mental health care may not always be an appropriate way to address those needs. "We want to come in early and

often and try to help people figure out their path to recovery that might not necessarily include being identified as someone with a mental illness forever,” she said.

Sometimes treatment outcomes remain obscure even long after the treatment. Participant 2 recalled a patient whose psychosis worsened over time, despite long engagement in therapy and a supportive family. She said that she could not be certain, looking back, that psychotherapy had benefited this client. “Do I think the therapy helped her? Nnoooooonnnmmmmmaaaaaayyyes. I think it functioned ... to keep her tethered to reality and diurnal cycles of sleeping and eating and a place to blow off steam. So I don’t think it was harmful.”

Participant 3 said that she often sees clients in her community outreach program for young adults thrive, achieving developmental and social milestones that are often viewed as unattainable for people with psychotic disorders:

It’s an embarrassment of riches how successful some of these young people that we’re supporting are. You know, I mentioned people are working. We have people living at college, we have someone in his master’s degree program. We have people who are looking to become peer mentors, people who are commissioned to create art for others. There’s like a lot of beauty and a lot of success in this cohort.

Conclusion

This study both supported and deepened the picture painted by existing literature on best practices for working with co-occurring psychosis and trauma, providing the nuance of individual voices to contextualize and humanize what can be understood from research data. Like the existing literature on the topic, participants in this study emphasized a need for further training and greater support for professionals working with this population, a need for flexible and modest goals for treatment outcomes, and the value of using trauma-informed care practices,

psychotherapy, and psychopharmacology. Several participants discussed the harmful impact of involuntary treatments, which were well documented in the literature. The following chapter will reflect on these findings and discuss how they support the current literature on this topic.

CHAPTER V

Discussion

The findings from this study show that these nine practitioners are largely creating their own skill base in working with the co-occurrence of psychosis and trauma. Although every respondent reported the co-occurrence of psychosis and trauma is common in their work, they all expressed a lack of confidence and expertise in treating it. No one reported substantial training in both psychotic disorders and post-traumatic stress disorders. The knowledge and skill they do have was largely self-created through their own experience and consultation with peers and supervisors.

These findings supported the findings of earlier literature, particularly the Melbourne study on communication between rape crisis counselors and mental health crisis clinicians (McLindon & Harms, 2011), which found that mental health crisis counselors had little contact with rape crisis counselors. Although the mental health counselors had little or no specific training in responding to disclosures of sexual or domestic violence, they all reported that they routinely treated people who disclosed having been victimized.

Several participants in this study mentioned that they feel “siloeed” in their professional specialty. A need for increased cross-training and collaboration between people specializing in traumatic-stress disorders and people specializing in psychotic disorders was noted by participants on both sides of that divide. One participant suggested that having a trauma clinician sit in on team meetings for the team specializing in psychotic disorders would be beneficial.

Treatment goals tend to focus on quality of life rather than external achievements or elimination of symptoms. Progress in treatment can be difficult to assess or define. Providers identified their clients' reports of increased tolerance for strong emotion and an expanded capacity to care for themselves in the face of difficult internal experiences as positive outcomes.

Participants reported that patients typically have complex needs that require long-term care throughout their lives. Effective treatment for this clinical population typically rests on a combination of psychiatric medication, psychotherapy, and community support. That set of needs was reflected in the literature. The literature review also showed a broad awareness that medication is only one part of the treatment for trauma survivors, as in the study that found EMDR as effective as Prozac in decreasing PTSD symptoms (de Bont et al., 2013).

What emerged in this study was a picture of the ways clinicians, psychiatrists, and case workers use these elements interdependently to support their patients' complex needs. For example, Participants 5 and 7 talked about the benefit of psychiatric medication in establishing regular routines and a sense of being cared for, even if the improvement in symptoms stemming from the drug itself is small. Participant 5 said, "For the trauma piece, psychotherapy really is the treatment for trauma, not psychopharm. So I conceive of the role of psychopharm as being to dial down acute symptoms so that the person can do the therapy."

