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Power, Threat, Meaning Framework informed audit: The ubiquitous experience of trauma in adults with psychosis

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In the context of the Power, Threat, Meaning Framework and trauma-informed care, this audit attempted to identify experiences of trauma and adversity for clients on the caseload of an NHS community psychosis team. Histories of trauma were found for every client. The number of trauma experiences ranged from 1–9, giving a mean of 2.7 per client. This confirms clients with psychosis as a highly traumatised group and supports the trauma model of psychosis.

Introduction

THE Power, Threat, Meaning Framework (PTMF) attempts to re-establish the link between trauma and adversity and subsequent experiences of emotional distress, including psychosis (Johnson & Boyle, 2018). The Framework highlights that misuse of power can lead to a range of threats to the person, framing the favoured question of the survivor movement 'what has happened to you?' (Sweeney et al., 2018) as 'how is power operating in your life?'. This reflects a shift from considering psychosis as a biological or neurological disease, to an adaptive reaction to adverse experiences, the best way an individual can cope at the time.

A broad definition of trauma is utilised in this report. Trauma refers to events or circumstances that had a lasting mental, physical, emotional or social impact on the individual. This includes developmental traumas and social

traumas (Sweeney et al., 2016). The PTMF suggests the term 'trauma' can sometimes be misunderstood as isolated and extreme events, rather than recurrent, adverse experiences embedded in people's relationships, lives, and structures of our social world.

Evidence is accumulating to support the trauma model of psychosis, with many researchers now arguing for a causal relationship between trauma and psychosis (Read & Gumley, 2010). One study demonstrated up to 93.8 per cent of those experiencing psychosis had experienced trauma (Kilcommons & Morrison, 2005). A meta-analysis by Varese and colleagues (2012) including 41 studies comprising eight general population surveys, ten prospective, and 18 comparison studies (of people experiencing psychosis with 'non psychiatric' controls), found those who had experienced childhood trauma were 2.8 times more likely to experience psychosis later in life. There is also growing evidence that the relationship has a 'dose-response effect' (e.g. Longden et al., 2016). Janssen and colleagues (2004) conducted a large-scale (N = 4045) prospective study and found participants who had experienced 'moderate' and 'severe' child abuse were 11 and 48 times more likely to have 'pathology level psychosis' (respectively) than those who had not suffered child abuse.

Individuals experiencing psychosis are unlikely to spontaneously disclose their experience of trauma (Read & Fraser, 1998a); hence, clinicians need to be responsible for initiating such conversations. However, staff report anxiety about harming clients and having limited training on how and when to initiate conversations about trauma (Read & Fraser, 1998b). This may explain why two-thirds of clients reported not being asked about their experience of abuse (Read et al., 2007). Without knowledge of trauma history, clients may not be offered the most appropriate treatments (Larkin & Read, 2008). The first two pillars of trauma-informed care are: recognising that trauma is common; and realising the widespread impact of trauma and understanding people's experience and behaviour in the context of coping or survival strategies (SAMHSA, 2014).

In accordance with the PTMF and trauma-informed care, this audit aimed to identify whether experiences of trauma could be established for all clients on the caseload of an NHS community psychosis team. Although this report is not based upon an illness model of psychosis, the team's operational policy determined that the team worked with clients with ICD-10 (World Health Organization, 1993) schizophrenia-spectrum diagnoses and clients with a bipolar disorder diagnosis with experiences of psychosis. The team included a senior clinical psychologist, consultant psychiatrist, community psychiatric nurses (CPNs), social workers and an occupational therapist. CPNs' and social workers' roles were referred to as care-coordinator.

