POST-TRAUMATIC STRESS DISORDER AND PSYCHOSIS

Ioanna Katsounari explains the importance of context in diagnosing people who have experienced trauma and who exhibit stress with secondary psychotic features

Abstract

The sociopolitical and historical contexts in which trauma takes place can have a major influence on the expression of post-traumatic stress disorder (PTSD), with or without psychotic features. This article shows that mental health professionals should understand the relationship between contextual factors, trauma and psychosis, particularly in immigrants and asylum seekers who have experienced trauma after torture. In helping such patients, it is important to understand the context of post-traumatic reactions, pre-morbid personality influences, individual strategies for the preservation of dignity and factors in host countries that may increase paranoia among people with PTSD, and to develop psychotherapies that are integrated with social support systems.

Keywords
Paranoia, psychotic symptoms, context, psychotherapy

RECENT RESEARCH has compared the symptoms of post-traumatic stress disorder (PTSD) with those of schizophrenia (Morrison et al 2003, Fleming and Richards 2006). There are similarities between the intrusive thoughts, images, and flashbacks that are commonly associated with PTSD and the hallucinations and delusions associated with psychosis, while the hyperarousal and hypervigilance that are features of PTSD can be compared to psychotic agitation.


It has been shown that features of PTSD and psychosis can exist together as part of a spectrum of experiences related to traumatic events (Morrison et al 2003, Fleming and Richards 2006).

Post-traumatic stress disorder with secondary psychotic features (PTSD-SP) is a syndrome comprising PTSD symptoms followed by psychotic features (Braakman et al 2009).

In people who experience this syndrome, hallucinations and delusions have been reported to follow the presentation of full-blown PTSD. These hallucinations are generally related to traumatic events but are often accompanied by non-trauma related content, while the content of delusions is mainly persecutory and/or paranoid (Hamner et al 2000).

Clinicians do not categorise many of these experiences as genuine delusions and hallucinations so they are more aptly described as ‘psychotic-like’ experiences. Furthermore, most clinicians lack therapeutic success with this complex clinical condition (Hamner 1997, Hamner et al 2000).

Formal thought disorders, such as flights of ideas and loose associations, are reported only rarely (Hamner et al 2000). The intensities of paranoid thinking and agitation are much higher in people who experience PTSD-SP than in those who experience PTSD without psychosis, or in those who experience psychotic disorders without PTSD (Sautter et al 1999). There are no disturbances of affect, however.
In identifying people who are most likely to experience PTSD-SP, ethnicity and cultural background may be important factors. Mueser and Butler (1987) and Wilcox et al. (1991) have noted that, among United States military veterans, those of Hispanic background are most likely to experience PTSD with auditory hallucinations. Meanwhile, in another US-based study, Sautter et al. (1999) found that African Americans are at a higher risk of experiencing PTSD-SP than Americans of other ethnic backgrounds. No diagnostic criteria for PTSD-SP are available, however, so study groups have been heterogenous and comparisons between their members have been difficult.

Trauma and psychosis

Opinions on the relationship between trauma, PTSD and psychosis differ, but there are two main theories: that psychosis can induce trauma and that trauma can induce psychosis. There is also debate about the extent to which psychotic reactions are mediated by environmental, developmental and cognitive factors.

Psychosis inducing trauma

Some researchers have studied the possible traumatic effects of primary psychosis, particularly among people who are admitted to hospital after living with schizophrenia or other psychotic-spectrum disorders for long periods of time, and who subsequently exhibit PTSD-type symptoms. This is because, in people with psychosis, the experience of hospital admission can produce emotional, cognitive and behavioural responses that may meet diagnostic criteria for PTSD (McGorry et al. 1991, Frame and Morrison 2001).

In discussing the relationship between trauma, PTSD and psychosis, Morrison et al. (2003) note that psychotic symptoms are always related to people’s developmental histories, and atypical histories can be explained by past traumas.

Trauma inducing psychosis

The view that trauma can induce psychosis is elicited from reports of symptoms of psychosis among trauma survivors, mainly military veterans, who have been diagnosed with PTSD (Sautter et al. 1999). Meanwhile, research among the general population indicates that trauma in childhood increases the risk of psychotic experiences later in life (Read et al. 2001, Kilcommons et al. 2008).

In the histories of psychotic populations, there is a high incidence of trauma and there are often similarities between the themes of delusions and hallucinations, and the traumatic events experienced before onset (Read et al. 2001, Kilcommons and Morrison 2005). It remains unclear, therefore, whether psychosis in people with PTSD is caused by trauma or is due to underlying psychotic disorders. It is known, however, that the nature and severity of traumatic events is unrelated to the presence...
or absence of psychotic features following PTSD (Braakman et al 2009).

**Other factors** Psychotic reactions to PTSD may also depend on environmental factors, such as culture, immigration experiences, social networks and the availability of mental health services (Wilcox et al 1991, Hamner 1997, Zayfert 2008); developmental factors, such as personality, psychopathology and coping abilities (Steel et al 2005); and cognitive factors, such as thoughts, beliefs and attitudes. Research has yet to address the influence of the wider sociopolitical environment on the development of psychotic reactions, particularly in people who have been persecuted or tortured.

