

Assessment and Treatment of Trauma in Early Psychosis

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DISCLOSURE

- All my clothes were made by my son, J. Mueser
- Bespoke Hand Tailored Suits and Shirts, with stores in New York City:



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Overview

- Trauma and PTSD in SMI and FEP
- Trauma of psychosis
- PTSD symptoms and associated problems
- Treatment of PTSD reactions to FEP
- Assessment of other traumatic experiences and PTSD in early psychosis
 - Overlap between PTSD and FEP symptoms
 - Distinguishing between PTSD symptoms and symptoms of psychosis of mania
- Treatment of PTSD in early psychosis using the Cognitive Restructuring (CR) program

Traumatic Event: DSM-5 Definition

An event involving some direct threat of death, severe bodily harm, or psychological injury to the self or another person.

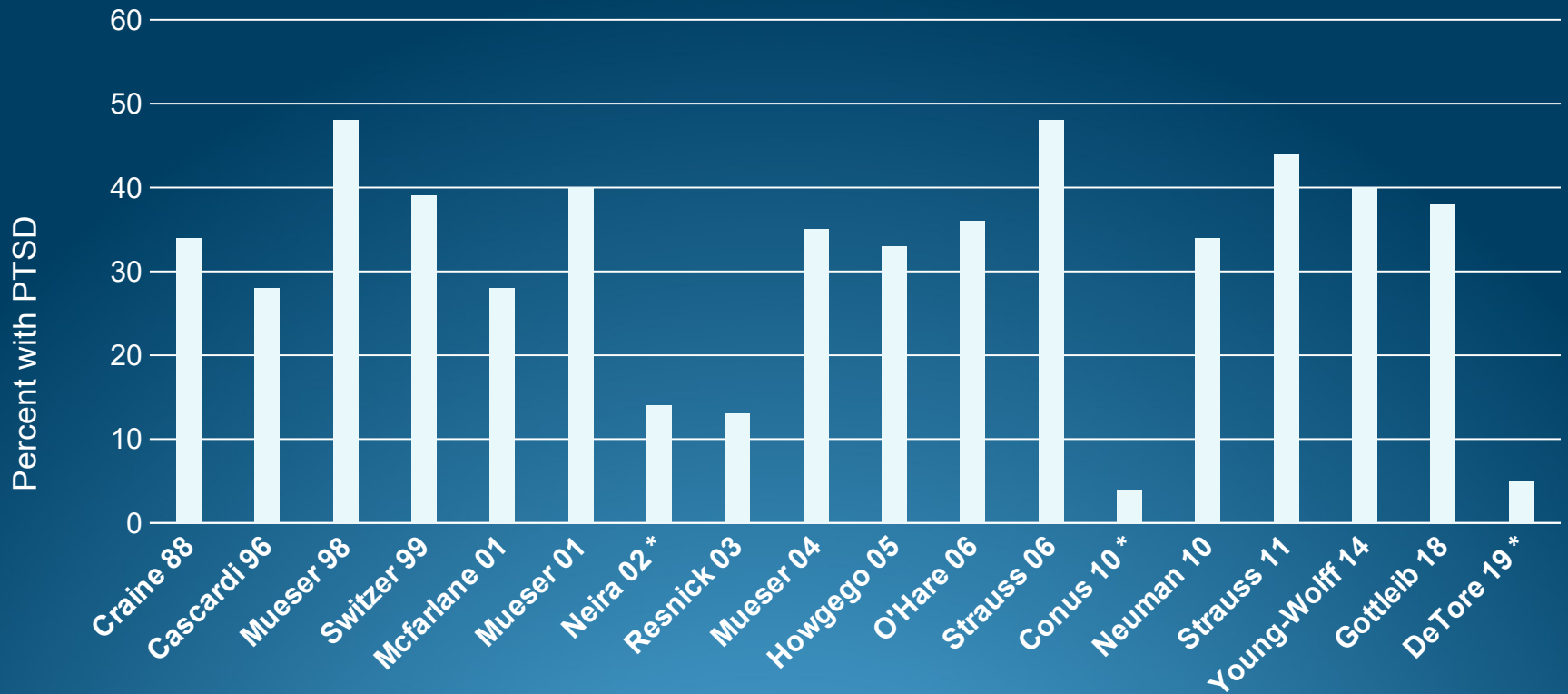
Common Traumatic Events

- Rape/ sexual abuse
- Combat
- Accidents
- Crime/assault
- Natural disasters (e.g., earthquake)
- Sudden, unexpected death of a loved one

