ISSUE BRIEF

# Addressing Trauma and PTSD in First Episode Psychosis Programs

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*"A focus on trauma will actually help clinicians to be more effective with some of their most distressed clients and will help staff to understand their own reactions to working with this population."*

—LOEWY, NIENDAM, AND WADELL (FORTHCOMING)

A significant percentage of clients with first episode psychosis have experienced one or more traumatic events. Determining if and how those traumatic experiences are related to the client's first episode of psychosis is a critical part of the clinical formulation. Understanding and addressing the impact of trauma may be essential to effective engagement, treatment, and recovery.[1]

This document encourages FEP providers to consider introducing trauma-informed approaches and trauma-specific treatment to their programs. SAMHSA's 10 organizational domains will be presented with a brief discussion about using these domains as a template for change. SAMHSA's six principles of a trauma-informed approach will also be described, with examples of how embracing these principles can enhance clinical practice.

Significant attention is paid to staff support, self-care, and resilience—all essential components of a trauma-informed organization. However, the bulk of this document is devoted to a discussion of one of SAMHSA's 10 domains: screening, assessment, and treatment. This domain reflects the need for an effective clinical response to clients whose psychosis is related in some way to traumatic experiences.

**SAMHSA'S 4 R'S OF A TRAUMA-INFORMED APPROACH**
*A program, organization, or system that is trauma-informed:*

- ***Realizes*** the widespread impact of trauma and understands potential paths for recovery;
- ***Recognizes*** the signs and symptoms of trauma in clients, families, staff, and others involved with the system;
- ***Responds*** by fully integrating knowledge about trauma into policies, procedures, and practices; and
- Seeks to actively ***resist re-traumatization.***

## IN A TRAUMA-INFORMED FEP PROGRAM . . .

- All staff—from the front desk to management—recognize the signs of trauma in clients, themselves, and others, and realize that psychotic symptoms may be tied to the experience of traumatic events.
- The agency responds to trauma in clients by making information about trauma and mental health readily available in the waiting room and on the website.
- Staff recognize symptoms of trauma, understand that clients who have experienced trauma may feel unsafe in situations they can't control, and provide choices wherever possible.
- The agency responds to primary and secondary traumatic stress among staff by providing opportunities for self-care and healing.
- Care is taken to ensure that clients and families are not re-traumatized by inadvertently replicating traumatic experiences, including interpersonal violence, abuse, neglect, and historical or cultural trauma.
- Clinical staff are skilled in treating both psychosis and trauma-related disorders.

[1] Trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being. Substance Abuse and Mental Health Services Administration. (2014). *SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach*. HHS Publication No. (SMA) 14-4884. Rockville, MD: Substance Abuse and Mental Health Services Administration.

## IMPLEMENTING A TRAUMA-INFORMED APPROACH: SAMHSA'S DOMAINS AND PRINCIPLES

SAMHSA's foundational document—SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach—provides a framework that can help organizations respond more effectively to the consequences of trauma. Becoming trauma-informed requires more than just attending a training or adding a new service component; it is a long-term process of integrating an understanding of trauma into all aspects of the organization. Being trauma-informed is consistent with good clinical treatment. It is another tool for FEP programs to use in helping their clients achieve recovery.

SAMHSA's 10 domains of organizational functioning (see text box) provide a roadmap for organizational change. Becoming trauma-informed entails building a strong foundation, measuring impact, supporting workforce development and new collaborations, reviewing and revising organizational policies, and making sure that effective trauma screening and treatment are available.

| SAMHSA'S 10 ORGANIZATIONAL DOMAINS |
|---|
| **BUILDING A STRONG FOUNDATION** |
| Leadership • Environment • Financing |
| **MEASURING ONGOING IMPACT** |
| Quality Assurance • Evaluation |
| **ENHANCING WORKFORCE CAPACITY** |
| Training and Development<br>Staff and Patient Engagement<br>Cross Sector Collaboration |
| **SUPPORTING EFFECTIVE PRACTICE** |
| Policy • Screening and Treatment |

The 10 organizational domains provide the roadmap, but SAMHSA's six principles are the bedrock of a trauma-informed culture. The principles emphasize the importance of both staff and clients feeling respected and supported, and they encourage healing and recovery through the development of authentic relationships between management, staff, clients, and community members. Ideally, all six principles are meant to be embedded throughout each organizational domain. Examples of how the principles apply in FEP programs are included on the following pages.

## SAMHSA'S SIX PRINCIPLES[2]

### Safety

*An FEP program reflects safety when staff and clients feel physically and psychologically safe throughout the organization. This requires that both the physical environment and interpersonal interactions promote a sense of safety.*

People who have experienced trauma often feel unsafe. They may respond with hyper-vigilance, distrust of authority figures, and the need to be in control, which may be puzzling or frustrating to others.

Safety is compatible with Coordinated Specialty Care (CSC) guidelines for assessing and ensuring physical safety of clients, family, and staff and with flexibility to deliver services at home or in neutral community spaces. One integration challenge is that all staff—not just individual providers—must be trained in recognizing and addressing fearfulness and safety.