A number of participants talked about the internal nature of successful treatment outcomes, citing clients' self-reports of improved mood, increased tolerance for emotional distress, and greater overall happiness as indicators of healing, even if those internal experiences were not matched by greater independent living skills or the cessation of psychotic experiences like hearing voices. The goal for these treatments was to improve clients' capacity to live with their psychotic illness, not overcome or cure it. As Participant 4 stated:

It's not towards the goal that there is this whole being that you will become and when you've reached it then you're all better. For people who have trauma, for people who have psychotic disorders, for people who have whatever life experiences they have, those are always going to be there. There are always going to be factors. Maybe psychosis isn't always going to be there, but having had psychosis is going to be there.

This perspective on treatment as an ongoing need, with the goal being maintenance and safety rather than recovery or cure, aligns with the medical model of psychotic illnesses that has risen to prominence during the 20th century (van der Kolk, 1994). One exception to this was the cases of patients whose psychotic symptoms emerged from and were rooted in overwhelming traumatic experiences. For these individuals, participants in this study repeatedly said they do see psychotic symptoms entirely resolve when the trauma itself is addressed. This finding is in accord with early work on the relationship between psychosis and dissociation (Moskowitz et al., 2011).

When Freud (1901) introduced the concept of psychoanalysis, he asserted that hysterical symptoms, which at the time were understood to encompass experiences we now view as psychotic and/or dissociative, would be resolved when the internal conflict and grief related to an earlier trauma could be spoken aloud by the patient while experiencing and tolerating the affect of the experience. This early theory has proved only partially true, but the participants in this study were in general agreement that psychotic symptoms stemming from specific early traumas would resolve when the underlying trauma was treated. Conversely, psychotic symptoms stemming from a primary, biologically based psychotic disorder will tend to persist.

This is one of the most significant findings of the study. Several participants spoke to the difficulty of knowing whether a patient's symptoms were psychotic, dissociative, or simply an

honest presentation of violent past experiences. Practices that were noted to be particularly helpful for treating one disorder were sometimes noted to be contraindicated for the other disorder. Further research on distinguishing between trauma-induced psychosis and primary psychotic disorders, and developing a differential approach to treatment in accordance with accurate diagnosis, would be valuable to both clinicians and clients.

Another significant theme of this study was the risks faced by people with psychotic illnesses and trauma histories. These risks included an elevated risk of suicide or self-harm, greater vulnerability to victimization by caregivers and strangers, medical complications related to treatment, and limited capacity to fully engage in personally meaningful activities.

This study added nuance to the discussion of re-traumatization via involuntary care, however, because participants tended to raise the issue in tandem with discussions of treatment alternatives they had found helpful to their clients. One participant talked about the Open Dialogues approach as a successful community-based treatment for keeping people safe and connected to family and community resources, as opposed to the coercive approach to care in inpatient hospitals. Participants who do use inpatient hospitalization and other involuntary treatment approaches recognized that these can create a breach of trust between provider and client. They identified a need to recognize and repair these breaches when an involuntary treatment seemed necessary to ensure someone's safety.

The most salient aspects of successful treatment included the establishment of trusting relationships, appreciation of the individual's real strengths, and support in making meaning of their experiences. Earlier research found that for people seeking help, feeling seen and understood by a trusted professional can be a successful outcome on its own (Walsh & Boyle, 2009). No single treatment modality emerged as a gold standard for patients with psychotic

disorders and trauma histories. Internal Family Systems was mentioned by a number of participants as helpful in their work with this population. This modality was cited as particularly useful for people whose psychotic symptoms were primarily stemming from a traumatic experience. Other providers stressed the value of family or couples therapy to strengthen social relationships and help a patient's loved ones understand their struggles.

These findings are consonant with the research on psychosis, trauma, and attachment (Allen, 2013), which finds that a reparative attachment in a therapeutic alliance can provide a stabilizing and healing effect for a person regardless of the severity or nature of their symptoms. Participants in this study addressed that directly, discussing how important they see the role of helping professionals being in the lives of people with long term mental illness, just because they are often the only people who can tolerate the person's symptoms and remain present throughout their lives to celebrate milestones and challenges.

Strengths of this Study

This study addresses a gap in the existing literature, giving insight into existing best practices for clinicians treating a common and challenging co-occurrence of mental health disorders and demonstrating a need for future research. The participants in this study each gave valuable interviews that reflected both common themes and unique insights, providing a robust data set to work with. During the coding process, this researcher found that the most salient codes, those related to the major themes discussed in the findings chapter, reached saturation, indicating that the breadth of the topic had been reasonably explored and no new codes were needed.

