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EARLY TRAUMA, PSYCHOSIS, AND VIOLENT OFFENDING

Claire Moore and Naomi Callender

though this is madness, yet there is a method in't

Shakespeare, Hamlet

Psychosis tends to be an experience that socially isolates the sufferer and generates fear and distance in others. This is likely intensified when this presentation is combined with offending. In this chapter, we aim to explore the role of trauma and the concept of meaning in these experiences. A brief review of relevant literature will be considered before sharing an insight into two patients’ journey from trauma to psychosis and violent offending.

Several terms will be used interchangeably within this chapter to describe the same presenting problems. This reflects a split in the literature between the use of diagnostic and non-diagnostic descriptors. The word psychosis is used to define a range of symptoms. These are characterised by altered perceptual disturbance, such as delusional or overvalued beliefs; sensory experiences that others are not experiencing, often described as hallucinations; disorganised speech and a loss of characteristics, such as emotional connection either with oneself or others, lack of drive/motivation and social withdrawal. An aim in this chapter is to outline the importance of incorporating a psychological understanding of psychosis within the literature and clinical practice.

The Presence of Trauma in Psychosis

Until relatively recently, psychosis has been conceptualised through a medical lens as a neurodevelopmental disorder, historically described as a “brain disease”. Therefore, pharmacological interventions have been viewed as the primary and most effective option. The relationship between childhood trauma and psychotic disorders has long been neglected (Read & Bentall, 2012), though there is a growing evidence for such a relationship. Additionally, research and clinical evidence highlight that those
suffering from psychotic experiences have an increased vulnerability for developing Post-Traumatic Stress Disorder (PTSD) from the psychotic experience and associated treatment such as involuntary detention, forced administration of medication, restraint and physical restrictions.

Green, Browne, and Chou (2017) conducted a systematic review and meta-analysis of the relationship between childhood abuse, psychosis, and violent offending. They concluded that individuals experiencing childhood adversity are more likely to develop psychosis in adulthood. Turner et al. (2020) explored the relationship between childhood adversity and psychosis, considering sexual, physical, emotional abuse, neglect, and interpersonal loss. Four in five of those individuals living with psychosis reported experiencing such an event. Bebbington and Freeman (2017) noted that disorders associated with delusional systems consistently occur in the context of a history of trauma. A Scottish census survey of forensic inpatients similarly supported this association (Karatzias et al., 2019). The majority (86%) of the patients included had been diagnosed with a psychotic disorder and childhood adversity was prevalent (79%), with physical abuse as the most reported experience (42%). McKenna, Jackson, and Browne (2019) explored the prevalence of childhood trauma in a UK high secure male forensic population. All 194 patients had been exposed to a traumatic event and 75% of these occurred in childhood, with 65% of individuals having experienced more than one type of trauma.

Within the Mental Health Service at Rampton, patients have attracted a range of psychiatric diagnoses, primarily paranoid schizophrenia (75%). Comorbid personality disorder is identified as present in 24%, 6% schizoaffective disorder, 2% delusional disorder, and 1% bipolar disorder. Only 2% have a diagnosis of PTSD or Complex PTSD (CPTSD). However, the prevalence of traumatic experience within this population is high. We found that, despite the low incidence of trauma-related diagnoses, 92% of our patients had experienced trauma throughout their lifetime, with 84% experiencing emotional, physical, and/or sexual abuse during childhood, 28% feeling traumatised by their offending, and 51% traumatised by the experience of psychosis itself and associated treatment.

Concerningly, only 4% had received treatment for trauma. The lack of acknowledgement regarding the experience of trauma in our patient group, and/or its relevance to diagnosis and treatment, could be partly explained, by an under-reporting of trauma. This is an essential component in the diagnostic criteria of PTSD. Therefore, mental images of sexual violence in an individual with disclosed sexual abuse might be conceptualised as flashbacks in an individual diagnosed with PTSD, but are more likely to be perceived as psychosis in an individual with an undisclosed sexual abuse history.