Method

Design and procedure

Approval for the audit was granted by Canterbury Christ Church University and the host NHS Trust. A two-stage process was employed to establish whether clients had experienced trauma. Firstly, individual semi-structured interviews were used to obtain information about every client on each care-coordinator's caseload. The Trauma and Life Events Checklist (TALE: Carr et al., 2018) was used as an aid to prompt care-coordinators' recollection of traumas their clients might have experienced. The semi-structured interview offered the opportunity to be flexible and gather additional information care-coordinators felt relevant. It was hoped individual interviews would create a safer environment to promote honesty and minimise feelings of shame if a client's trauma was unknown. Consent was obtained to participate and audio-record the interviews. Recordings were transcribed by the second author; all names were removed and replaced with codes.

If a trauma history was not identified in this first stage, the second stage reviewed clients' electronic clinical records to identify if trauma had been recorded. Fisher and colleagues (2011) found retrospective accounts of adversity were stable over time and not influenced by current psychosis, with convergent validity

across case-records and self-report measures. As such, electronic records were regarded as an important and valid source of clients' experiences of trauma. All correspondence was searched first, followed by risk assessments and the clinical document repository. Case notes were only reviewed in circumstances where no trauma history had been found in other areas of the clinical record.

Trauma histories were categorised using the TALE and recorded in an anonymised spreadsheet. Where a trauma did not fit easily into the TALE categories, this was noted separately on the spreadsheet. As the audit aimed to support the hypothesis of trauma as causal in the development of psychosis, traumas connected to the experience of psychosis itself were excluded from analysis.

Participants

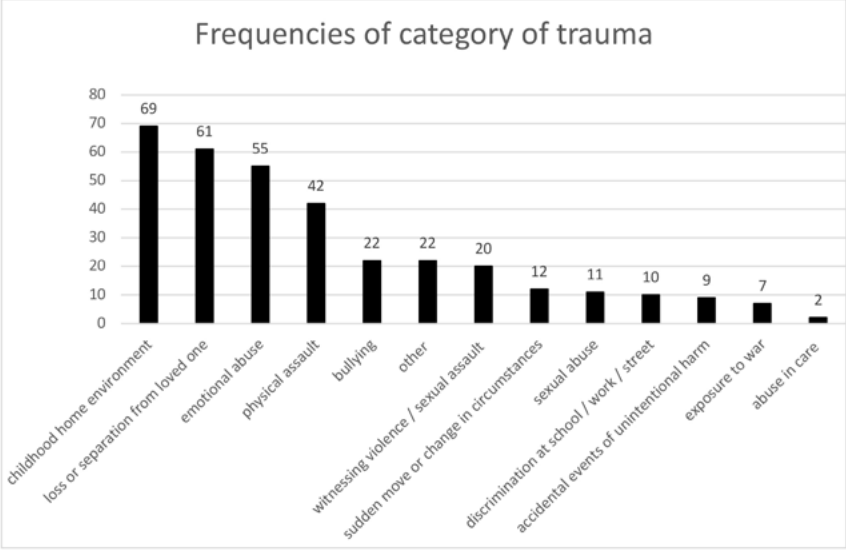
Participants included all seven care-coordinators. This comprised four CPNs, two social workers and one student social worker.

Data analysis

Traumas were grouped into the following categories: childhood home environment (including disrupted attachment, awareness of sexual abuse in the family, going hungry/thirsty, not having clean clothes or a safe place to stay); loss or separation from a loved one (including suicide); emotional abuse (including feeling unsafe, unloved or unimportant); physical assault (including being held at gunpoint); bullying (including harassment at school/work/on the street); witnessing violence or sexual assault; sudden or unexpected move or change in circumstances; sexual abuse; discrimination; accidental events of unintentional harm; exposure to war; and abuse in care. An 'other' category was created to combine low frequency trauma, including gender dysphoria, poverty, homelessness, and non-violent crime. An experience could be counted in multiple categories if applicable, e.g. bullying might also contain physical assault. The type and number of traumas for the caseload were analysed using descriptive statistics.

Results

Experiences of trauma were identified for all 136 clients on the caseload at the time of the audit. These were identified for 80 clients in the audits first stage and 56 in the second stage. Figure 1 displays frequencies of the categories of trauma. The range of experiences of trauma per client was 1 to 9, giving a mean of 2.7 per client.