The respondents' richly detailed case material and insight into their own work affirmed what is shown in earlier literature. The findings provided insight into practice gaps, such as the

need for more training across disciplines. The findings also provided evidence that helping systems, such as insurance companies and hospitals, fail to fully support both clinicians and their patients.

Limitations of the this Study

The study's small and relatively homogenous sample creates limitations. As noted in the findings, the participants represent a deep but narrow look at the perspectives of helping professionals in a specific time and place. Their responses offer valuable insight for those working in similar settings, but the degree to which these findings can reliably extrapolate to other settings is limited.

First, the sample size falls below the minimum set by Smith College, representing fewer voices and perspectives than the school's Human Subjects Review Board approved and expected would be included. This researcher's efforts to meet the requirement for 12 to 15 participants were discussed in detail in Chapter III. The small size necessarily provides a smaller data set for the study.

The small sample size in this study also reflects an important lack of diversity among the participants. The snowball sampling method in particular created a limitation around the diversity of the sample, since it meant that every participant had a professional or social connection to at least one other participant. The participants in this study were varied in their training, work experience, and theoretical stance, but most had a direct connection to either Smith College School for Social Work or Cambridge Health Alliance, where this researcher completed her training. As discussed in the findings, this overlap gave a deep look at the knowledge and skill of people learning, working, and teaching in this particular time and place in history, but the relevance of these findings in other contexts may be limited.

The narrow sample and use of a single researcher means that the study risks replicating patterns of oppression, particularly towards people of color and people who have immigrated to the United States. Diverse perspectives were underrepresented in the personal identities and experiences of the researcher and study participants. The interview guide included questions about the impact of racism and social bias on individuals with psychotic disorders or trauma histories, yet responses to these questions were so varied, I was unable to draw any significant findings from them. This indicates a need for further study on the experiences of immigrants and people of color who experience these disorders, which will be discussed in more detail below.

Recommendations for Future Research and Clinical Practice

Based on this study's findings and review of existing literature, productive future research on the best treatments for co-occurring psychosis and trauma could go in several directions. For example, future qualitative, quantitative, or mixed method studies could focus on learning more about how social identity impacts individual experience, exploring more about effective cross-discipline training and collaboration, and learning more about meaningful treatment outcomes.

As mentioned above, more in-depth research is needed on the impact of social bias, particularly racism, on the development of these disorders, experiences in treatment, and outcomes. Many participants noted that cultural differences in how people are treated by family and community have a substantial impact on their recovery from mental illness.

Future beneficial studies on clinical practices could include additional qualitative studies focused on one treatment modality or intervention mentioned in this study, such as Internal Family Systems. Additional quantitative research might also test the efficacy of cross-discipline

training and support for improving confidence and efficacy in mental health professionals treating this population.

Consumer-led research on what people receiving treatment have found helpful or not helpful, along the lines of existing research in the trauma-informed care literature, would also be beneficial. That would give greater insight into what treatment outcomes can be desired or expected, from the point of view of people seeking care.

These findings reflect the need for cross-discipline training, collaboration, and support for helping professionals working with people who have experienced both traumatic stress and psychotic symptoms. This population often has complex treatment needs that require awareness of best practices for both trauma and psychosis. Several participants noted that treatments known to be effective for one of these disorders can cause harm for people suffering from both. Treatment can be time consuming and anxiety-producing for both the professional and the patient. Flexibility and realistic expectations were stressed as valuable in planning and evaluating treatment goals.

Conclusion

This study addressed a gap in the literature between existing research on the experiences of people who have experienced both traumatic stress and psychotic symptoms, and what their mental health providers know or believe about how to help them. The nine experienced helping professionals who participated in this study brought their unique and nuanced perspectives to the interviews, contextualizing and complicating the research covered in the literature review.

The existing literature establishes an understanding of what psychotic experiences are, how people commonly respond to traumatic experiences and how those experiences can continue to impact them over time, and how these two disorders frequently co-occur and interact in the

mind and body of an individual patient. In the past two decades, researchers have established strong relationships between early childhood trauma and later experiences of psychosis. Other studies have explored the effectiveness of individual therapeutic modalities for treating this population, such as EMDR, medication, and psychotherapy.

What emerged in the findings of this study was a consensus that trusting relationships serve as the key factor in mental health recovery for this population. Every respondent talked about the importance of love, respect, and ongoing support, both in the family and social relationships their patients have and in the therapeutic relationship. These relationships were cited as the healing factor, and often having the opportunity to build a trusting relationship was an explicit goal of therapy.