[2] Material in this section is based in part, with permission, from the following publication: Loewy R. L., Niendam T., & Wadell P. (in press). *Assessing and treating trauma in team-based early psychosis care, in Intervening Early in Psychosis: A Team Approach.* Edited by Hardy, K. V., Ballon, J. S., Adelsheim, S., & Noordsy, D. L. Washington, DC, American Psychiatric Publishing.

**PRACTICE TIPS**

- What makes a person feel safe widely varies. Ask people what makes them feel safe or unsafe.
- Take time to familiarize clients with the physical environment, including washrooms and exits.
- Give clients options and make it clear that they always have the right to refuse.
- Ensure that staff feel safe in their workspaces and implement clear guidelines for managing risk.

## Trustworthiness and transparency

*An FEP program reflects trustworthiness and transparency when organizational operations and decision-making are conducted with the goal of building and maintaining trust with clients, staff, and others involved with the organization.*

Trustworthiness and transparency are closely related to safety. Trust in others is often shattered by violence or abuse. People who have experienced trauma may have difficulty trusting others, even those with good intentions. Building a trusting relationship requires being honest, following through with commitments, and following up to see how things are going.

Trustworthiness and transparency are compatible with the CSC team-based approach that depends on trusting relationships among team members. However, transparent communications are more difficult in complex, decentralized organizations.

**PRACTICE TIPS**

- It may take time to build a trusting relationship with some of your clients. Let them know you don't expect them to trust you immediately and that you are willing to work to gain their trust.
- Be authentic. Trauma survivors are often finely attuned to people's emotional states; better to acknowledge your feelings openly than to pretend you are fine when you are not.

## Empowerment, voice, and choice

*An FEP program reflects empowerment, voice, and choice when the organization fosters a belief in resilience and in the ability of people to heal from trauma and psychosis, builds on the strengths and experiences of clients and staff, and offers opportunities for self-determination and growth.*

Trauma can affect an individual's sense of personal worth, strength, and competence. For people who have experienced trauma and psychosis, the most important message a provider can convey is hope. People can and do gain control over their lives, develop strategies for well-being, and recover from traumatic experiences. Even if a patient has a long history of complex trauma, healing can happen.

Empowerment, voice, and choice are compatible with the CSC focus on strength-based perspectives, resilience, and recovery. These principles can be implemented through person-centered planning, shared decision-making, and other good clinical practices that promote clients' primary role in establishing treatment goals. An integration challenge arises through interaction with other service agencies and sectors that have traditionally lowered expectations for people diagnosed with mental illnesses.

**PRACTICE TIPS**

- Provide information or links to online resources about trauma and resilience.
- Have an open discussion with clients about how to stay in close communication while also respecting boundaries and the need for privacy.
- Use best practices such as person-centered planning and shared decision-making to engage the client in treatment decisions.

## Collaboration and mutuality

*An FEP program reflects collaboration and mutuality when it supports healing relationships through shared decision-making, engaging clients in treatment goals and strategies, ensuring that everyone has a valued role, and supporting collaboration among all levels of staff.*

Traumatic events often elicit feelings of powerlessness by the individual experiencing them. As a result, trauma survivors are often acutely aware of power differences in relationships. Unless you work to level the inherent imbalance between staff and client, you may unintentionally recreate the kind of situation in which abuse occurred. An organizational culture that models collaboration among all levels of staff will likely find it easier to support mutuality between staff and clients.

Collaboration and mutuality are compatible with the CSC model of shared decision-making in treatment planning. An integration challenge can arise in organizations that have a strong hierarchical orientation, as collaboration requires engaging staff as equal partners on treatment teams, sharing information about treatment options with clients, and facilitating client control over treatment goals and decisions.

**PRACTICE TIPS**

- When you meet a new client, ask if they have a preference in how they are addressed.
- Pay attention to power differentials based on race/ethnicity, gender/gender identity, sexual orientation, social class, language and literacy skills, and other aspects of identity that are differentially privileged in society.
- When possible, explore the client's values and preferences about treatment (e.g., whether to target psychosis or trauma symptoms first). Explain your thinking if you need to deviate from their expressed priorities, such as providing psychoeducation before addressing trauma.

## Peer support

*An FEP program reflects peer support by engaging patients in peer-to-peer mutual support activities and peer-led individual or group interventions as key vehicles for establishing safety and hope, building trust, and promoting healing.*

Peers are people with shared experiences, cultures, values, or interests. Peer support works because people who have been through similar challenges can empathize easily. In addition, peers share "experiential knowledge" and provide hope through a positive demonstration of recovery. For trauma survivors who may isolate themselves, have damaged self-concepts, or struggle to move forward in life, peer support can help rebuild self-confidence, make new social connections, and model effective strategies for coping with distress.

Peer support is compatible with the common use of peer and family partners in CSC programs. Successful integration of this principle requires clearly defining the peer role on the CSC team, providing excellent peer supervision by a team leader who understands and values that role, and ensuring that peers are well trained in principles of trauma-informed care.