Discussion

The results from this audit showed it was possible to identify experiences of trauma for all clients on the caseload of an NHS community psychosis team. This gives support to the PTMF and the trauma model of psychosis.

The most commonly identified traumas related to the childhood home environment. This reiterates the importance of a nurturing environment on mental health, and supports research highlighting relationships between childhood maltreatment and adversity and development of psychotic experiences (McGrath et al., 2017). Interestingly, previous research tended to focus on physical and sexual assault (e.g. Kilcommons & Morrison, 2005), which may be why lower rates of trauma were found.

Through the interviews, it became apparent that some care co-ordinators lacked confidence in discussing trauma and feared distressing their clients. These challenges resonate with those reported in the literature regarding trauma conversations, such as anxiety around further harming clients, and how and when to initiate these conversations (Read et al., 2007). It is clear from the current audit that clients had been asked about trauma, and in some cases, this had got lost through time. There were several barriers to identifying trauma in the electronic records, including the considerable number of records to review; disclosures occurring between five and 25 years ago; disclosures having not been adequately recorded in the 'background' or 'history' sections of reports/letters; and not informing care plans. This is consistent with research reporting low levels of 'appropriate action' taken to record disclosures of trauma and provide appropriate support and follow up to clients within mental health services (Read, 2013). A striking number of 'personal history' sections commenced in adulthood or at onset of psychosis. Furthermore, the 'background' and 'history' sections of many letters/reports had been copied and pasted over long periods of time with few or no changes, suggesting that either new information was not being incorporated into these records or clients were not routinely asked about their experiences of trauma, consistent with the literature (Hepworth & McGowan, 2013). The lack of focus on trauma in the electronic notes was striking compared with the recording of forensic history, medications, sections, diagnoses etc. This again highlights the importance of trauma-informed care and changing the frame from 'what's wrong with you?' to 'what's happened to you?'.

Implications and future directions

Given the presence of trauma for people experiencing psychosis, trauma-focused therapies need to be routinely offered to this group, e.g. eye movement desensitisation and reprocessing (Miller, 2015).

Of note is the high rates of trauma related to the childhood home environment. It may be important for clinicians to carefully consider whether, and how, to involve clients' families in their care, given the possibility of trauma, which may have led to the development of psychotic experiences. Open conversations with clients about the involvement of family in their care are warranted.

There is a clear need for NHS Trusts to emphasise the importance of assessing trauma in the development of clients' experience of psychosis. The PTMF guided discussion and template may support such assessment, facilitating understanding of psychosis as an intelligible response to trauma, whist simultaneously avoiding any impetus to diagnose PTSD as co-morbid with psychosis. Standardised location and format for recording trauma histories in the clinical records is also required.

Limitations

Although this audit gives support to the role of trauma in the development of psychosis, the adulthood experiences identified did not necessarily precede the onset of psychosis. Unfortunately, accurate dates for trauma and onset were not available in each clients' records. As such, not all traumas recorded could be implicated in the development of psychosis. Nonetheless, the audit demonstrates this is a highly traumatised group, with

experiences of trauma likely impacting upon their experiences of psychosis.

A limitation of the evaluation is the accuracy of the trauma frequencies and categorisation. There is an element of subjectivity when determining what may be experienced as traumatic when reading from clinical records. Consideration was given to the description of the event, and the impact on the client, when assessing if a situation could be considered traumatic; nonetheless, this could not be considered completely accurate. Reliability could have been increased by using a second coder. Similarly, this evaluation could not claim to have captured every trauma experienced by clients as it relied on information available in the records at the time.

Findings from this audit were generated from one NHS community psychosis team only. Whilst this provides rich data and recommendations for this team, it is not necessarily generalisable to clients living in other areas. Therefore, replicating this audit in other psychosis teams would further strengthen the evidence base.

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