Importance of Trauma for FEP and Schizophrenia

- Trauma and other adverse events in childhood increase risk of developing psychosis
- Psychiatric admission for PTSD increases likelihood of subsequent first admission for psychosis
- High rates of trauma in people with psychosis, both before and after onset of psychosis
- Trauma history associated with more severe symptoms and distress
- Psychotic symptoms can occur secondary to PTSD

Rates of PTSD in Persons with SMI (* = FEP)



Trauma of Psychosis

- Experience of psychosis traumatic for client and relatives
- PTSD reactions common to psychotic symptoms and treatment experiences (e.g., involuntary hospitalization, seclusion & restraint)
- 31-46% of FEP clients have “PTSD syndrome” related to their psychotic episode
- PTSD reactions in FEP related to higher levels of distress and worse functioning
- Treatment of psychosis-related PTSD syndrome in FEP may reduce distress and self-stigma beliefs, and improve functioning

DSM-5 Symptoms of PTSD

- Exposure to traumatic event

Symptom criteria:

- Intrusion symptoms (e.g., intrusive memories, flashbacks, nightmares)
- Avoidance of trauma-related stimuli (e.g., avoiding memories, situations related to trauma)
- Over-arousal (e.g., hypervigilance, difficulty sleeping, anger outbursts, exaggerated startle)
- Negative alterations in cognition or mood (e.g., inability to remember parts of event, persistent negative feelings, detachment from others)

Other Common Symptoms Related to PTSD

- Depression
- Suicidality, self-injurious behavior
- Psychotic symptoms
 - Hallucinations
 - Mild delusions (e.g., paranoia)
- Substance use problems

Treatment of PTSD Reactions to FEP

- PTSD symptoms due to psychotic symptoms and treatment experiences common in people with FEP
- Clients also report experience of being labeled/diagnosed with mental illness and exposure to people with serious mental illness is upsetting, confusing, and traumatizing
- “Processing the Psychotic Episode” module of IRT (#6 Standard modules) designed to reduce post-traumatic reactions to experiencing an FEP
- Usually provided within first 3-6 months of engagement in program
- Generally requires 4-8 sessions to complete
- Recommended for all clients, not only for those with PTSD symptoms

Processing the Psychotic Episode

2 different sections:

1. Telling your story

- Exploring upsetting aspects of psychotic episode
- Review how telling story could be helpful with example
- Work together to develop client's cohesive narrative

2. Challenging self-defeating thoughts and beliefs

- Rationale for cognitive restructuring to identify and modify self-stigmatizing beliefs
- Practice cognitive restructuring to address self-defeating thoughts

Processing the Psychotic Episode, cont'd

- Prior to beginning module assessments conducted to evaluate distressing symptoms and beliefs related to FEP
- These measures are used to track changes in distressing PTSD symptoms related to FEP and self-stigmatizing beliefs
 - The Post-Psychotic Episode Symptom Checklist (PPESC)
 - The Self-Stigmatizing Beliefs Checklist (SSBC)

#1: Telling Your Story-A Step by Step Guide (starting on p. 297)

1. Normalize and empathize with any client reluctance to discuss psychotic episode
2. Describe benefits to processing the psychotic episode
3. Review checklists of upsetting psychotic symptoms and treatment experiences (pp. 294-296)
4. Review example of first-person account of psychotic episode (Michael's) story (starting on p. 297)
5. Help client tell his or her own story
6. Use frequent check-ins to assess anxiety and distressing feelings and provide positive reinforcement and feedback