**Meaning and context**
The meanings people derive from traumatic events, and how they respond to them, can depend on the context in which they formed their primary beliefs about life and human relationships.

In a study of severely traumatised Ethiopian immigrants who had immigrated to Israel, Grisaru et al (2003) found that severe stress and trauma can induce a brief, reactive psychosis rather than classical PTSD. However, the authors noted that, in the Ethiopian culture, it is regarded as normal for individuals to exhibit somatic symptoms and dissociative phenomena in the belief that they are possessed by spirits. Thus, Ethiopians with predisposing personality traits might react to stress with culturally accepted exaggerated responses that mirror brief reactive psychosis.

In a study of black South Africans who had been tortured, Kagee and Naidoo (2004) argue that, because of the unique cultural, political, and historical context, the psychological distress experienced by the study’s subjects was probably different from that experienced by people in different contexts. One reason for this may be that, among black South Africans, distress is more intimately tied with perceptions of family, community and societal wellbeing than among many people from other ethnic and cultural backgrounds (Swartz 1998).

Hollander (2008), meanwhile, describes the psychological responses of citizens in Argentina during the ‘dirty war’, between 1976 and 1983, when an authoritarian government used torture in its campaign against people suspected of being subversive. According to the author, the main psychological response of the perpetrators, victims and witnesses of torture is denial.

By disassociating themselves from arbitrary and unjust repression, victims can protect themselves from anxieties that may otherwise overwhelm them. Some citizens disavowed, not only their identities but also their capacities to believe and act on their perceptions of reality. Such profound dissociation can also protect the parts of their personalities that identify with the victims’ ethical values and political beliefs (Hollander, 2008).

Luhrmann (2007) notes that beliefs about the self formed in familial, social and cultural contexts can contribute to paranoid symptoms, particularly following trauma. People who live where freedom of expression, particularly of needs and desires, is restricted can form negative beliefs about themselves and others. Luhrmann (2007) also describes how experiences of chronic humiliation or subordination, an extreme example of which being torture, increases the risk of psychotic symptoms.

Survivors of wars, torture, repression or violence may live constantly in fear and become hypervigilant (Bracken et al 1995, Summerfield 1999, Abrahamian 2008). Such physiological over-arousal can lead to restlessness, paranoid thinking and hypersensitivity to certain sounds, or hyperacusis (Basoglu and Mineka 1992). These signs and symptoms of psychosis are adaptive rather than pathological but in people who experience PTSD, they may persist even when threats have disappeared. They are ways of externalising chronic, internalised threats, but they may reinforce a sense of persecution.

Furthermore, people who have been tortured may develop faulty self-image and social knowledge, and may misinterpret intrusions. These responses can lead to psychotic presentations, including withdrawal (Kilcommons and Morrison 2005). After all, trauma is more likely to disturb personalities that are already premorbid and vulnerable (Steel et al 2005).

A model for the development of post-traumatic stress reactions and psychotic features is shown in Figure 1. It illustrates the unique reactions of people who have experienced torture and other trauma, and the contexts and other pre-disposing factors on which these reactions depend.

**Support structures**

For many people who experience trauma, adaptation and development of secondary reactions depend on the adequacy of social support structures (Williams and Joseph 1999). Thus, social support is an environmental variable that affects the symptoms of PTSD and psychosis, and the search for support in the environment is considered to be an active stress-management strategy.

Support, such as encouraging the disclosure and reappraisal of events, can affect victims’ emotions,
including fear, panic, grief, guilt, and shame, and their coping strategies, including the extent to which they avoid specific thoughts and behaviours.

Immigrants and asylum seekers who have experienced trauma must relocate to different social environments or contexts, and this may involve coping with unknown languages and cultural differences, ambiguous asylum processes, unemployment and a lack of social support. Such relocation can add to their stress, as they must trust other people in a foreign context, and this in turn can make their mental health problems worse (Nicholson and Neufield 1992, Gracie et al 2007).

The symptoms of PTSD are not usually diagnosed as a psychotic reactions because of their transient nature and the lack of clear-cut diagnostic criteria. However, the role of context and other variables can be investigated to ensure that the reactions of people experiencing PTSD are not labelled prematurely as psychotic.

Traditional models of psychopathology, such as those of Bracken et al (1995) and Summerfield (1999), do not take into account the political, social, cultural and individual contexts of people’s reactions to traumatic events, but describe the distress experienced after such events as psychiatric conditions. As a result, researchers and clinicians who use these models risk conveying an expectation of continual psychopathology in the aftermath of events. In their analysis of people who have experienced trauma they may also fail to take into account strategies to preserve personal dignity and factors that increase paranoia.

It is important, therefore, to develop psychotherapies that include social support interventions, particularly for immigrants and asylum seekers who have PTSD. For such people, the host country is the new context for recovery, and the quicker they can socialise normally, the sooner they will become less distressed.

References