### PRACTICE TIPS

- Offer evidence-based and evidence-informed peer-led trauma treatment options and recovery supports, such as peer-led Seeking Safety, Wellness Recovery Action Planning for Trauma, and Intentional Peer Support.
- Create opportunities for clients to meet peers, whether clients or peer support workers, either in-person or virtually.
- If your clinic has peer partners, offer training in trauma-informed peer support.[3]

## History, gender, and culture

*An FEP program reflects history, gender, and culture when it incorporates policies and protocols that are responsive to the racial, ethnic, and cultural needs of clients; offers gender-responsive services; leverages the healing value of traditional cultural connections; and addresses historical trauma.*

Incorporating historical, cultural, and gender-based practices in treatment for clients with trauma histories is not just a best practice, it is essential to good care. The neurobiological underpinnings of trauma-related mental health problems may be universal, but cultural, historical, and gender factors affect how a person talks about, relates to, and experiences the difficult events in their lives. As an FEP practitioner, it is important to recognize that cultural factors also may alter a client's response to treatment, to be aware of implicit bias, to practice the skills of cultural humility,[4] and to remain open to partnering with culturally-based healers.

[3] A trauma-informed peer support curriculum and trainer's manual are available from the National Center on Trauma-Informed Care: https://www.nasmhpd.org/sites/default/files/TIPS_CurriculumTrainerManual_03-21-2017.pdf. Several national organizations also offer trauma-informed peer support training.

[4] Tervalon, M. & Murray-Garcia, J. (1998). Cultural humility versus cultural competence: A critical distinction in defining physician training outcomes in multicultural education. *Journal of Health Care for the Poor and Underserved, 9*(2), 117–125.

Addressing history, gender, and culture are compatible with CSC clinical assessment, conceptualization of psychosis, and recognition of the importance of identity issues for transition-age youth. An integration challenge arises when evidence-based treatment models do not address these issues.

**PRACTICE TIPS**

- Don't assume that an event you consider traumatic was experienced that way by your client, or vice versa.
- Ask your clients if there is a cultural or religious support person they would like to have involved in their treatment.
- Be aware of how current political and social events may be triggering for some clients.

## A HEALTHY ORGANIZATIONAL CLIMATE: STAFF SUPPORT, SELF-CARE, AND RESILIENCE

Trauma-informed clinical practice is highly relational. It rests on a foundation of self-reflection, self-care, and compassion for self and others.

Working with FEP clients can be uniquely rewarding, but also demanding. Staff may need to cope with vicarious trauma as well as trauma from their own lives. It is essential when working with clients who have experienced trauma to avoid unintentionally activating traumatic memories in either client or staff. When staff learn to recognize their own triggers, their interactions with other staff and with clients become safer and more healing.

*"You have to create a healthy organizational environment in addition to emphasizing self-care. It doesn't matter how many deep breaths you take if the air is polluted."*

—HEIDI MILLER, MD, FAMILY HEALTH CENTERS OF ST. LOUIS

Many organizations find that trauma-informed training is well-received when it focuses on resilience, acknowledges the primary and secondary traumatic stress staff have experienced, and gives teams an opportunity to discuss and practice trauma-sensitive interactions. It is also important to make sure that opportunities to practice self-care are accessible. Adding or linking to wellness programs such as yoga, mindfulness meditation, and therapeutic massage—and making them available for both staff and clients—can be helpful. Many agencies also integrate communication and wellness techniques into ongoing operations (e.g., opening staff meetings with a "mindfulness minute," breathing exercise, or check-in).

Increasingly, trauma-informed organizations are moving away from the concept of "self-care" to focus on the development of healthy, caring organizational communities. When "self-care" is conceived as an individual activity, it can too easily come to feel like one more burden on staff who already have too much to do and too little time to do it. A trauma-informed organization should be a place where management strives in every way to support staff well-being. An example would be basing the selection of "employees of the month" on exemplary self-care as well as working hard and performing well. Management can work to ensure that pressures to generate revenue do not undermine trauma-

sensitive practices. Trauma-informed organizations are also ready to respond if staff bring up their own trauma histories, offering peer support, warm referral, an Employee Assistance Program (EAP), or other forms of assistance.

Because some FEP staff may initially feel uncomfortable in addressing clients' trauma histories, it is essential to provide ongoing clinical supervision and support. In addition to adequate training, staff benefit from on-site consultation, reflective supervision, and debriefing after difficult conversations. There are many ways to organize and implement these supports, depending on the program's structure and resources. If you already have a clinical supervision model, giving the supervisor additional training may be enough. Some programs have contracted with external experts to be available as needed. Another approach is to establish a learning collaborative where staff can meet regularly with others doing similar work to share and process their experiences.

## TRAUMA INQUIRY AND ASSESSMENT

The period of information gathering that often precedes enrollment in an FEP program provides a unique opportunity to begin trauma inquiry. The person making a referral may have information about potentially relevant traumatic events or circumstances. Interviewing the potential client along with family or significant others may reveal problems with trust or attachment. Meeting with team members allows for observation of the client's reactions to different roles and perspectives.

In many clinical settings, it often is helpful to provide information about the impact of trauma as the first step in trauma inquiry and assessment. However, many individuals experiencing early psychosis will be more focused on their immediate concerns, and they may not be ready for or interested in general information. To facilitate engagement, it is important for FEP providers to inquire and be responsive to the client's understanding of their most pressing needs and treatment goals.