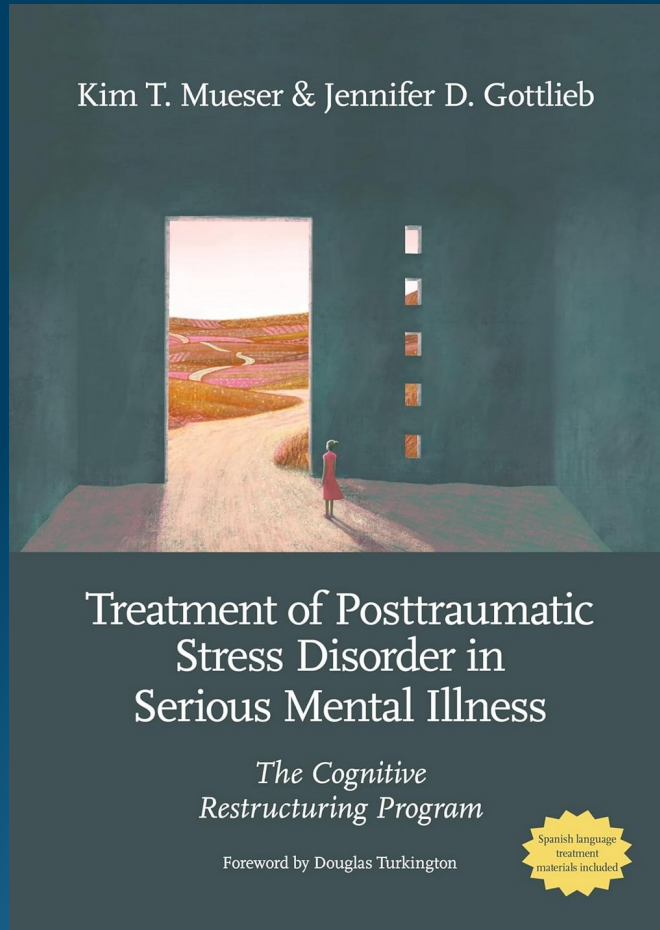
[More detailed guidance provided in IRT manual]

#2: Challenging Self-Defeating Thoughts and Beliefs

1. Review purpose and rationale for topic
2. Assess self-stigmatizing beliefs
3. Provide introduction to cognitive restructuring
4. Teach 6-step process of cognitive restructuring
5. Practice cognitive restructuring in session and at home
6. Re-administer SSBC and PPESC

[More detailed guidance provided in IRT manual]

Recently Published



*Treatment of
Posttraumatic Stress
Disorder in Serious
Mental Illness: The
Cognitive Restructuring
Program. American
Psychological
Association, 2025*

Distinguishing Psychotic Symptoms from PTSD Symptoms

- Psychotic symptoms
 - Hallucinations
 - Delusions
- Negative symptoms
- Manic or hypomanic symptoms

Hallucinations vs. Intrusive Memories in PTSD

- *Intrusive memories*: memories of traumatic event repeatedly and unexpectedly pop in person's mind, causing distress without altering awareness of their surroundings
- *Hallucinations*: sensory perceptions of the external world (usually visual or auditory) of stimuli that are not present
- *Hallucinations* can also be *intrusive memories* if they are clearly related to traumatic events (e.g., wounded soldier hear voices of fallen comrades calling to him)
- If hallucinations not clearly related to trauma, they are just hallucinations
- If intrusive memories of trauma are only experienced in person's mind but not perceived in outside world, they are just intrusive memories

Hallucinations vs. Flashbacks in PTSD

- *Flashbacks*: a momentary re-experiencing of traumatic event when person is transported back to time of event and (usually briefly) loses touch with current reality (date, time, location)
- *Flashbacks* are a dissociative symptom and are much less common than *intrusive memories*
- *Hallucinations*: sensory perceptions (usually visual or auditory) of stimuli in the external world that are not present
- *Hallucinations* are usually experienced with loss of contact with current situation
- If flashback is confirmed (person transported back to traumatic situation), probably not a hallucination
- If hallucination is related to traumatic event but not involve loss of contact with current reality, it may also be an intrusive memory

Distinguishing Valid vs. Delusional Memories of Traumatic Events

- Memories of traumatic events are usually valid, but sometimes people:
 - have *delusional memories of traumatic events* that did not occur and should *not* be treated for PTSD
 - have *delusional elaborations* about actual traumatic events that occurred and *should* be treated PTSD
- Characteristics of delusions of traumatic events:
 - Extreme reports of severe trauma with multiple perpetrators
 - Reports of bizarre traumatic experiences (e.g., Satanic ritual child abuse, alien abductions)
 - Lack verification of severe abuse or are contradicted by other evidence
 - High client motivation to uncover more lost memories of traumatic events
- Some individuals have experienced traumatic events (e.g., childhood physical abuse and neglect) which form the basis for delusional elaborations (e.g., being forced by drug lords to fly a helicopter at gunpoint)
 - Can be treated for PTSD
 - Primary focus on actual traumatic events experienced

Avoidance of Trauma-Related Stimuli vs. Negative Symptoms

- Common *negative symptoms*
 - *Apathy*: lack of motivation and reduced effort to pursue personal goals or change one's current life
 - *Avolition*: Difficulty initiating and sustaining behaviors necessary for improving functioning
- *Avoidance of trauma-related stimuli* in PTSD
 - Efforts to avoid distressing situations, thoughts, feelings, etc. that remind person of traumatic event
- *Negative symptoms* may appear to overlap with *Avoidance* symptoms
 - Both result in social withdrawal and reduced engagement in work, school, leisure, and other activities
- Anxiety is key distinction between negative and avoidance symptoms:
 - *Avoidance symptoms* in PTSD are driven by anxiety associated with trauma-related stimuli
 - The *negative symptoms* of apathy and avolition occur due to low motivation, not anxiety