Another factor contributing to the lack of trauma treatment in this population may be the belief that psychotic and delusional experience do not inform or provide understanding of the internal world of the sufferer. That approach means that there is no relevance to their experience, thoughts, and/or feelings. We do not ask them what happened to them, we just accept that there is “something wrong with them”. Nonetheless, there is growing evidence of the importance of understanding and formulating the function of psychosis (Andrew, Gray, & Snowden, 2008; British Psychological Society, 2013; Corstens, Longden, McCarty-Jones, Waddingham, & Thomas, 2014; Read & Bentall 2012).
Links Between Trauma, Psychosis, and Violent Offending?

It is widely accepted that the presence of “mental disorder” is a risk factor for violence and it is included as a relevant factor in structured risk assessment guides. Fazal, Gulati, Linsell, Geddes, and Grann (2009) completed a meta-analysis which suggested that men with schizophrenia are four times more likely to commit an act of violence compared to men in the general population. They also concluded that most of the excess risk was mediated by comorbid substance abuse, rather than directly the presence of psychotic symptoms. Similar assertions are made in relation to associations with schizophrenia and offences such as arson and murder (Anwar, Långström, Grann, & Fazal, 2011). However, the way in which psychosis and offending is linked continues to be debated.

Possible explanations for the association between mental illness and violence have highlighted the presence of positive symptoms of schizophrenia, in particular delusional beliefs and persecutory ideations. Swanson et al. (2006) suggested that the clusters and degree of prominence of these symptoms may also be important to consider, given the moderating effect of negative symptoms on the likelihood of committing serious violence. Skeem et al. (2006) highlighted the importance of looking beyond symptoms to understand violence in this group. An increase in symptoms may not necessarily equate to an imminent increase in risk and, conversely, an amelioration of symptoms may not equate to a reduction in risk. Again, this highlights the importance of understanding the presenting problem rather than grouping effect based on a broad diagnostic or categorical term.

The literature also highlights that the presence of childhood trauma, recent violent victimisation, previous conduct problems, co-morbidity, and specific delusions can be associated with an increased risk of violence to others, in individuals suffering from psychosis. Storvestre et al. (2020) suggest that childhood physical and emotional neglect may be of specific importance to later violent behaviour. They concluded that individuals with a diagnosis of schizophrenia and history of violence had higher exposure to childhood trauma compared to individuals with the same diagnosis and no history of violence. Buchanan, Sint, Swanson, and Rosenheck (2019) conducted a longitudinal multivariable analysis with 1,435 individuals, all with a diagnosis of schizophrenia. Follow-up after 18 month indicated that a history of previous injurious violence, recent violent victimisation, severity of drug use, childhood sexual abuse, and medication non-adherence were associated with future injurious violence. Buchanan et al. highlighted strong effects of previous injurious violence and recent violent victimisation on future violent behaviour. Green et al. (2017) concluded that individuals with psychosis who had also experienced childhood trauma were twice as likely to be violent as individuals with psychosis with no reported childhood trauma.

Understanding the Pathway to Psychosis

A comprehensive review of the literature and evolving chronology of the understanding of psychosis is outside the scope of this chapter; however, there are several emerging
perspectives that have been useful in providing further understanding, and a review of relevant literature will be provided here.

Firstly, our understanding of the impact of early childhood trauma highlights biological changes in the brain which mirror those seen in individuals diagnosed with psychotic disorders. Fosse, Moskowitz, Shannon, and Mulholland (2019) outline how the structural changes in the brain, particularly to the hippocampus, amygdala, and prefrontal cortex, can be observed in individuals with psychotic disorders as well as those who have experienced early adversity. Interestingly, amongst other changes they note increased sensitivity to stress, deficits in episodic memory, and a prioritisation of biologically relevant information, thus leading to elevated levels of stress hormones. This is significant in considering that the causality of changes could equally, or alternatively, be explained by exposure to childhood trauma, rather than purely neurodevelopmental/genetic origins, often associated with psychotic disorders.

Consideration of the role of dissociation, attachment, and affect regulation are considered important in understanding the functional links between trauma and psychosis. Moskowitz, Heinmaa, and Van Der Hart (2019) describe psychosis as a form of dissociation – an attempt to cope with the experience of trauma by dividing the personality. This expands on the more common view of dissociation which can focus exclusively on depersonalisation and derealisation, and alternatively conceptualises it as a failure to integrate trauma experience. Individuals therefore become “stuck”, with parts of them attempting to function as normal, and other parts “frozen” in the trauma experience. Moskowitz et al. hypothesise that, at some point in the individual’s life, the ability to dissociate has been central to survival in an environment of adversity (physically and psychologically).