Since FEP clients are typically young, FEP providers need to be aware of their state's mandated reporting requirements[5] and be skillful in identifying and responding with safety precautions to the possibility of ongoing abuse or victimization. It can be helpful to engage other trauma-informed mental health programs to assist with complex family circumstances, including potential ongoing violence or abuse, and multigenerational trauma. Expanding the focus from current to lifetime trauma can be a natural step; training and supervision are helpful in overcoming any reluctance to "re-open old wounds." However, it is important to remember that clients may not volunteer information about traumatic events unless they are encouraged and supported to do so. Every client should be given an explicit opportunity to discuss traumatic experiences.

The basic principles of trauma-informed inquiry and assessment in an FEP program include:

- Whenever possible, build trust before asking about trauma.
- Transparency is essential; if there is a concern about mandated reporting, inform the client about your obligation but try to do so in a way that doesn't discourage them from sharing their distress with you.

[5] Child Welfare Information Gateway. (2016). Mandatory Reporters of Child Abuse and Neglect. Retrieved from https://www.childwelfare.gov/topics/systemwide/laws-policies/statutes/manda/

- Conceptualize assessment as an ongoing process rather than a "one-and-done."
- Discuss why you need to know about their experiences and what you are going to do with the information.
- Respect confidentiality; give the client control over sharing information whenever possible.
- Early in treatment, work with clients to help them safely disclose information necessary for diagnosis and treatment planning.
- Make sure clients have all the supports they need before they reveal details about traumatic experiences.
- Circle back repeatedly to give clients an opportunity to share additional information or new perspectives.
- Validate disclosures and reassure clients that what happened was not their fault.

Mental health programs vary widely in how they implement these principles. For example, some clinics use environmental cues—posters, brochures in the waiting room—to help inform clients about the impact of trauma and to signal that clinic staff are open to talking about trauma and abuse. In other settings, clinicians make this part of their opening discussion with clients. Similarly, the integration of formal screening processes with more informal inquiry often depends on organizational norms and requirements. Some programs choose to screen for traumatic experiences, while others feel that knowing about specific events is less important than identifying clinical consequences of traumatic experiences, such as PTSD. FEP programs need to think through what approaches work best for them and their clients at each stage of treatment.

While little research on trauma screening practices in FEP programs has been conducted, clients in other settings have expressed preferences for culturally-relevant screening tools[6] and, if a screening interview is used, being interviewed by someone who is clinically skilled and comfortable discussing trauma.[7] However trauma inquiry is organized and delivered, specific training and supervision are required to ensure that trauma is assessed in a supportive and effective manner.

Given the age range of FEP clients, more than one tool or inquiry process may be needed to provide developmentally appropriate assessment. Resources are readily available from the National Center for PTSD, the National Child Traumatic Stress Network, and elsewhere. Whichever process you end up using, one of the challenges is to re-open the conversation repeatedly without simply asking the same questions several times. As in all FEP care, strong team collaboration and sharing information (with appropriate client permission or notification) can help different providers be supportive and avoid re-traumatization.

[6] Hiratsuka, V. Y., Moore, L., Dillard, D. A. et al (2016). Development of a screening and brief intervention process for symptoms of psychological trauma among primary care patients of two American Indian and Alaskan native health systems. *Journal of Behavioral Health Services and Research, 44*(2), 224–241.

[7] Goldstein, E., Athale, N., Sciolia, A. F., & Catz, S. L. (2017). Patient preferences for discussing childhood trauma in primary care. *Permanente Journal, 21,* 16–55.

### IMPACT OF TRAUMA AT DIFFERENT AGES

- *Trauma in early childhood* may affect attachment, ability to form trusting relationships, and ability to self-soothe, and may lead to self-destructive behaviors.
- *Trauma in later childhood* may affect emotional regulation, cognitive development, ability to concentrate, ability to track time or stay grounded, or capacity to identify and respond to danger. It may also lead to fear of specific situations or circumstances.
- *Trauma in adolescence* may damage self-concept and social skills, affect capacity to handle criticism, and lead to maladaptive coping such as risky or challenging behaviors or use of substances.
- *Trauma in early adulthood* may interfere with development of intimacy and positive self-image in domains of education, career, and family, reducing the ability to buffer later emotional stress.

## TRAUMA AND THE CLINICAL PROCESS

FEP programs have several advantages in responding to trauma. Due to the clients' young ages, clinicians are often sensitive to the importance of engagement and attuned to developmental issues. The team model used in most FEP programs is particularly well suited to working with trauma-related issues, since trauma is often reflected in all aspects of a person's life. Providing training, coaching, supervision, and support can help FEP providers fully integrate trauma-sensitive practices in the clinical process.

### Engagement strategies

Getting past the stigma of mental illness is critical to engaging a young person having their first encounter with mental health services. Giving clients a chance to talk about "what happened to them" rather than focusing on "what's wrong with them" may be a comfortable way to begin the conversation. However, clients may also have deep shame about traumatic experiences, especially in childhood. It is not uncommon for child abuse survivors to feel that what happened to them was their fault. Engagement strategies that focus on the whole person—not just their diagnosis or their trauma histories—and that prioritize the client's strengths and goals are most likely to be successful.

Because trauma often results from the misuse of power, survivors may distrust anyone seen as holding a position of authority, including providers. Reluctance to engage in treatment may be a way to minimize threat and reduce distress; recognizing it as a coping strategy can help build trust and set the stage for a positive therapeutic relationship.