Manic Symptoms vs. Over-arousal Symptoms in PTSD

- *Decreased need for sleep* in mania may be confused with *difficulty sleeping* in PTSD (an overarousal symptom)
 - Key distinction is person's affective stance regarding sleep disturbance
 - In mania, people have reduced *need* for sleep (e.g., only 2-3 hours/night); they feel fully awake and refreshed after just a few hours of sleep
 - In PTSD, people have *difficulty* falling and staying asleep, *despite wanting to sleep*; they feel groggy, tired, and distressed after trying to sleep
- *Anger outbursts* in PTSD overlap with *irritability* in mania
 - Differential diagnosis between mania and PTSD based on other symptoms
 - If other symptoms of mania are present (e.g., *grandiosity, increased self-esteem, decreased need for sleep, pressured speech*), diagnosis = manic episode
 - If other PTSD symptoms are present (e.g., *intrusive memories, avoidance of trauma-related stimuli, exaggerated startle response*), diagnosis = PTSD
 - PTSD in bipolar disorder less likely to be present during manic episodes than in depressive episodes or when mood is stable

Misdiagnosis of PTSD as Schizophrenia

- *Hallucinations, delusions, and bizarre behavior* can all occur in severe PTSD in the absence of other disorders
 - Can lead to misdiagnosis of schizophrenia when PTSD is proper diagnosis
 - Clients with PTSD symptoms avoid talking about their traumas, so if not asked by clinicians their symptoms may be attributed to another disorder
- Need to systematically screen *all* clients with FEP for PTSD
- If person has many PTSD symptoms, but few schizophrenia symptoms (e.g., negative symptoms, impaired functioning), they may have only PTSD; their psychotic symptoms may improve with treatment
- If person has many PTSD symptoms *and* schizophrenia symptoms, they may have both disorders

Misdiagnosis of PTSD as Bipolar Disorder

- Major depression is most common comorbid disorder with PTSD
- People with PTSD often seek treatment for depression without revealing their trauma history, and are prescribed antidepressant medications
- Antidepressants can precipitate mania both in individuals with bipolar disorder AND those with no history of bipolar disorder (called the “switch process”), sometimes resulting in hospitalization
 - Mania precipitated by antidepressants indistinguishable from manic episode of bipolar disorder, BUT cannot be diagnosed as bipolar disorder UNLESS:
 - Antidepressant is discontinued and manic symptoms persist (> 1 week)
- After stopping antidepressant, if PTSD is not assessed some PTSD symptoms can mistaken for manic symptoms (e.g., sleep difficulties, anger and irritability), leading to misdiagnosis of bipolar disorder
 - Underscores importance of routine screening for PTSD in all clients with SMI

Assessment of Other Traumas and PTSD Not Due to Psychotic Episode

- No “typical” client with SMI & PTSD
- Screening recommended for all clients, but especially if known to have trauma history (e.g., childhood sexual assault)
- Conduct screening after completing “Processing the Psychotic Episode” Module
- Brief trauma and PTSD screening measures valid in clients with SMI
- Measures can be administered by self-report or interview
- Prepare client by explaining you will ask about some difficult experiences he/she may have had in the past
- Be matter-of-fact and use behaviorally specific language
- Avoid “loaded” words such as “abuse” or “rape” unless client uses them

Stressful Events Screening Questionnaire (SESQ)

- Page 98 in NAVIGATE IRT manual
- 16 questions
- Sexual abuse/assault, physical abuse/assault, witnessing violence, accidents, combat and unexpected death of a loved one
- Identify traumatic event(s) *currently* most distressing to client

Difficult Life Events Inventory (DLEI; Mueser & Gottlieb, 2025)

- Pages 58-59, Exhibit 3.2 in Mueser & Gottlieb, *Treatment of PTSD in SMI: The Cognitive Restructuring Program* book
- 18 questions
- Similar items covered as Stressful Events Inventory
- Identify traumatic event(s) *currently* most distressing to client

PTSD Checklist (PCL-5)

