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Editorial
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Trauma in Psychosis: A Diagnostic and Conceptual Exclusion

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Editorial

The lifetime prevalence of psychosis is estimated at 7.49 per 1000 with a high economic burden globally [1,2]. The debilitating effects of psychosis result in cognitive [3] and social [4], deficits which in turn affects occupational and interpersonal functioning. The predominant approach to the treatment of psychosis has remained bio-medical, despite advances in psychotherapeutic sciences and the emphasis on a biopsychosocial approach [5]. However, compliance with antipsychotic medication (APM) is often a challenge among Persons Living with Psychosis (PLP) and relapse rates high (67%) post-discontinuation of treatment [6], indicating that APMs are only part of the solution and often a "band-aid" approach to treatment. This indicates that there is an imperative need to explore the interplay of non-biological factors that perpetuate psychotic manifestations. Since the advent of psychiatry, a critical understanding of the development of mental illnesses has been the notion of stress-vulnerability [7]. Relatedly, the most robust factor associated with psychosis development has been the experience of adverse life events or trauma [8].

This underlying element in psychosis has been known to fuel psychotic manifestations, [9,10] and discontinuation of these events promotes a reduction in PPSX [11]. The relationship has been known to persist even after controlling for other risk factors such as genetics and sociodemographics [12,13]. In fact, many studies have noted underlying factors playing a role in the manifestation of psychosis, beginning with Freud, who identified and argued strongly for unconscious and subconscious mechanisms interplaying in psychosis [14]. This observation has been validated by many modern-day psychoanalysts as well [15]. Other, more pragmatic schools of psychology such as cognitive-behavioral and person-centered, have also identified and placed in evidence the role of underlying psychological processes in the development and maintenance of psychosis. Features such as anxiety, worry [16-19], and depression have been observed to promote and maintain PPSX [20]. Moreover, not only have they argued for an underlying influence of these factors on psychotic illness but have also found that anxiety, depression and psychosis measure a common psychopathological factor labeled 'common mental distress' [21] indicating that they, in fact, they share similar underlying psychological processes. This is further sustained through studies that have found treatment targeting underlying factors in delusions, for example, has led to better recovery trajectories [22,23]. Similarly, adding trauma interventions to care as usual for PLP has shown health and economic benefits [24]. Despite this surmounting evidence Trauma-Focused Interventions (TFI) remain at the periphery of most primary treatment services and treatment services and tertiary services remain are often inaccessible to the population [25,26]. In fact, scientists have observed that persons experiencing psychosis are often excluded from randomized controlled trials as well as from TFI, in the worry that such treatment would exacerbate psychotic symptoms, despite contradictory evidence [27].

Insights from global literature and practitioner views suggest various reasons for this gap: First, trauma itself is often known by its most severe counterpart - Post-Traumatic Stress Disorder (PTSD) and in the quest for obtaining objectivity and precision, the Diagnostic and Statistical Manual (DSM) has since its third version sequentially controlled the criteria for diagnosis, until its 5th version which only notes exposure to 3 types of events as qualifying one for a diagnosis of PTSD. This conceivably excludes a large proportion of the population experiencing symptoms from trauma exposure, such as to adverse life events and stressful events that have been closely linked to various mental health conditions, particularly psychosis and from psychosis itself. Furthermore, criterion D, E, and F in the diagnostic manual would also be observable effects, only if early identification has been possible. In situations where trauma exposure has gone unnoticed or been provided little attention, many individuals may find strategies to manage these themselves, making symptoms less apparent; which

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despite "band-aiding" the wound, continues to impact the psyche and worsens with additive stressors.

Second, Trauma-Related Symptoms (TRS) from ALEs mimic distress, behavioral and emotional problems such as lashing out, irritability, withdrawal, loss of connection, and belongingness which can often be related to behaviors secondary to PPSx. Delineating TRS from those related to PPSx remains a challenge, especially when the practitioner lacks a trauma-focused orientation. It is a well-known fact that as in any medical science, the practitioner's clinical orientation is critical to the treatment a patient receives.

Third, additive stressors play a critical role in precipitating PPSx, with a dose-response-effect relationship between trauma and psychosis [28]. The accurate representation of this information relies on retrospective accounts from PLP which is contingent upon intact cognitive performances. Identifying accurate details in case histories requires detailed attention, which is resource-intensive and may seem like an exhaustive process given the client to practitioner ratio, especially in low resourced settings. Alongside disorganized symptoms of PPSX, this perpetuates the dismissal of the subjective narratives as simply being related to one's idiosyncrasies or delusional thinking.

Lastly, the dramatic manifestation of PPSx often demands precedence over other symptoms and illnesses [29]. A diagnosis of PTSD as comorbid with psychosis spectrum conditions are often provided when symptoms meet the criteria mentioned in diagnostic texts, indicating a severity threshold. However, it must be taken into account that not all trauma exposures lead to PTSD [9], yet have a lasting impact on the psyche of the individual. Therefore effects of trauma exposures may not always be as dramatic as those observed in PTSD and may manifest as loss of trust, anxiety, depression, fear, and other psychological symptoms. Further, a primarily neglected approach to diagnostics in psychiatric sciences, include the lack of observation of cultural influences [30] and subjective notions of trauma appraisal and manifestation, especially since differential stress sensitivities among individuals create differential vulnerabilities [10].

The oversight of ALEs and TFIs in psychosis, at the very least, perpetuates a cycle of lost trust and hope, distress, learned helplessness, and unhealthy coping mechanisms, maintaining the cycle of ALE and psychosis. Various forms of new-age interventions such as Narrative Exposure Therapy (NET) [31] and Cognitive Analytic Therapy (CAT) focus on addressing internalized patterns from these experiences and aid in recovery [32]. While it draws from principles of psychoanalysis, it combines the pragmatic approaches of cognitive, behavioral and humanistic schools, in offering short term, targeted conceptualizations of mental illnesses or psychosis. Trauma-Focused Cognitive Behavior Therapy (TFCBT) and Cognitive Processing Therapy (CPT) have also shown promising results [28].

Delineating psychological trauma, PTSD, and psychosis requires further investigation and innovative research methods that allow for the decolonization of ideas and perspectives. The RDoC approach developed by The National Institute of Mental Health (NIMH) appears to show promise toward this end. By providing a platform for transdiagnostic characterization of symptoms and adopting a dimensional approach to diagnostics, this methodology could prove useful in accounting for variations between psychological trauma and PTSD and the impact each/either has on psychosis. Further research into this avenue - focusing on delineating symptoms of psychosis from trauma as well as building evidence for more inclusive PTSD diagnostic criteria such as the complex PTSD diagnosis in ICD-11 (WHO), is paramount to furthering psychiatry, especially psychosis studies. It is also imperative that policymakers observe these patterns and trends while remaining cognizant of the fact that less than 13% of trauma-related research represents LMICs [1]. Lastly, Research endeavors must challenge the status quo in psychiatry and promote an understanding of the science that caters to all individuals, from varied demographics, cultural backgrounds, and life experiences. Ultimately, it is the unique prerogative to psychiatric sciences to pay attention to individual differences, allowing it to stand-out from other health and medical sciences. Goals of policy makers in psychiatric sciences, therefore, must transcend developing precision at the cost of inclusivity.

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