### Diagnosis and formulation

The impact of trauma varies depending on the developmental stage at which it occurred. Being familiar with the age-specific impacts of trauma (see sidebar) can help clinicians recognize when symptoms or problem behaviors may result from earlier traumatic experiences. Clinicians also need to be able to distinguish the symptoms of post-traumatic stress from the symptoms of psychosis—for example, flashbacks from hallucinations, fear and avoidance from paranoia, and dissociation from delusion. Symptoms of both trauma and psychosis often co-exist in the same individual, and at times, symptoms that are clearly psychotic may reflect trauma-related content. The question of differential diagnosis may be more or less important depending on the diagnostic eligibility criteria of the particular FEP program.

A timeline is one way to gather information that can help with formulation. As traumatic experiences are identified and placed on the timeline, details about the trauma do not need to be elaborated, but the impact on the client and the family system can be explored. While some FEP clinicians suggest that the less intense exposure that occurs while developing the timeline can reduce PTSD in some clients, they also suggest that mechanisms to help clients monitor their own stress levels (such as a "stress thermometer ratings") be introduced to ensure that exposure doesn't create high levels of distress.[8]

## The team approach and family involvement

One of the key premises of trauma-informed care is that "You don't have to be a therapist to be therapeutic." Everyone has a role to play in creating a healing environment, and the multi-disciplinary, multi-element treatment team promoted in the CSC model provides an excellent platform for involvement. In addition to mental health, trauma often affects an individual's family relationships, success in school or work, ability to make and keep friends, and even religious faith. It increases the likelihood of substance abuse, suicide, and disconnection from support systems. CSC team members need to have a thorough knowledge about how client trauma can undermine progress in school, work, and relationships. They also need to be prepared to coach others on how to support client resilience and trauma recovery.

*"The clinical experts surveyed in this study did not rate the use of trauma-focused treatment, or any component intervention including exposure interventions, as inappropriate for individuals with comorbid early psychosis and trauma-related disorders."*

—CRAGIN ET AL, 2017

While a trauma-informed approach provides a unifying framework that is applicable for all team members, it also introduces a set of issues that require support and supervision. Team members need to explore their own experience with primary and secondary trauma, learn to identify when they (and others) are being triggered, and fully embrace an empowering, non-hierarchical, and collaborative team process. Some form of ongoing team supervision is helpful.

FEP providers cannot count on finding trauma-informed community supports for their clients. While the trauma-informed classroom movement is gaining ground, teachers who understand that problems with attention, learning, and classroom behavior may be trauma-related are still in the minority. Few schools—and even fewer workplaces—have policies and procedures to support students or employees with trauma histories. Team members addressing supported employment and education needs can increase the likelihood of client success by helping school and work settings make appropriate accommodations. They also can help clients see the role of traumatic experiences in previous "failures."

Similarly, substance abuse treatment and suicide prevention programs that do not take trauma into account may be unsuccessful or even damaging to clients with trauma histories. Trauma survivors often have impaired capacity to regulate emotional states, and may use drugs, alcohol, or risky behaviors to help manage uncomfortable emotions. Confrontational or abstinence-based treatments that withdraw a successful (albeit unhealthy) coping strategy without first teaching alternatives are unlikely to be successful and may further damage the client's sense of self-efficacy.

Working with families or other support persons also requires a thorough understanding of trauma and comfort in working with these issues. Families are often the primary support system for FEP clients, and for those whose children have experienced trauma, information about how to recognize and respond is essential. While details of trauma may not be shared with all support persons, some mutual understanding should be developed about how trauma has affected the client, how they are coping, and how to provide trauma-informed supports.

[8] Bendall S., Alvarez-Jimenez, M., Killackeya, E., Jackson, H. at al (2015). Trauma-informed psychotherapy for psychosis (TRIPP). Retrieved from http://iepa-vcl.eppic.org.au/content/tripp-trauma-informed-psychotherapy-psychosis

There are also many potential sources of traumatic stress within families. In addition to maltreatment (abuse, neglect, or exposure to substances) young people may experience loss and bereavement, dislocation, premature adult responsibilities such as caretaking, failure to be protected against bullying or victimization, and exposure to domestic violence.[9] Family members may be trauma survivors as well and have many of same issues and risks as the client, or they may be dysregulated and unable to be supportive. Intergenerational trauma is common, and in some cases, potentially traumatic behaviors may be seen as "normal" in the context of family or culture. A strengths-based, trauma-informed approach to families is clearly indicated.

### Treatment planning, safety, and relapse planning

Team treatment planning helps address trauma by integrating different aspects of treatment into a coherent whole, helping to overcome the fragmentation that often results from trauma. The team provides the client with multiple healthy relationships, a key part of recovering from the destructive interpersonal dynamics that often form the core of traumatic experiences. Team-based planning also can be a vehicle to integrate new disclosures about trauma that may occur over time as clients feel safer with providers, and it can open the door to using the client's preferred modes of expression (e.g., music, art, or literature), creating a sense of safety and validation and building the positive collaborative relationship essential to healing the wounds of trauma.[10] Peers play an essential role in team-based planning, often supporting clients in identifying goals and developing crisis plans that reflect the client's own values and preferences.