Specific clinical practices, including psychiatric medication, psychotherapy, and community outreach efforts, were identified as helpful to the extent that they supported the establishment of trusting relationships. In a small number of cases, medications were seen to be helpful in allaying psychotic symptoms irrespective of the relationship between provider and patient. For most, however, the relationship was the primary site of healing, not the clinical practices or medications.

Participants in this study frequently talked about a distinction between a “primary” or “biological” psychotic illness, which would tend to persist over time and regardless of changes in the person’s social context or emotional maturity, and a psychotic illness arising primarily as a response to trauma. In the latter case, this study’s participants said they often see psychotic features resolve. In particular, paranoid ideation and auditory hallucinations would tend to subside when the trauma that triggered them was appropriately addressed.

Recently published studies addressed in the literature review found that people with persistent psychotic illnesses still benefit from trauma-focused therapy. The benefits found in that research included increased capacity for self-preservation and greater emotional regulation. Participants in this study did not reflect that research, instead stating that they perceived offering trauma-focused therapy to individuals with unmanaged psychotic symptoms to be dangerous and ineffective. Several participants commented on the risk of attempting trauma-focused therapy with psychotic patients, listing symptom exacerbation, emotional dysregulation, harm to self or others, or suicide, as potential risks. Participants also discussed the risk of vicarious trauma and burnout to the clinician when working with these complex, high-risk cases.

Conversely, all participants were able to recall moments of profound healing and change in working with this population. Several spoke about the resilience, ferocity, and strength exhibited by their clients. They also talked about the strong value of teamwork, training, and support for clinical staff.

If there is one takeaway for social work practice and research from this study, it should be to prioritize the development and maintenance of healthy, trusting relationships between providers and clients, and to strengthen the ties of both staff and the people they serve the community they live in.

References

- Allen, J. G. (2013). Treating attachment trauma with plain old therapy. *Journal of Trauma & Dissociation*, 14(4), 367–374.
- American Psychiatric Association. (1952). *Diagnostic and statistical manual of mental disorders* (1st ed.) Washington, DC: Author.
- American Psychiatric Association. (1980). *Diagnostic and statistical manual of mental disorders* (3rd ed.) Washington, DC: Author.
- American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Washington, DC: Author.
- Barrantes-Vidal, N. (2013). Trauma and psychosis: Is it easier to study quarks than subjective meaning? *Acta Psychiatrica Scandinavica*, 129(6), 478–479.
- Berry, K., Barrowclough, C., & Wearden, A. (2007). A review of the role of adult attachment style in psychosis: Unexplored issues and questions for further research. *Clinical Psychology Review*, 27(4), 458–475.
- Berzoff, J. (2011). Why we need a biopsychosocial perspective with vulnerable, oppressed, and at-risk clients. *Smith College Studies in Social Work*, 81(2-3), 132–166.
- Berzoff, J., Flanagan, L. M., & Hertz, P. (2011). *Inside out and outside in*. Plymouth, England: Rowman & Littlefield Publishers, Inc.
- Calabrese, J. D., & Corrigan, P. W. (2005). Beyond dementia praecox: findings from long-term follow-up studies of schizophrenia. *Recovery in mental illness: Broadening our understanding of wellness*, 63–84. Washington, DC, US: American Psychological Association; 2005.
- Chu, J. (2011). *Rebuilding shattered lives* (2nd ed.; pp. 1–375). Hoboken, NJ: John Wiley & Sons Inc.