- 20 item self report rating scale, with items corresponding to PTSD symptoms (in IRT manual)
- Ratings linked to most distressing event(s) identified in SE
- Clients rate how much they have been bothered by each symptom in the past month on an anchored 5-point scale
- Total PCL scores over 45 indicate probable PTSD
- The PCL has good reliability with structured interviews for PTSD, such as the Clinician Administered PTSD Scale, including in people with FEP and SMI
- PCL can also be used to monitor effects of treatment for PTSD

Verifying PTSD Diagnosis

- PCL indicates person probably has PTSD
- If high PCL score, clinician should spend a few minutes reviewing with client most distressful event experienced, and most distressing symptoms
- Clinician should have some understanding of what happened to person as most distressing event
 - For some types of trauma there may be multiple distressing events linked to PTSD (e.g., childhood physical or sexual abuse) with upsetting memories associated with them
 - Brief probing needed to get at least some understanding of nature of some of the traumatic event(s) experienced (intrusive and upsetting memories of event is strongest PTSD symptom linked to event)
- At least 1 clear memory of traumatic event needed to treat PTSD
- Clinician can't treat PTSD if they don't understand nature of traumatic event
- Account of traumatic event needs to be plausible to clinician

Psychotic Distortions vs. Delusional or Recovered Memories

- Sometimes plausible account of traumatic event is combined with or complicated by delusional elaboration related to event:
 - Woman with schizoaffective disorder reported multiple instances of physical abuse and neglect from parents who had drug problems (appeared plausible based on account and available history)
 - Woman also reported she was kidnapped as teenager by drug dealers who forced her to fly helicopter at gunpoint doing drug deals (implausible)
- In these situations, recommendation is to confirm PTSD diagnosis and proceed with treatment
- When working on PTSD, primary focus is on plausible part of event, with less attention to delusional elaboration

Psychotic Distortions vs. Delusional or Recovered Memories, cont'd

- Sometimes account of traumatic event is less plausible, or appears patently delusional, such as accounts of:
 - Ritual Satanic abuse
 - Alien abduction
 - Delusions of control by others
 - Extreme reports of sexual abuse with multiple perpetrators occurring over extended periods of time
- When traumatic event appears implausible, explore whether any other traumatic events were reported on SESQ (esp. childhood sexual abuse); if so re-assess PTSD symptoms with PCL
- If no other traumatic events identified, or events don't meet PCL severity criteria, **DO NOT TREAT PTSD** related to delusional event (it may worsen symptoms)
- Steer conversation away to more practical concerns (functioning, goals)

Cognitive Restructuring (CR) Program for PTSD in SMI (Mueser & Gottlieb, 2025)

- Core ingredients of CR program described in NAVIGATE IRT manual
- Full CR for PTSD program described in recently published book (Mueser & Gottlieb, 2025)
- CR program empirically supported by RCTs
- 6-16 sessions usually needed to treat PTSD in early psychosis clients
- Core ingredients of program:
 - Monitoring PTSD & depression over time
 - Breathing retraining
 - Psychoeducation about trauma and PTSD
 - Cognitive restructuring

Routine Monitoring of Symptoms During Treatment

- PTSD and depression monitored every 3 sessions with PCL (linked to index trauma) and BDI-2 (e.g., session 1, 4, 7, etc.)
- Give at beginning of session
- Score immediately and discuss any changes with client
- Explore possible factors contributing to improvement
- Normalize and reframe lack of change early in treatment

Breathing Retraining

- Routinely taught in IRT
- Strategy for managing anxiety
- Reduces over-arousal symptoms of PTSD
- Needs to be practiced daily when person is *not* highly stressed in order to master skill

Psychoeducation About Trauma and PTSD (2-3 sessions)

- Information taught in interactive fashion about PTSD symptoms and related problems
- Handouts and worksheets used
- Lets person know “They are not alone”
- Explains PTSD is not their fault or sign of weakness
- Recommended resource for PTSD handouts (in online appendix):
 - Hamblen, J. L., & Mueser, K. T. (2021). *Treatment for Postdisaster Distress: A Transdiagnostic Approach*. Washington, DC: American Psychological Association

Cognitive Restructuring (CR) (4-8 sessions)

- Based on Ehler and Clark's cognitive model of PTSD
- Targets trauma-related thoughts and beliefs underlying PTSD symptoms:
 - "The world is an unsafe place"
 - "You can't trust anyone"
 - "I have no future"
- CR taught using the "5 Steps of CR" in IRT Dealing with Negative Feelings module
- 5 Steps of CR taught as a skill for dealing with any (everyday) negative feelings
- As person's skill using the 5 Steps of CR grows, focus of CR shifts to addressing trauma-related thoughts and beliefs

5 STEPS OF COGNITIVE RESTRUCTURING

1. Situation

Ask yourself, "What happened that made me upset?" Write down a brief description of the situation.