Integral to the extensive literature on trauma and attachment systems is an understanding of the need for processes like dissociation in children faced with early trauma, particularly when inflicted by a caregiver figure. Moskowitz and Montiroso (2019) describe a “relational trap” whereby the attachment system motivates the child to stay close to the caregiver who is responsible for keeping the child safe and nurtured, while the defence/threat system motivates them to flee from the person, who is also the source of emotional and physical harm.

Gumley and Liotti (2019) posit that disorganised attachment can lead to the increased likelihood that dissociation is implemented when faced with subsequent traumas. The process of dissociation, in this example, allows the child to feel safe, when unable to achieve physical safety, but keeps the adult stuck in a cycle where trauma is maintained and reinforced. The emotion regulation strategies, that an individual develops to “survive” their early attachment experiences, are the basis for the negative and positive symptoms identified within psychosis. As such, the individual with psychosis may be more likely to disconnect, focusing on threat rather than connection, leading to physical and social withdrawal and emotional inhibition, or to develop overvalued ideas or hallucinations which allow for symbolic expression.

Complementary to this explanation is the double bind theory and communication deviance, capturing the significance of developmental relational experiences. The double bind theory was proposed by Bateson, Jackson, Hayley, and Weakland (1956)
and conceptualises trauma as a relational pattern rather than an event. Bateson et al. proposed that a child learns that what the caregiver *explicitly* and *implicitly* expresses are contradictory, and that this experience is forbidden to be acknowledged or discussed. A pattern then develops where the child is unable to trust their own perceptions and is required to suppress their own emotional responses, contributing to confusion about what is real and what is imagined, and what is an internal experience and what is another person’s experience. Psychosis, particularly delusions, is therefore a means of avoiding the control of this double bind and expressing the emotion and behaviour that is forbidden. de Sousa, Varese, Sellwood, and Bentall (2014) explored this theory via meta-analysis, re-termining the concept communication deviance, finding that the prevalence was high in families of an individual who later developed psychosis.

Moskowitz and Montiroso (2019) highlight that although they would not, and could not insist, that all delusions must have their genesis in childhood experiences, they would suggest that many, if not most, delusions are explanations for powerful emotional experience, which may be memory-based. Hardy (2017) highlights the importance of memory processes in an individual’s pathway from trauma to psychosis, drawing upon cognitive behavioural, attachment, and neuropsychological understanding of psychosis and PTSD. She proposes that vulnerability factors contribute to psychotic experience when combined with trauma. These are then reinforced and perpetuated by the coping responses of an individual. Vulnerability factors are identified as emotion regulation strategies, event memory processes, and personal semantic memories. Emotional regulation is considered in the context of trauma where there is repeated exposure to threat and the deprivation of core developmental needs. In the context of heightened emotional arousal of this kind, memory is affected. Hardy proposes that the perceptual and sensory information experienced tends to be enhanced, and episodic memory encoding inhibited. Therefore, intentional recall may be more difficult, whereas the associated sensory and perceptual stimuli are more intensely experienced and easily triggered. Implementation of emotion regulation may lead to increased fragmentation between the episodic memory and perceptual memories, leading to continued intrusions. The third vulnerability factor, personal semantic memory, holds an individual’s core beliefs or appraisals of events where the meaning of experience is attributed. As this is also influenced by our internal working models and attachment systems, these filters are likely to be applied in understanding experiences, and in retrieving memories, therefore providing a reinforcing effect. In summary, Hardy posits that psychosis is associated with a weakened ability to integrate contextual information with trauma-based memory intrusion, occurring in the absence of any episodic context, so that they are experienced as occurring in the here and now, and as if the past is present.

Central therefore to the pathway to psychosis is the relevance of affect regulation in the experiencing of trauma, particularly when this is repetitive, complex, or chronic in nature. Porges (2004) explains the impact of psychological experience, such as trauma, on the body, allowing us to further understand the physiological and biological impact. Porges (2011) describes how we have evolved to cue and detect the affective states of others, and the environment, thus allowing us to safely engage,
or to flee danger. This dialogue between social connection and threat response is key to us thriving as human beings.