- de Bont, P. A. J. M., van Minnen, A., & de Jongh, A. (2013). Treating PTSD in patients with psychosis: A within-group controlled feasibility study examining the efficacy and safety of evidence-based PE and EMDR protocols. *Behavior Therapy, 44*(4), 717–730.
- Engel, R. J., & Schutt, R. K. (2017). *The practice of research in social work* (4th ed.). Thousand Oaks, CA: Sage Publications.
- Felitti, V. J., Anda, R. F., Nordenberg, D., Williamson, D. F., Spitz, A. M., Edwards, V., et al. (1998). Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults. *American Journal of Preventive Medicine, 14*(4), 245–258.
- Freeman, D., & Fowler, D. (2009). Routes to psychotic symptoms: Trauma, anxiety and psychosis-like experiences. *Psychiatry Research, 169*(2), 107–112.
- Freud, S. (1901). *A case of hysteria, three essays on sexuality, and other works* (pp. 1–37), Oxford, England.
- Gibson, L. E., Alloy, L. B., & Ellman, L. M. (2016). Trauma and the psychosis spectrum: A review of symptom specificity and explanatory mechanisms. *Clinical Psychology Review, 49*(C), 92–105.
- Goodman, L. A., Salyers, M. P., Mueser, K. T., Rosenberg, S. D., Swartz, M., Essock, S. M., et al. (2001). Recent victimization in women and men with severe mental illness: prevalence and correlates. *Journal of Traumatic Stress, 14*(4), 615–632.
- Harris, N. B. (2014). *How childhood trauma affects health across a lifetime*. [Ted Talk] https://www.ted.com/talks/nadine_burke_harris_how_childhood_trauma_affects_health_across_a_lifetime
- Heisler, E. J., & Bagalman, E. (2015). *The mental health workforce: A primer*. Congressional Research Service (pp. 1–24). Retrieved from: <https://fas.org/sgp/crs/misc/R43255.pdf>

- Henderson, J. T., & Bekhuis, T. (2016). Historical concepts of mental illness. *Salem Press Encyclopedia of Health*, 1–7.
- Herman, J. L. (1992). *Trauma and recovery*. New York, NY: Basic Books.
- Levine, P. (2015). *Trauma and memory*. Berkeley, California: North Atlantic Books.
- Liotti, G., M.D. (2004). Trauma, dissociation, and disorganized attachment: three strands of a single braid. *Psychotherapy Theory, Research, Practice, Training*, 41, 472–486.
- Luhrmann, T. M., & Marrow, J. (2016). *Our most troubling madness*. Oakland, California: University of California Press.
- Maatz, A., & Hoff, P. (2014). The birth of schizophrenia or a very modern Bleuler: A close reading of Eugen Bleuler’s “Die Prognose der Dementia praecox” and a re-consideration of his contribution to psychiatry. *History of Psychiatry*, 25(4), 431–440.
- McLindon, E., & Harms, L. (2011). Listening to mental health workers' experiences: Factors influencing their work with women who disclose sexual assault. *International Journal of Mental Health Nursing*, 20(1), 2–11.
- Moskowitz, A., Schafer, I., & Dorahy, M. J. (2011). *Psychosis, trauma and dissociation*. West Sussex, UK: John Wiley & Sons.
- Mueser, K. T., Lu, W., Rosenberg, S. D., & Wolfe, R. (2010). The trauma of psychosis: Posttraumatic stress disorder and recent onset psychosis. *Schizophrenia Research*, 116(2-3), 217–227.
- Muskett, C. (2013). Trauma-informed care in inpatient mental health settings: A review of the literature. *International Journal of Mental Health Nursing*, 23(1), 51–59.
- Oh, H., Devylder, J. E., & Chen, F.-P. (2015). To Treat or Not to Treat: Responding to Psychotic Experiences. *British Journal of Social Work*, 45(7), 2003–2019.

- Padgett, D. K. (2008). *Qualitative methods in social work research*. Thousand Oaks, CA: SAGE Publications.
- RAINN. (n.d.). *Victims of sexual violence: Statistics*. Retrieved July 6, 2016, from <https://www.rainn.org/statistics/victims-sexual-violence>
- Rauch, S. A. M., Defever, E., Favorite, T., Duroe, A., Garrity, C., Martis, B., & Liberzon, I. (2009). Prolonged exposure for PTSD in a Veterans Health Administration PTSD clinic. *Journal of Traumatic Stress, 22*(1), 60–64.
- Read, J., Os, J., Morrison, A. P., & Ross, C. A. (2005). Childhood trauma, psychosis and schizophrenia: a literature review with theoretical and clinical implications. *Acta Psychiatrica Scandinavica, 112*(5), 330–350.
- Russo, D. A., Stochl, J., Painter, M., Dobler, V., Jackson, E., Jones, P. B., & Perez, J. (2014). Trauma history characteristics associated with mental states at clinical high risk for psychosis. *Psychiatry Research, 220*(1-2), 237–244.
- Samuels, G. M., & Ross-Sheriff, F. (2008). Identity, oppression, and power feminisms and intersectionality theory. *Affilia, 23*(1), 5–9.
- Trevillion, K., Hughes, B., Feder, G., Borschmann, R., Oram, S., & Howard, L. M. (2014). Disclosure of domestic violence in mental health settings: A qualitative meta-synthesis. *International Review of Psychiatry, 26*(4), 430–444.
- van den Berg, D. P. G., de Bont, P. A. J. M., van der Vleugel, B. M., de Roos, C., de Jongh, A., van Minnen, A., & van der Gaag, M. (2016). Trauma-focused treatment in PTSD patients with psychosis: symptom exacerbation, adverse events, and revictimization. *Schizophrenia Bulletin, 42*(3), 693–702.