2. Feeling

Circle your strongest feeling:

Fear/Anxiety

Sadness/Depression

Guilt/Shame

Anger

3. Thought

Ask yourself, "What am I thinking that is leading me to feel this way?" Write down your thoughts below:

Is this thought a Common Style of Thinking?

- All-or-Nothing Over-Generalizing
- Catastrophizing Emotional Reasoning
- Self-Blame Mental Filter

If yes, circle the one:

Must/Should/Never

Overestimation of Risk

4. Evaluate Your Thought:

Now ask yourself, "What evidence do I have for this thought?" Write down the answers that do support your thought and the answers that do not support your thought.

Things that DO support my thought:

Things that DO NOT support my thought:

5. Take Action!

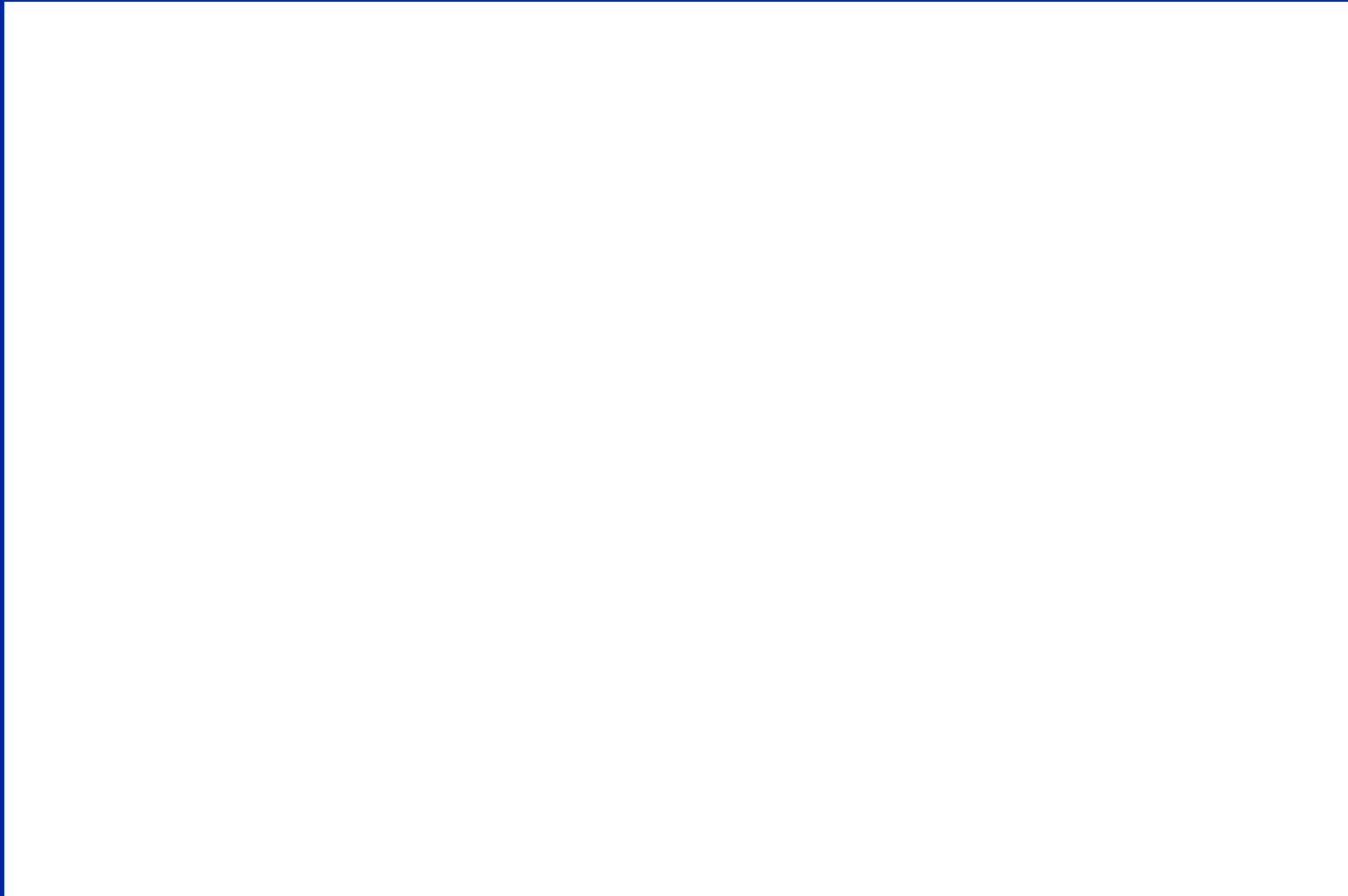
Next, ask yourself, "Do things mostly support my thought or do things mostly NOT support my thought?"