Hopefully, by the time discharge planning begins, both the client and support persons will be well aware of how trauma affects the client's feelings of safety. They will be able to identify specific environmental cues that can trigger traumatic memories and potentially lead to a relapse, be able to monitor and assess levels of distress, and have well-practiced and effective coping skills. Connections will have been made with trauma-informed peer and professional supports in living, learning, and working environments. The next step is formalizing a transition plan for a new therapist, if that is part of the picture.

## TREATMENT MODELS AND APPROACHES

### Trauma-specific treatment models

Most trauma treatment models have been developed and tested primarily on populations other than those with diagnoses of psychotic disorders. Without evidence of safety and effectiveness, and concerned that processing trauma may trigger worsening of psychosis, many FEP clinicians have been leery of using these treatment models—even with clients with PTSD or known histories of complex trauma. However, three recent reviews have concluded that although the evidence is still somewhat limited, trauma-focused therapies can be both safe and effective for people with psychotic disorders.[11] Evidence is accumulating that cognitive behavioral therapy (CBT), prolonged exposure (PE), and eye movement desensitization and reprocessing (EMDR) can reduce post-traumatic stress symptoms in people with severe mental illnesses, with positive but less consistent effects on psychotic symptoms, affect, and functioning.[12] The inclusion of exposure interventions in treatment protocols appears to contribute to effectiveness.

[9] YoungMinds. (2018). Beyond Adversity: Addressing the mental health needs of young people who face complexity and adversity in their lives. Retrieved from https://youngminds.org.uk/resources/policy/beyond-adversity/

[10] Muenzenmaier, K., Margolis, F., Langdon, G. S., Rhodes, D., Kobayashi, T., & Rifkin, L. (2015). Transcending bias in diagnosis and treatment for women with serious mental illness. *Women and Therapy, 38,* 141.

[11] Keen, N., Hunter, E. C. M., & Peters, E. (2017). Integrated trauma-focused cognitive-behavioral therapy for post-traumatic stress and psychotic symptoms: A case series study using imaginal reprocessing strategies. *Frontiers in Psychiatry 8,* 92.

[12] Swan, S., Keen, N., Reynolds, N., & Onwumere, J. (2017). Psychological interventions for post-traumatic stress symptoms in psychosis: A systematic review of outcomes. *Frontiers in Psychology, 8,* 34.

*"I was a little scared of what it would stir up but I'm happy with the outcome." (Veteran with PTSD after PE)*

—GRUBAUGH ET AL, 2017

One recent study of symptom exacerbation and relief in seven FEP clients with PTSD[13] found that all but one reported feeling distressed as an immediate reaction to talking about trauma, but that all described the intervention as having been beneficial and worthwhile. The authors note that their findings illustrate a "clinical paradox," where talking about trauma can be distressing and even lead to temporary worsening of psychotic symptoms, but ultimately be part of the healing process. This finding supports the focus on developing emotional regulation skills before going too deeply into exposure and suggests that both clinicians and clients be ready to slow down the process and use stress management techniques at any point where exposure becomes too intense. Clients should also be informed ahead of time that the intervention may lead to temporary distress and symptoms as well as relief.

## Clinical practice guidelines

To date, no clinical trials have been conducted on trauma treatment in individuals in the earliest stages of psychosis. While further research is needed, FEP clinicians require immediate guidance on how to work with their clients who have both issues. Recently, an expert consensus process was used to develop clinical practice guidelines on the treatment of comorbid early psychosis and trauma-related disorders.[14] The process was based on a survey of expert clinicians from across the country, and addressed treatment modalities, approaches, interventions, and treatments; clinical context; age and developmental level; barriers; and potential improvements. Items were rated on a scale of 1–9, with items scoring 6.5–9 being named "first-line," 3.5–6.49 "second-line" and 1–3.49 "third-line." Items receiving 50 percent or more ratings of 9 were named "treatments of choice." Overall, trauma-focused treatment was rated as a first-line treatment for clients at all stages of psychosis, including first episode and clinical high risk. For treating trauma symptoms, techniques for managing anxiety or stress and psychoeducation were rated as interventions of choice, with meditation or mindfulness, cognitive restructuring, interpersonal effectiveness, emotion-focused techniques, and case management rated as first-line interventions. For areas in which consensus was reached, preliminary clinical practice guidelines were developed.

## Sequencing and timing

In the expert consensus process cited above, integrated treatment (i.e., the same provider simultaneously treating both psychosis and trauma) was rated as a first-line approach, and sequenced treatment as a second-line approach. Treating only one condition was considered a third-line approach. According to the guidelines, practitioners should:

- Begin by providing psychoeducation about early psychosis and trauma.
- Use anxiety and stress management interventions to help clients develop coping skills to reduce distress.
- Throughout treatment, provide case management to identify and coordinate resources.
- Select from first-line interventions to address residual psychotic and trauma symptoms.

[13] Tong, J., Simpson, K., Alvarez-Jimenez, M., & Bendall, S. (2017). Distress, psychotic symptom exacerbation, and relief in reaction to talking about trauma in the context of beneficial trauma therapy: Perspectives from young people with post-traumatic stress disorder and first episode psychosis. *Behavioral and Cognitive Psychotherapy,* 1–16.