- van den Berg, D. P. G., van der Vleugel, B. M., de Bont, P. A. J. M., Thijssen, G., de Roos, C., de Kleine, R., et al. (2016). Exposing therapists to trauma-focused treatment in psychosis. *European Journal of Psychotraumatology*, 7, 411–12.
- van der Kolk, Bessel (2014-09-25). *The body keeps the score: Brain, mind, and body in the healing of trauma* (Kindle Locations 852-853). Penguin Publishing Group. Kindle Edition.
- van Zelst, C., van Nierop, M., van Dam, D. S., Bartels-Velthuis, A. A., Delespaul, P., & GROUP-investigators. (2015). Associations between stereotype awareness, childhood trauma and psychopathology: A study in people with psychosis, their siblings and controls. *Plos One*, 10(2), e0117386–16.
- Varese, F., Smeets, F., Drukker, M., Lieveerse, R., Lataster, T., Viechtbauer, W., et al. (2012). Childhood adversities increase the risk of psychosis: A meta-analysis of patient-control, prospective- and cross-sectional cohort studies. *Schizophrenia Bulletin*, 38(4), 661–671.
- Walsh, J., & Boyle, J. (2009). Improving acute psychiatric hospital services according to inpatient experiences: A user-led piece of research as a means to empowerment. *Issues in Mental Health Nursing*, 30(1), 31–38.
- World Health Organization (2014). *Premature death among people with severe mental disorders*. Retrieved from http://www.who.int/mental_health/management/info_sheet.pdf

Appendix A

Interview Guide

Introduction

Thank you for participating in this study. The data collected from this study will be used to complete my Master's in Social Work (MSW). The results of the study may also be used in publications and presentations. My core research question is, "What clinical practices are most effective in helping people who experience co-occurring psychosis and trauma?" This interview will last about one hour. If you feel uncomfortable or distressed, you may pause or stop the interview. You may withdraw your participation during or after the interview, up until May 1, 2017.

Interview

1. What training did you do to prepare for your current role as a helping professional? Did it include specialized training in working with psychosis or trauma recovery?
2. What setting do you work in (ex. Community outreach, inpatient unit, outpatient therapy, etc)? How long have you been doing this work?
3. What insights from your training and experience inform your approach to treating the co-occurrence of psychosis and trauma?
4. Can you discuss a case of yours where these co-occurring disorders played a central role in the work?
5. What are your clients' key vulnerabilities and strengths?
6. In what ways do race, culture, and other aspects of stigma create particular vulnerabilities for these clients? In what ways can they be protective factors?

7. Have any of your clients been diagnosed with personality disorders? How has that diagnosis impacted their treatment and recovery?
8. Who else was part of your clients' circle of care (for example, psychiatrist, family supports, case manager)? What other supports would you expect someone with these disorders to have or need?
9. What worked well for you in the cases you're discussing?
10. What was most challenging experience you've had in working with your clients? What do you see as risks or pitfalls generally in treating clients with these co-occurring disorders?
11. How do you know if a client is getting better? How do you set goals and assess progress?
12. What important elements of this topic have we not yet explored?

Appendix B

Institutional Review Board Approval Letters



School for Social Work
Smith College
Northampton, Massachusetts 01063

February 10, 2017

Sierra Black

Dear Sierra,

You did a very nice job on your revisions. Your project is now approved by the Human Subjects Review Committee.

Please note the following requirements:

Consent Forms: All subjects should be given a copy of the consent form.

Maintaining Data: You must retain all data and other documents for at least three (3) years past completion of the research activity.