Within Porges’s *polyvagal theory*, physiological arousal is controlled by the autonomic nervous system (ANS) and made up of two main branches (sympathetic and parasympathetic), with the parasympathetic branch divided into two pathways (ventral-vagal and dorsal-vagal) (Porges, 1995; 2004; 2011). This gives the ANS three main states of responding: first, being safely engaged and socially connected (safe and engaged); second, being energised to move in response to danger (fight/flight); and third, shutting down or collapsing when escape is not possible (freeze/dissociate). Each state is associated with emotions, physical feelings, behaviour, styles of attachment and communication, and capacities for self-regulation through which we react to our environment (Dana, 2018; Gilbert, 2009).

Central to this is the concept of neuroception – the subconscious process of detecting threat. This involves scanning for sign of threat from the outside environment, within our own autonomic nervous system and between our own and other’s systems (Dana, 2018). The ANS draws information from the current environment to ensure that we move between these states in an effective way, ensuring that we respond in a way that keeps us safe and socially connected. Trauma, particularly complex childhood trauma distorts the regulation of this system, resulting in overwhelming levels of physiological arousal characterised by chronic hypervigilance.

Of particular importance here is the freeze response (Levine & Frederick, 1997; Porges, 2011). When we are unable to escape or powerless to stop traumatic experience the ANS (mentally) shuts down, minimising the potential for psychological and physical damage. This state is controlled by the parasympathetic ANS (dorsal-vagal branch) and leads to adaptive survival responses overriding the other systems, particularly those linked to social engagement and connection. In this state of chronic hypervigilance, connection becomes at best deprioritised, at worst, unsafe and terrifying. Considering the relational trap described by Moskowitz and Montirosso (2019) we can see how such a physiological scar could lead an individual to neither feeling safe enough to stay, nor safe enough to leave.

Our current, and working, understanding draws from these emerging perspectives and is posited on several key principles.

- Psychosis symptomology has its base in a chronic hypervigilant state rooted in dissociation. This impacts on the individual’s ability to filter and differentiate information from multiple systems and in turn leads to difficulty in deciphering what is past and present, theirs or mine, reality, or fantasy.
- Delusional and/or overvalued ideas are an individual’s attempt to make sense of the body’s heightened threat response, to facilitate disconnection and overcompensation, to achieve safety, and/or to promote action allowing expression of emotions, sensations, and actions suppressed through trauma (Moskowitz, Heinmaa, & Van Der Hart, 2019).
- The body’s overriding focus on survival rather than connection exists as a wound between the person and the world (Van der Hart, Nijenhuis, & Steele, 2006).
This prevents re-connection and the potential for a corrective emotional experience. It maintains a disorganised attachment style, further damage to relationships, increased potential for victimisation, and emotional dysregulation (Levine & Frederick, 1997).

In this brief introduction, we have presented an overview of some of the important interrelated factors and systems we perceive are useful in understanding and formulating the experience of psychosis. These are developing ideas and require continued exploration, research, and clinical reflection. We hope to bring these to life in the following section through case examples, focusing on the importance of understanding risk and the role of psychosis in the use of violence.

**Case Study 1: Nate**

Nate is a 27-year-old male, who was admitted to our service after his mental health deteriorated in prison. He was at that time serving an Indeterminate sentence for Public Protection (IPP) following an assault and rape conviction, with a seven-year tariff, which expired four years ago. He had accessed mental health services since the age of 21, due to hearing voices, and had made numerous attempts to take his own life. Nate had spent little time in the community, moving between inpatient settings and prison. He was first convicted at the age of 13 and went onto amass over 40 convictions including violence, drug offences, and breaches of imposed orders.

Nate had also attracted labels of psychopathy, antisocial personality disorder, borderline personality disorder, and treatment-resistant paranoid schizophrenia.

On the ward, Nate would respond to unseen stimuli, was highly suspicious, and presented as aggressive, threatening, and intimidating. Meeting Nate for the first time was shocking, coloured by extreme distress and utter confusion (both his and mine); he could only tolerate sitting with me for ten minutes, before retreating to his room. Within that time, he shouted obscenities over his shoulder, poured water into his eyes, searched for cameras and recording equipment, showed me the “microbots” in his forearm and described small leprechaun-type creatures, which he perceived to be wreaking havoc.