[14] Cragin, C. A., Straus, M. B., Blacker, D., Tully, L. M., & Niendam, T. A. (2017). Early psychosis and trauma-related disorders: Clinical practice guidelines and future directions. *Frontiers in Psychiatry 8,* 33.

A forthcoming book chapter also presents an integrated trauma-psychosis framework as a way to work with both sets of issues in an FEP population.[15] The authors describe how providing psychoeducation about psychosis and trauma can help the client explore how each contributes to current distress. They suggest working on coping skills early in treatment to create a positive experience for clients and to support later exposure to traumatic memories. They also caution that while exposure is a critical aspect of addressing trauma symptoms, psychotic symptoms should be stabilized first. Similarly, a single protocol for integrating cognitive-behavioral approaches for post-traumatic stress and psychotic symptoms was recently tested in a case-series study, with very positive results.[16]

One frequent clinical concern with trauma-specific treatments is that high levels of distress brought on by exposure interventions may lead to premature treatment drop-out. This issue was addressed in a study of prolonged exposure therapy in veterans with psychotic disorders.[17] The authors note that veterans with the highest levels of distress were the most likely to drop out of treatment early, but they dropped out prior to the beginning of trauma exposure. They suggest the use of motivational interviewing or other techniques to increase commitment to treatment and tolerance for distress. They also suggest not avoiding exposure interventions, but instead beginning exposure earlier so that the client can experience symptom relief and remain engaged in treatment.

## Promising new treatment models for addressing trauma in FEP clients

While no clinical trials have yet been conducted of trauma-based treatment for FEP clients, several promising treatment models are under development. Sarah Bendall and associates at the National Centre of Excellence in Youth Mental Health in Melbourne, Australia, have developed and pilot-tested a model called TRIPP (trauma-informed psychotherapy of psychosis). The model incorporates principles of trauma-informed care, operationalizes guidelines for addressing trauma in early psychosis, and provides a flexible intervention strategy reflecting core elements of evidence-based PTSD treatment.[18] Basic components of TRIPP include:

- Engagement that focuses on developing a trusting, collaborative relationship
- Brief screening with in-depth assessment deferred until emotional regulation skills have been assessed and/or developed
- A module on safety concerns, including suicidality, self-harm, and substance abuse as well as development of coping and emotional regulation skills
- Psychoeducation on trauma, carried out concurrently with the safety and timeline modules
- Development of a timeline, which informs formulation and is a less intensive exposure intervention than is common in PTSD treatments

[15] Material in this section is based in part, with permission, from the following publication: Loewy R. L., Niendam T., & Wadell P. (in press). *Assessing and treating trauma in team-based early psychosis care, in Intervening Early in Psychosis: A Team Approach.* Edited by Hardy, K. V., Ballon, J. S., Adelsheim, S., & Noordsy, D. L. Washington, DC, American Psychiatric Publishing.

[16] Keen, N., Hunter, E. C. M., & Peters, E. (2017). Integrated trauma-focused cognitive-behavioral therapy for post-traumatic stress and psychotic symptoms: A case series study using imaginal reprocessing strategies. *Frontiers in Psychiatry, 8,* 92.

[17] Grubaugh, A. L., Veronee, K., Ellis, C., Brown, W., & Knapp, R. G. (2017). Feasibility and efficacy of prolonged exposure for PTSD among individuals with a psychotic spectrum disorder. *Frontiers in Psychology, 8,* 977.

[18] Bendall S., Alvarez-Jimenez, M., Killackeya, E., Jackson, H. at al (2015). Trauma-informed psychotherapy for psychosis (TRIPP). Retrieved from http://iepa-vcl.eppic.org.au/content/tripp-trauma-informed-psychotherapy-psychosis

- Formulation, occurring at the end of timeline development and culminating in a written document given to the client
- A strengths-based approach used throughout the clinical process

A second promising approach to treating trauma-related symptoms in early psychosis is being developed by Tara Niendam and colleagues through the Trauma Adolescence Mental Illness Internship, a collaboration between the Departments of Pediatrics and Psychiatry at UC Davis.[19] Trauma-integrated cognitive behavioral therapy for psychosis (TI-CBTp) draws on three evidence-based trauma treatment models (trauma-focused cognitive behavioral therapy, prolonged exposure therapy, and cognitive processing therapy). TI-CBTp relies heavily on skill-building, uses a combination of imaginal and in vivo exposure, focuses heavily on safety enhancement and relapse management, and provides family or other support persons with a basic understanding of how trauma impacted the client. Basic components of TI-CBTp include:

- Assessment of psychosis, trauma, risk, and culture, including collateral sources of information
- Formulation and treatment planning, including a decision tree to guide the course of treatment
- Psychoeducation designed to clarify and normalize the client and family's response to traumatic experiences
- Skill building, including relaxation skills, affect regulation, and cognitive coping
- Exposure designed to decouple thoughts and memories from negative emotions and to overcome avoidance
- Relapse management planning and enhancing safety in preparation for discharge

## Working with trauma and distressing voices

The relationship between hearing voices and traumatic experiences has often been noted, and theoretical models for understanding this relationship are emerging.[20] Medication remains standard treatment for people who hear voices and also receive a diagnosis of psychosis. However, for many clients, the content of their voices appears to be related to traumatic experiences. In response, clinicians are developing and evaluating ways for working directly with trauma-related voices.[21] There are at least two discrete approaches. The first is based on premises of the cognitive approach to therapy—that trauma can influence core beliefs about oneself, which in turn affect emotions and behaviors. This theoretical approach leads to strategies such as distancing or strongly talking back to the voice. The second approach is based on the commonly observed relationship between hearing voices, traumatic experiences, and dissociation. This approach recommends engaging with the content of the voice to reduce conflict between dissociated parts of the self. Proponents of the Maastricht Approach[22] suggest that voice dialogue work can help to confront and dispel the belief that voices are powerful and need to be feared. While further research is clearly needed, these emerging approaches are examples of creative clinical work currently being done at the intersection of psychosis and trauma.