In addition, these requirements may also be applicable:

Amendments: If you wish to change any aspect of the study (such as design, procedures, consent forms or subject population), please submit these changes to the Committee.

Renewal: You are required to apply for renewal of approval every year for as long as the study is active.

Completion: You are required to notify the Chair of the Human Subjects Review Committee when your study is completed (data collection finished). This requirement is met by completion of the thesis project during the Third Summer.

Congratulations and our best wishes on your interesting study.

Sincerely,

A handwritten signature in black ink, appearing to read 'Elaine Kersten'.

Elaine Kersten, Ed.D.
Co-Chair, Human Subjects Review Committee

CC: Susanne Bennett, Research Advisor



School for Social Work
Smith College
Northampton, Massachusetts 01063
T (413) 585-7950 F (413) 585-7994

March 28, 2017

Sierra Black

Dear Sierra,

I have reviewed your amendments and they look fine. The amendments to your study are therefore approved. Thank you and best of luck with your project.

Sincerely,

A handwritten signature in black ink, appearing to read 'Elaine Kersten'.

Elaine Kersten, Ed.D.
Co-Chair, Human Subjects Review Committee

CC: Susanne Bennett, Research Advisor

Appendix C

Recruitment Materials

Email posted to professional mailing lists

Hello,

I am completing my social work training at Smith College. For my research thesis, I am conducting research into what clinical practices are most effective in with the co-occurrence of psychosis and complex post-traumatic stress disorder. I am recruiting experienced clinicians and counselors who work with this population to share their insight based on experience in the field. I'm looking for study participants who have completed their training and credentialing, worked for at least one year in the field, and have experience with at least five clients who fall into this clinical population. Participants will be asked to do a one-hour interview in person or by phone. This study protocol has been reviewed and approved by the Smith College School for Social Work Human Subjects Review Committee (HSRC).

Please contact me at sblack@smith.edu if you have further questions or wish to volunteer for the study.

Thank you,

Sierra Black

MSW candidate, Smith College

Social work intern, Cambridge Health Alliance

sblack@smith.edu

xxx-xxx-xxxx

Poster hung up in clinic staff lounges and posted to Facebook groups:

Do you treat clients who experience both complex post-traumatic stress and psychosis?



Experienced clinicians sought for research study

I am seeking mental health professionals to share their expertise treating co-occurring psychosis and complex post-traumatic stress disorder. Participants should be available for a one-hour interview in person or by phone. Interviews will focus on your professional expertise.

Interview subjects should be mental health or counseling professionals who have completed their training, worked for at least one year in their field, and worked with at least five clients who have co-occurring psychosis and complex post-traumatic stress disorder.

This study protocol has been reviewed and approved by the Smith College School for Social Work Human Subjects Review Committee (HSRC).

For more information or to volunteer, contact Sierra Black at sblack@smith.edu, or call xxx-xxx-xxxx.

Appendix D

Consent Forms



Consent to Participate in a Research Study
Smith College School for Social Work • Northampton, MA
2017

.....
Title of Study: Exploring Clinical Best Practices for Working with the Co-Occurrence of Psychosis and Complex Post-Traumatic Stress Disorder

Investigator: Sierra Black, sblack@smith.edu
.....

Introduction

- You are being asked to be in a research study of clinical best practices for treating individuals experiencing psychosis and complex post-traumatic stress disorder.
- You were selected as a possible participant because you are a mental health or counseling professional who has completed your training, worked for at least one year in your field, and worked with at least five clients who have experienced both complex post-traumatic stress and psychosis.
- Criteria for exclusion include recent personal experience of significant trauma or loss, significant symptoms of vicarious trauma, lack of experience, or lapsed professional credentials.
- I ask that you read this form and ask any questions that you may have before agreeing to be in the study.

Purpose of Study

- The purpose of the study is to gather unique insights from individuals and discover trends across practitioners that offer guidance on further research and developing effective practice.
- This study is being conducted as a research requirement for my master's in social work.
- Ultimately, this research may be published or presented at professional conferences.

Description of the Study Procedures

- If you agree to be in this study, you will be asked to do the following things: participate in a 60 minute interview regarding your identity, training, experience, and insight into best practices for treating the co-occurrence of psychosis and complex post-traumatic stress disorder.

Risks/Discomforts of Being in this Study

None.