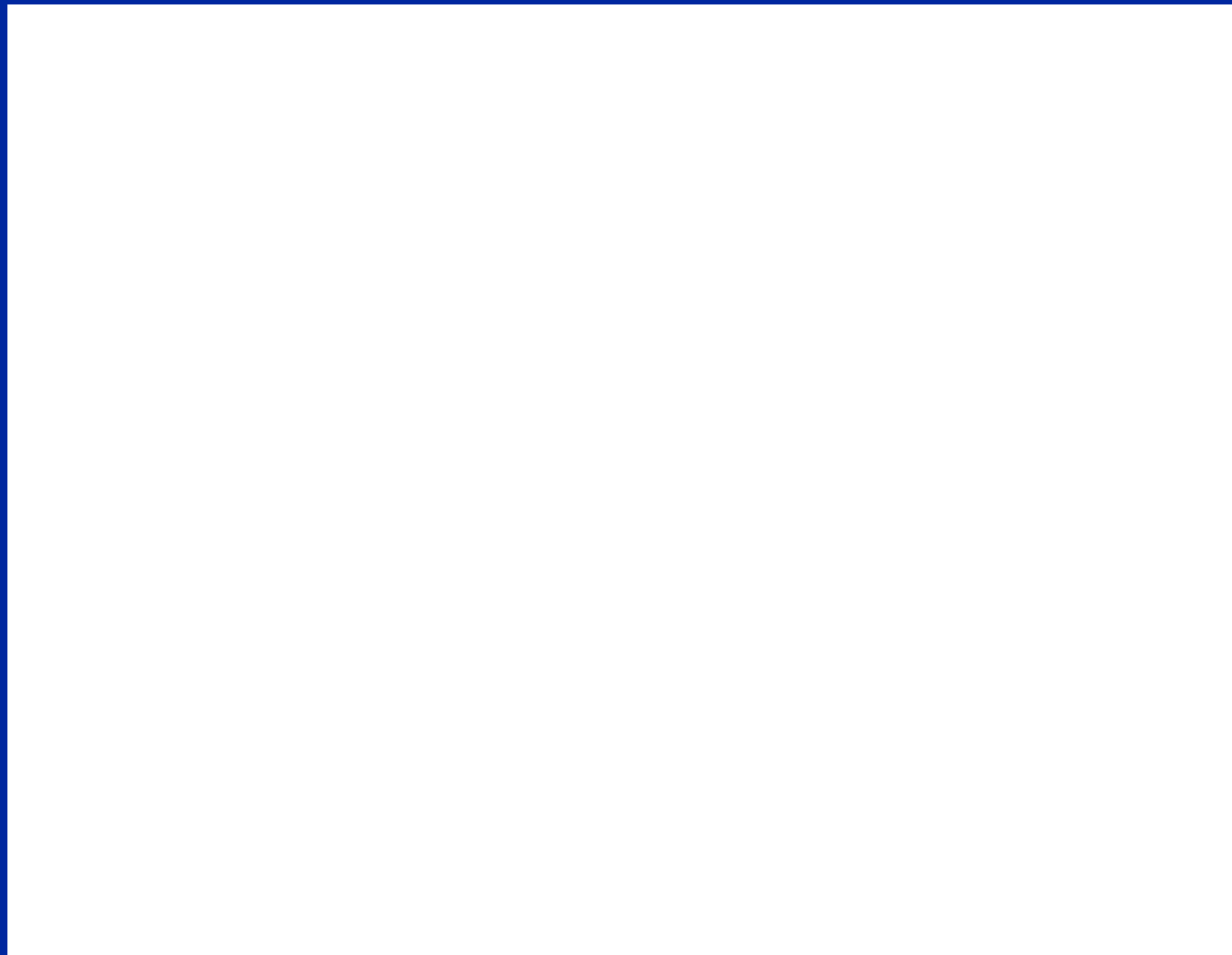
NO, the evidence does *not* support my thought. Come up with a new thought that is supported by the evidence.

New Thought _____

YES, the evidence *does* support my thought. Decide what you need to do next in order to deal with the situation. Write down your Action Plan for dealing with the upsetting situation:









Next, ask yourself, “Do things mostly support my thought or do things mostly NOT support my thought?” Look at all the things that support your thought and balance that against all the things that do not support your thought. Check below whether your thought is supported by the evidence or not.