Nate had experienced relational trauma. Given the evidence base that secure attachment is essential to recovery (Van der Hart et al., 2006) and the importance of understanding the function of psychotic symptomology, we focused on establishing a secure and consistent base, whilst acknowledging that this would not be an easy process for either of us. Over time, Nate spoke more openly about his range of experience, both in the past and present, but remained mistrusting. This was characterised by a disorganised attachment style, dismissal of the importance of the relationship – a push/pull approach where I was both desperately needed and feared as an attachment figure. At times, Nate would try to destroy the relationship, making threats to rape and harm me, but then frantically try to avoid abandonment.

In formulating his experience, we could see that he was haunted by several perceptual experiences which he found distressing and traumatising in nature. In addition to those already described, he believed that he was physically bent over – hunched in
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his appearance. He described the “aura” of a person changing into a “demon”, which represented a sense that the person was evil and would ultimately harm him. Washing his eyes out with water would reset the image of that person. He also heard several voices, but the one which was most powerful, and distressing was the voice of a naked man, a ghost whom he described as cruel. This included telling Nate that he deserved to be abused, that he was disgusting, bent, defective, fat, ugly, violent, and a paedophile. Nate believed that this man kept him safe, by alerting him to those that he could not trust, that wanted to harm, abuse, and deceive him. Ultimately, the man told him that he could not and should not rely on anyone.

This voice also kept him disconnected; Nate believed that it had the power to inflict cancer and death on those that he cared about, those that cared for him, or that he was close to. Ultimately it was not safe for Nate, for those around him or for those forming a relationship with him. It was clear that his pushing and pulling in the therapeutic relationship was an attempt to both keep himself and me safe. In pushing people away and denying connection he was protecting others from the part of himself which he saw as bad – the part that raped and hurt others.

Nate’s childhood history was characterised by experiences of mistreatment, abandonment, and neglect. He was unable to make sense of these early experiences or how he felt. This was particularly evident in his relationship with his main abuser, who inflicted horrific abuse, but who also provided Nate’s only sense of attachment, belonging, and intimacy. It was unsafe to risk losing this attachment, but also risky to maintain it. Nate made sense of this dialectic by developing the belief that his abuse was a response to him being bad. It was punishment. However, his body’s physical reactions to the abuse (i.e., sexual arousal and ejaculation) created further confusion and reinforced the sense that there was something wrong with him. Why would he enjoy this? Given the pleasure/comfort he felt, the only explanation he could find was that he was homosexual. This became enmeshed with the view of himself as bad and vulnerable, and a need to be punished.

Nate’s inability to escape this situation, to have power over his abuser/s or his family meant that he was unable to mobilise, to fight back, or to flee. He used several regulation strategies to manage distress – abusing substances, inhibiting his emotions, and disengaging from others – but this did not alleviate his fear or make him feel safe. Even after the abuse had ended, his threat system remained hypervigilant and alarmed, altering his ability to accurately read the affect state and intent of others. He could not distinguish between past and present and began to misinterpret cues of social engagement as risky. This process maintained a cycle of threat and disconnection, preventing opportunities for connection that would help heal the wound with the world.

By the age of 14 Nate had started to hear the main voice. It initially provided him companionship and distance, through dissociation, by allowing him to separate from and dismiss the part of him that was a vulnerable child. It also provided a mechanism for managing anxiety; the voice was someone that would look after him and protect him, seek evidence for, and highlight risk of harm from others. Ultimately it allowed him to act violently in a “legitimate response” to threat. The voice encouraged him to remain disconnected, to rely solely on it. In this way it paralleled the relationship
with his abuser, keeping Nate connected with the part of him that felt abused and alone. His sense of threat was reinforced by the belief that his vulnerability (which he linked to homosexuality) was physically manifested for all to see in that he was literally bent over. His use of intimidation and ultimately violence was a way of hiding that, to avoid feeling shameful and to regain control and power, when he felt controlled and powerless. His innate desire to connect, to feel love and/or kindness was thwarted by the belief that the voice had the power to kill those he cared about, or those that cared about him. This created another relational trap, where attachment was needed but feared. Ultimately this disconnect, hypervigilance, and misinterpretation of threat drove his violent behaviour. This in turn reinforced his feelings of defectiveness, shame, and a desire to be punished, perpetuating the cycle.