Benefits of Being in the Study

- The benefits of participation could include a sense of pride in passing on insight and practical skill.
In addition, reflecting on your work in this way may help you to pull together your ideas and techniques in a structured way, gaining new insight in the process.

- The benefits to social work/society are: This study aims to capture some of the unique wisdom of senior clinicians. It may contribute the specific insights of these individuals, and holds potential to point the way towards future research to expand the evidence base for trauma-focused therapy with patients who experience psychosis.

Confidentiality

- Your participation will be kept confidential. Interviews will be conducted in a private setting at a professional office or over the phone. In addition, records of this study will be kept strictly confidential. Recordings of the interviews and any related notes will be kept in secured data storage. Physical documents will be kept in a locked filing cabinet. Identifying details will be obscured in any presentation or publication of the findings.
- All research materials including recordings, transcriptions, analyses and consent/assent documents will be stored in a secure location for three years according to federal regulations. In the event that materials are needed beyond this period, they will be kept secured until no longer needed, and then destroyed. All electronically stored data will be password protected during the storage period. I will not include any information in any report I may publish that would make it possible to identify you.

Payments/gift

- You will not receive any financial payment for your participation.

Right to Refuse or Withdraw

- The decision to participate in this study is entirely up to you. You may refuse to answer any question or withdraw from the study *at any time* up until April 1, 2017 without affecting your relationship with the researchers of this study or Smith College. Your decision to refuse will not result in any loss of benefits (including access to services) to which you are otherwise entitled. If you choose to withdraw, I will not use any of your information collected for this study. You must notify me of your decision to withdraw by email or phone by April 1, 2017. After that date, your information will be part of the thesis or final report.

Right to Ask Questions and Report Concerns

- You have the right to ask questions about this research study and to have those questions answered by me before, during, or after the research. If you have any further questions about the study, at any time feel free to contact me, Sierra Black at sblack@smith.edu or by telephone at xxx-xxx-xxxx. If you would like a summary of the study results, one will be sent to you once the study is completed. If you have any other concerns about your rights as a research participant, or if you have any problems as a result of your participation, you may contact the Chair of the Smith College School for Social Work Human Subjects Committee at (413) 585-7974.

Consent

- Your signature below indicates that you have decided to volunteer as a research participant for this study, and that you have read and understood the information provided above. You will be given a signed and dated copy of this form to keep.

.....

Name of Participant (print): _____

Signature of Participant: _____ Date: _____

Signature of Researcher(s): _____ Date: _____

.....

1. I agree to be audio-taped for this interview:

Name of Participant (print): _____

Signature of Participant: _____

Date: _____

Signature of Researcher(s): _____

Date: _____

Form updated 6-13-16

Appendix E

Volunteer or Professional Transcriber’s Assurance of Research Confidentiality Form

This thesis project is firmly committed to the principle that research confidentiality must be protected and to all of the ethics, values, and practical requirements for participant protection laid down by federal guidelines and by the Smith College School for Social Work Human Subjects Review Committee. In the service of this commitment:

- All volunteer and professional transcribers for this project shall sign this assurance of confidentiality.
- A volunteer or professional transcriber should be aware that the identity of participants in research studies is confidential information, as are identifying information about participants and individual responses to questions. The organizations participating in the study, the geographical location of the study, the method of participant recruitment, the subject matter of the study, and the hypotheses being tested are also be confidential information. Specific research findings and conclusions are also usually confidential until they have been published or presented in public.
- The researcher for this project, - *Sierra Black* - shall be responsible for ensuring that all volunteer or professional transcribers handling data are instructed on procedures for keeping the data secure and maintaining all of the information in and about the study in confidence, and that that they have signed this pledge. At the end of the project, all materials shall be returned to the investigator for secure storage in accordance with federal guidelines.

PLEDGE

I hereby certify that I will maintain the confidentiality of all of the information from all studies with which I have involvement. I will not discuss, disclose, disseminate, or provide access to such information, except directly to the researcher, - *Sierra Black* - for this project. I understand that violation of this pledge is sufficient grounds for disciplinary action, including termination of professional or volunteer services with the project, and may make me subject to criminal or civil penalties. I give my personal pledge that I shall abide by this assurance of confidentiality.

_____	Alison Mandel	_____	Signature
_____	April 15, 2017	_____	Date
_____	Sierra Black	_____	<i>Sierra Black</i>
_____	April 15, 2017	_____	Date