[19] Folk, J. B., Tully, L. M., Blacker, D. M., Liles, B. D., & Niendam, T. (in preparation) Uncharted waters: Treating trauma symptoms in the context of early psychosis.

[20] Berry, K., Varese, F., & Bucci, S. (2017). Cognitive attachment model of voices: Evidence base and future implications. *Frontiers in Psychiatry 8,* 111.

[21] Steel, C. (2017). Psychological interventions for working with trauma and distressing voices: The future is in the past. *Frontiers in Psychology, 7,* 2035.

[22] Romme, M. & Escher, S. (2000). *Making Sense of Voices.* London: Mind Publications.

### Medication management

Medication guidelines for co-occurring trauma and psychosis have not yet been developed; general psychopharmacological practice is to address each disorder separately.[23] Antipsychotic medications are the treatment of choice for psychosis, and in some studies of PTSD, have reduced intrusive traumatic ideation and hypervigilance.[24, 25] Several selective serotonin reuptake inhibitors have FDA approval for PTSD; other antidepressants have shown efficacy in reducing symptom severity. The benzodiazepines are considered relatively contraindicated because they may worsen PTSD symptoms.[26]

From a trauma-informed perspective, involving clients in decision-making about medications can help establish trust, collaboration, and empowerment. Traumatic events can create a sense of powerlessness, and clients with trauma histories are often particularly sensitive to having control over decisions. Consider using a shared decision-making process, providing options, discussing risks and benefits, and exploring the client's values and preferences concerning medication.[27]

## CONCLUSION

A large percentage of young people in FEP programs have experienced one or more traumatic events and/or severe conditions of adversity. They may have PTSD in addition to a psychotic disorder, or they may engage in trauma-related behaviors such as substance abuse and self-harm. Whether or not they have a diagnosable trauma-related condition, their developmental trajectory will almost certainly have been affected by their experiences. In order to maximize their chances for a full recovery, FEP programs need to become trauma-informed and embrace trauma-specific treatments designed for young clients. A number of creative treatment approaches addressing the intersection of trauma and first episode psychosis are currently being developed and tested. Anecdotal reports and exploratory studies are promising, and more rigorous research is underway.

Developing a trauma-informed organizational culture is a good place to start. Staff need to understand the impact of trauma and consider how it affects their own lives and their own professional practice before they start addressing client trauma. As staff understanding deepens, comfort level with trauma rises. Clinical training and support can help current practice catch up with the need to address the traumatic experiences of clients.

Becoming trauma-informed is a long-term, developmental process, requiring a commitment of both administrative and clinical leadership. However, the payoff for both clients and staff comes in improved staff and client satisfaction and wellness. Templates to help guide trauma-informed organizational change exist, and national research/demonstration projects have explored and evaluated attempts to develop trauma-informed services in primary care, child welfare, education, juvenile justice, cross-sector networks, and other service systems. The task is to apply what we have learned to FEP programs.

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[23] Material in this section is based in part, with permission, from the following publication: Loewy R. L., Niendam T., & Wadell P. (in press). *Assessing and treating trauma in team-based early psychosis care, in Intervening Early in Psychosis: A Team Approach.* Edited by Hardy, K. V., Ballon, J. S., Adelsheim, S., & Noordsy, D. L. Washington, DC, American Psychiatric Publishing.

[24] Ahearn, E. P., Juergens, T., Cordes, T., Becker, T., & Krahn, D. (2011). A review of atypical antipsychotic medications for posttraumatic stress disorder. *International Clinical Psychopharmacology 26*(4), 193–200.

[25] Carey, P., Suliman, S., Ganesan, K., Seedat, S., & Stein, D. J. (2012). Olanzapine monotherapy in posttraumatic stress disorder: Efficacy in a randomized, double-blind, placebo-controlled study. *Human Psychopharmacology, 27*(4), 386–391.

[26] Guina, J., Rossetter, S. R., DeRhodes, B. J., Nahhas, R. W., & Welton, R. S. (2015). Bezodiazepines for PTSD: A systematic review and meta-analysis. *Journal of Psychiatric Practice, 21*(4), 281–303.

[27] For more information about medication management in FEP programs, including specific tools and resources to support shared decision-making, please see *Optimizing Medication Management for Persons Who Experienced a First Episode of Psychosis*, available free online at https://www.nasmhpd.org/sites/default/files/Brochure%20-Optimizing%20Medication%20Management%20for%20Persons%20Who%20Experienced%20a%20First%20Episode%20of%20Psychosis_0.pdf.

## RECOMMENDED CITATION

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