NO, my thought is NOT supported by the evidence.

YES, my thought IS supported by the evidence.



Steps of an Action Plan

1. Define the goal
2. Brainstorm possible strategies
3. Plan how to put the best strategy into practice
4. Set a time of situation to follow up on your plan

Common Situations Calling for Action Plans

- Developing plans to deal with new, realistic concerns instead of avoiding them as before (e.g., health problem, early signs of abuse in a new relationship)
- Identifying and implementing coping strategies for PTSD symptoms that interfere with daily life and personal goals (e.g., intrusive memories, avoidance of important activities, sleep difficulties)
- Making a plan to remember a new, more accurate thought when the old trauma-related thought keeps coming up
- Making a plan to practice using the 5 Steps of CR in distressing situations between therapy sessions

Getting at Trauma-related Thoughts and Beliefs

- Negative feelings stemming from trauma often occur naturally, presenting opportunities to examine with the 5 Steps of CR (sometimes from beginning of treatment)
- Routine monitoring of PTSD symptoms with PCL can identify distressing symptoms, which can then be addressed with the 5 Steps CR, such as:
 - Repeated experiencing of intrusive and distressing memories of traumatic event
 - Avoidance of situations or people that remind person of traumatic event

Getting at Trauma-related Thoughts and Beliefs, cont'd

- Ask directly if thought may be trauma-related
- Mention commonly heard theme (“I’m to blame”) or scenario (fear of shopping; being afraid of men in public) and ask about connection to trauma (mugging; sexual abuse)
- Address trauma-related thoughts from psychoeducation worksheet, “How Trauma Affects Our Thoughts and Feelings” (in Hamblen & Mueser book)
- Use Posttraumatic Cognitions Inventory (PTCI; Foa et al., 1999) to identify trauma-related thoughts

Honing in on Trauma-related Thoughts, cont'd

Downward Arrow approach: Ask questions about upsetting thought to explore even more upsetting (trauma-related) underlying thoughts

C: “The clerk yesterday at the store looked at me like he was going to try to assault me after I left.”

T: “If that’s true, what does that say about you that that would possibly happen?”

C: “That he somehow could peg me as someone who was weak or can be taken advantage of.”

T: “And if that’s the case, what might that say about you?”

C: “Well, that people just know....”

T: “That people know what?”

C: “That, that everyone knows I’m totally worthless because my dad beat me up all the time.”

Working with Trauma-related Thoughts and Beliefs

- Make general trauma-related thoughts more explicit by linking them to traumatic event:
 - “I’m shameful” because: I didn’t tell anyone about the sexual abuse & should have / I didn’t stop it & could have / I felt some sexual feelings which means I’m bad or not normal”
 - “Because I was physically abused by my parents and boyfriend, nobody can’t be trusted”
 - “I have to be on guard all the time because because I was abused as a child & have been assaulted as an adult”

Working with Trauma-related Thoughts, cont'd

- When evaluating evidence, understand nature of traumatic experience(s) that give rise to upsetting thought or belief
- Prompt client to consider what is similar vs. different in their lives from when trauma(s) occurred and now
- Look for exceptions to absolutist beliefs, however minor (e.g., one person who could be trusted)
- Focus on gradually weakening core/trauma-related beliefs by review of evidence (e.g., “Is thought completely true?”) and making minor changes in thought rather than major changes that require entire rejection of thought
- Always check to make sure changes in thought/belief are accompanied by some reduction in distress
- Consider using ratings of belief and distress (e.g., 0-100 scale) to highlight small changes following CR

Summary

- Trauma and PTSD are common in clients with FEP
- People with FEP also often have posttraumatic reactions to psychotic symptoms and coercive treatment experiences
- Standardized treatment exists in NAVIGATE IRT program for helping people with FEP process the psychotic episode, overcome their traumatic experience, and challenge self-stigmatizing beliefs (“Processing the Psychotic Episode” module)
- Brief guidelines also provided in IRT for assessing and trauma and PTSD due to other lifetime traumatic events (e.g., physical and sexual abuse/assault, sudden unexpected death of loved one)
- Full treatment program for PTSD in people with SMI (including early psychosis) provided in new book: Treatment of PTSD in SMI: The CR Program (Mueser & Gottlieb, 2025)
- Components of CR program include: Breathing Retraining, Psychoeducation about PTSD, and Cognitive Restructuring