This process was also a critical factor in Nate’s rape offence. He described the voice ridiculing him telling him that he was ugly, fat, and gay, and that he needed to rape his victim to prove that he was heterosexual and therefore not vulnerable to further abuse. Nate described being desperate to escape his vulnerability; this, coupled with a desire to be attractive to his victim and to have connection and sexual contact, meant that he was able to dismiss her enough to force sexual contact/rape. However, this act also provided evidence that he was disgusting and worthy of punishment, thus keeping him trapped.

Case Study 2: Jason

Jason is a 34-year-old male, admitted whilst on remand for murder. His transfer from prison was due to a deterioration in his mental health. Jason had not engaged with mental health services before but had visited his doctor several times with concerns related to physical symptoms which did not appear to be organically caused. The GP on each occasion considered Jason’s presentations as symptomatic of depression and anxiety, and prescribed pharmacological and psychological interventions, with which Jason did not engage. Prior to his admission Jason was diagnosed with delusional disorder.

Jason left school with qualifications and was in gainful employment prior to being arrested for the offence. He had no history of violence, no cautions, or convictions of any kind. He was a homeowner and had two stable relationships of note, one which had ended just prior to him offending. Jason is serving a life sentence, with a tariff of 27 years, after being found guilty of shooting a colleague.

On meeting Jason for the first time, I experienced him as shy and embarrassed. He was unwilling to make eye contact, placating and self-deprecating. He exhibited a great deal of shame for his offence, describing himself as a monster. Initially, we focused on establishing a therapeutic relationship. Jason was untrusting and suspicious, he struggled to talk about his life, the offence or his current situation.

Over time Jason described a long-standing sense of distrust for others, anxiety in social situations and a strong preference for isolation and small trusted groups of people. He used alcohol as a way of coping with day-to-day living because it allowed him to feel more confident around others. Just prior to the offence he had split with a long-term girlfriend with whom he lived and he had accepted a new job. This decision brought him back into contact with his father, from whom he was estranged.
Jason struggled to connect with his new colleagues and described how they bullied him. He believed that this was due to being brought into his father’s business in a senior position. Jason reported that their behaviour escalated, he was assaulted, his car was tampered with and his house broken into. One man in particular targeted Jason relentlessly and when he heard him talking about a contract killing, he became convinced that they were planning to kill him, or a member of his family. Jason became chronically hypervigilant, unable to leave his house, eat, or sleep. He stated that he could not run, due to the risk to his family, so borrowed a shotgun from a friend for protection. However, he was unable to tolerate the level of distress he was experiencing, and went to the victim’s house, shooting him when he answered the door.

During the trial, and to date, Jason maintains that the threat of harm from the victim and his colleagues was real. Jason believed there was a failure by the court and his defence team, with a paucity of evidence presented to illustrate the harassment he had been exposed to.

So, what factors led to the deterioration of Jason’s mental health to such an extent that he committed a fatal act of violence that appeared completely out of character? It emerged that Jason’s history was peppered by physical abuse and emotional neglect; his father was a violent alcoholic who subjected the family to extreme levels of violence and control. At the age of three Jason was beaten for “noisily” eating an apple, resulting in him being hospitalised with a fractured skull and broken arm. Jason believes that neighbours and teachers knew what was happening but that his father was “untouchable”; people were too scared to stop or to even challenge him.

Jason felt that he needed to protect his mother and younger brother from this treatment and would try to direct his father’s abuse away from them onto himself. He would often run away, to hide out, but he knew that his mother and brother would be punished for his “wrong doings”. He was caught in a relational trap, unable to stay but unable to leave. Part of him remained frozen in that state, trying to become invisible, to remain below his father’s radar whilst needing to be present to protect others.

His mother finally split from his father when Jason was 16, initially seeking refuge and then making the decision to move to another country to get away from her husband. Jason was left behind and spent time homeless and living in bedsit accommodation. He was subject to further abuse and intimidation in this environment and withdrew further. Despite these challenges he was able to secure an apprenticeship and achieved a period of stability, where he engaged in two long-term relationships. Often these relationships became stressful when Jason was unable to attend social or family events due to his high levels of mistrust and hypervigilance. The second of these relationships ended prior to his offence. He reported feeling ashamed that he was not and could not be “normal”, and that this had resulted in the breakdown of a relationship with someone he cared deeply about. He felt defective and alone, paralleling his feelings as a child, and he started to rely on alcohol to help him manage his feelings of distress. He became dependant, and his employer arranged for him to have some time off and to complete a detox programme. This relationship was supportive and protective in nature, but Jason was ashamed, and struggled to return to...
work. It was at this point that his father offered him a job. Coming back into contact with his father was a difficult decision, but Jason hoped that his father could be the father he needed him to be.

Jason was exhibiting characteristics of undiagnosed PTSD/CPTSD for most of his life, and this had a significant impact on his ability to live adaptively and to connect with others. He suffered with chronic hypervigilance, flashbacks, nightmares, relationship difficulties, and used alcohol and social withdrawal to manage these symptoms, to no avail. It remains unclear whether Jason was subject to harassment in the build up to the offence, or whether his chronic hypervigilance, lack of support and exposure to stressful situations, distorted his reality. Either way his experience was real to him, and terrifying.

Regarding the pathway from trauma to psychosis, it is evident that as a child Jason was unable to mobilise, to fight or to flee. He remained traumatised throughout his adult life, unable to feel safe or secure. The breakdown of the relationships with his partner and at his previous workplace exacerbated a sense of shame and left him without the support that had previously been protective, allowing him to feel “safe enough” and to function, albeit, to a limited extent. His desire for his father to “be the dad I needed him to be”, and for a new start, led to a recapitulation of neglect and abuse. His exposure to new social connections alongside his chronic hypervigilance led to an experiencing of others as unsafe and himself, as at risk. A further parallel to his childhood experience was a sense that he could not flee, once again feeling responsible for protecting his family from threat.

It is postulated that, given Jason’s chronic arousal, he was unable to differentiate between past and present, leading to further traumatisation. This interpretation allowed him to make sense of the bodily fear that he was experiencing and prompted a symbolic enactment of events. Dissociation allowed him to express his anger, to act and to destroy the risk, eradicating it both from his childhood and adult experience, by ending the victim’s life. Without the belief that he or a member of family would be killed, he would not have acted. In this way, “Psychosis” allowed him to react, to fight, and to ultimately be rid of the fear, in a way that he could not be as a child. Unfortunately, Jason’s attempt to escape trauma in this way further traumatised him. He was unable to see the vulnerable traumatised boy, instead labelling himself as a monster who deserved to be punished and to never feel safe.

Whilst on remand, Jason’s beliefs became more entrenched. He began to believe that his victim’s associates had infiltrated the prison and poisoned his food. He described severe pain in his abdomen and a massive swelling on his jaw. He started to refuse food and water and his mental and physical health deteriorated further. Medical examination could find no reason for the physical ailments he described, which further added to his sense of distrust. This paralleled his first presentation at the GP where no organic cause could be found for physical ailments.

Jason still believes that he is at risk of being poisoned by his victim’s associates. These beliefs keep him stuck in the trauma of the past, replicating the sense that he will never be free or safe. They have reinforced core beliefs which originated in childhood: that the world is not safe, that people will hurt him, and that he is defective. Killing his victim reinforced his sense of defectiveness and provided an
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explanation for his mistreatment. His punishment is now justified, in the way it felt justified as a child, but never was.

The child part of him, which remains frozen in trauma, continues to express and reach out for care. Its needs are dismissed and remain unheard. His somatisation of distress through physical ailments/pain, associated with poisoning and its residual effects, is postulated to be an attempt to gain care. This was the only way he could elicit care as a child and adolescent. Unfortunately, now, confirmation of a physical reason for the pain he feels reinforces his belief that he is not safe, while denial of a physical reason for his pain reinforces the sense that he will not be cared for and that he cannot trust others. Once again, this leads to a re-enactment of his trauma.

Conclusions

In this chapter we have discussed the pathway from trauma through psychosis to violence. We have embedded this within the current literature and highlighted relevant case examples. As illustrated, there is “method to madness”, clear evidence for the need to understand and make sense of what is being communicated through delusional and/or psychotic experience. It is therefore vital to look beyond diagnostic frameworks and to ask, “what happened to you?” In doing so we can explore the function of hypervigilance, the parallels with childhood experience, and the efforts to avoid further victimisation. In these examples we can see that individual efforts to escape trauma led to re-enactment, keeping the victim trapped by their own means and creating other victims of trauma.

There are several barriers to working with this patient group, and we hope that those challenges are illustrated within the case examples. The development of a trusting relationship is clearly the biggest challenge, and the most important as a therapeutic factor. The relational impact of trauma and therefore the importance of connection within the therapeutic relationship has also been illustrated as key; trauma is fundamentally a chronic disruption of connection, and as such connection is essential to recovery. Given this the therapist may be pushed and pulled as a symbolic representation of the patient’s experience of disorganised attachments in the past. Learning to sit with them in the chaos, uncertainty and fear is key to this process.

The exact mechanism that links trauma to psychosis needs further exploration. However, several key characteristics are emerging:

- Firstly, the child experiences trauma where they are unable to mobilise, either related to the relational trap, or Porges’s (2011) “Freeze” state.
- Secondly, there remains an inability to accurately detect affective states of others, and the environment, or to integrate contextual information and/or an overreliance or prioritisation of feedback from the threat system or parasympathetic ANS (dorsal–vagal branch) (Hardy, 2017; Porges, 2011).
- Thirdly, the adaptive survival responses override the other systems in response to this threat, particularly linked to social engagement and connection (Dana, 2018; Gilbert, 2009). The interpretation of information is distorted in a way that the individual experiences the past, and therefore the threat, as present.
We posit that this process of paranoid overcontrol is an effort to avoid fear which focuses attention and recall on fear. In trying to understand their bodily reactions to this threat, they focus on the need to survive rather than to thrive. Connection, which would be the antidote to their experience, is dismissed. This process keeps the person frozen in a reality which is based in past trauma and drives future trauma. For the men in our service, the use of violence is a defence against fear, one which does not allow them to escape from the original trauma, and one that reinforces their sense of defectiveness and lack of connectedness. Levine and Frederick (1997) comment that much of the violence that plagues humanity is the result of unresolved trauma and attempts to establish empowerment. Psychosis or delusional belief systems can facilitate the use of violence, providing justification and thereby making the act more tolerable. The urge to solve trauma through re-enactment can be severe and compulsive; we are inexorably drawn into situations that repeat the original trauma in both obvious and subtle ways.

This working model of psychosis is useful in facilitating understanding, connection, and healing. It allows us, and the patient, to better understand the function of their psychotic experience and related beliefs and enables multidisciplinary teams to respond to underlying drivers of presenting behaviours, rather than reacting to the behaviour. It limits re-traumatisation and re-enactment, further facilitating the ability to separate the past from the present, through a reduction in chronic levels of arousal and greater ability to integrate contextual information when faced with trauma-based memory retrieval. The focus can therefore shift back to social connection, away from threat, thus allowing corrective emotional experience, and a healing of the “wound with the world” that Van der Hart et al. (2006) so powerfully describes.

Given the functional nature of delusions and perceptual disturbance described, we have also seen a reduction in the most disturbing symptoms (i.e., derogatory and abusive voices); there is greater integration of parts and a reduced need to make sense of the body’s heightened threat response, to facilitate disconnection or overcompensation. Targeting trauma as a treatment for psychosis in our service has also contributed to reductions in risk-related ratings as measured by structured assessment measures, as well as local system clinical observation measures and progression to lower security placements.

We continue to explore this working model; early findings are promising and although the sample size is small, there is a growing number of case examples, such as those presented here, which further strengthen the hypothesis presented within this chapter. We hope that this approach will contribute to the steadily improving understanding of the trajectory of psychosis.

Further Reading
References


Shafer (Eds), *Psychosis trauma and dissociation: Evolving perspectives on severe psychopathology* (pp.7–27). John Wiley & Sons Ltd.


