Stories that Kill
Distinguishing Trauma from Psychosis and Impacts on Mortality
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Traci Baxendale Ball, LMSW, CAADC
etacsolutions2008@yahoo.com
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Michigan’s Virtual Clinic for Trauma Spectrum, Sexual Disorders, Addictions
Learning Objectives

• Identify how trauma impacts mortality and describe transgenerational transmission

• Identify tools to empower and sustain trauma informed practice

• Verbalize how treating primary psychotic disorder may 'miss the mark' and therefore provide an obstacle to recovery
What enables our diagnostic process?

Trauma vs Psychosis?
There is no ultimate tool other than use of self

The diagnostic question cannot be answered accurately without:
1. The work of self
2. Resonance
3. Education of client/clinician
How do we know trauma stories Kill?

• Research
• Patient testimony
• Personal experience

Research
• ACE
• COLEVA

Patient Testimony
• Health
• Mental Health/Addiction

Personal Experience
• Wisdom/embrace of our own history enriches our practice when coupled with clinical practice and research
Trauma stories correlate with symptoms.
WHAT FUELS AND SUSTAINS YOUR FIRE

A five minute breakout discussion:

• What was the impetus ‘in the beginning’ when you began trauma informed care?

• How do you sustain the practice of trauma informed care, especially in environments that may not nurture this practice?

• What is the alternative to providing trauma informed care?

• Do you feel it is important to distinguish psychosis from trauma and if so, why?
FUEL TO SUSTAIN YOUR FIRE

Concept One: Embracing your personal history and being transparent about it in a way that reflects your boundaries, personality and mode of practice.
A Killing in 1998: Early Death and Homicide
Though certainly not my first exposure to severe trauma, this death brought me up close and personal, while practicing in the field, with the concepts of shock, re-experiencing, despair.

I was introduced to the Transformational Void that occurs after a severe trauma. Survivors that develop PTSD describe this disconnection from reality (like psychosis).
A Story about Trauma that Kills: From Foster Care to Grave
Transgenerational Trauma

- Conditions of poverty, violence, sexual abuse, addiction and the study of Epigenetics

- Conditions are transmitted Transgenerationally

- This is more than learning in vivo (learning from your environment)

- Resilience and Risk is passed on

- Anecdotal Evidence

- Research

“The root of suffering is attachment”
The Buddha
Clinical observations by Selma Fraiberg, child trauma researchers such as Byron Egeland, Inge Bretherton, and Daniel Schechter have empirically identified psychological mechanisms that favor intergenerational transmission, including dissociation in the context of attachment, and "communication" of prior traumatic experience as an effect of parental efforts to maintain self-regulation in the context of post-traumatic stress disorder and related alterations in social cognitive processes.

Enslavement and slavery, civil and domestic violence, sexual abuse, and extreme poverty are also sources of trauma that can be transferred to subsequent generations.
Transmission of Trauma and family Health Landscape

Generations are wiped out as a result of compounded multiple high risk health behaviors. Throwback to the Genogram.
The Biology of Transgenerational Trauma
What is means for PTSD......

Transgenerational epigenetic inheritance is the idea that epigenetic marks (i.e., DNA methylation, histone modifications) can be acquired on the DNA of one generation and stably passed on through the gametes (i.e., sperm and eggs) to the next generation. In other words, experiences and environmental exposures can change the way your DNA works (without changing the DNA itself) and this could be passed on to your offspring.
EROSION OF HEALTH

It is no longer disputable that trauma creates lifelong, chronic, health problems. Many survivors do not experience violent death. Still the insidious consequences of trauma are hidden away as risk factors for early mortality.
“Nothing lays the tracks so sneakily for early human death, as purposeful human cruelty, from an attachment object”.

Quote from writings on Trauma – Traci Baxendale Ball
Why is Relational Trauma so Powerful in Health Outcomes?

• Biologically programmed for attachment
• Necessary for survival
• If attachment if threatened by behavior of parent, the child adopts coping strategies that preserve the attachment
FUEL TO SUSTAIN YOUR FIRE

CONCEPT TWO: RESONANCE WITH YOUR CLIENT – GETTING IT RIGHT
The Clinicians Compass, historically and fundamentally empathic, begins from a new orientation.

“What happened to you?” is a starting point and the new Miracle Question.
The client’s story, which brings them to treatment, is sacred.
There are many ‘truths’ or realities. The client will inform you about theirs.
The job of the clinician is to create CONGRUENCE and to find an alliance.
Styles of Resonance

• Motivational and Engaging.

• This approach frees the clinician from control and analysis.

• The clients perspective is not challenged but incorporated into the clinician’s understanding of how to help.
A To Do list for MI and Trauma

Play dumb to the clients cognitive distortions
Set aside corrections
Focus on the distress in their story

Corrections to the narrative can be started later.......
• Resonance comes from the ability to listen vs correct

• Resonance gives the client the strength to do the work of recovery

The biggest communication problem is we do not listen to understand.
We listen to reply.
Creating Space for Trauma Work

Challenges to clients story will squeeze the space needed to do trauma work- resistance fills the treatment space

Focus instead on alignment
What Survivors Most Need to Hear

• *I believe you.*

• *What happened has contributed to your symptoms and the problems you are having.*

• *Your attachment to those that hurt you was non-optional*
Resonance Through Recognition

We must recognize above everything else,
That the child is well trained in keeping secrets.
That their choices and options as young adults,
Are inextricably linked with experienced trauma.
Therapy threatens secrets,
And the defenses the patient has put in place,
To cope with overwhelming feelings of loss.
• Careful assessment of trauma honors the clients story.

• Research indisputable: trauma directly impacts mortality. Not treating it contributes to the clients early death.

• Each diagnosis carries its own kind of stigma. Their internal experience of their symptoms tell them they are re-experiencing trauma.
Recovery depends on the clinician helping the client understand how their symptoms are actually their heroic attempts to survive intense emotional pain.
No alliance = no work to be done
Posturing with client deepens the groove the trauma carved
Find something to fall in love with about your client.

In the tapestry of life we are all connected. Each one of us is a gift to those around us, helping each other be who we are, weaving a perfect picture together.

~ Anita Moorjani

www.anitamoorjani.com
FUEL TO SUSTAIN YOUR FIRE

Concept Three: Education for you and your client on Trauma and Health, and the Dichotomies of Trauma
What is the research that tells us how Trauma Kills?
David McCollum COLEVA Project

Consequences of Lifetime Exposure to Violence and Abuse

- Neurological
- Dental
- Surgery
- Rheumatology
- Dermatology
- Mental Health
- Behavioral issues
- Orthopedics
- Respiratory/pulmonary
- Oncology

- ENT
- Infectious disease
- General/Other Categories
- Cardiovascular
- Gastrointestinal
- Ophthalmology
- Ob-Gyn
- Allergies
- Genito-Urinary
- Endocrine
HEALTH CONSEQUENCES OF ACE

• Suppressed immune system (illness resistance)
• Affected endocrine system (body functions)
• Activated CNS (info processing, learning, mental distress)

Summary: the body is worn down from relational distress
Anesthesia to Annihilation

GETTING IT RIGHT CAN INTERRUPT A LETHAL TRAUMA BASED BEHAVIOR:

• Smoking, drinking, use of pot, inhalants, pills during early adolescence – ACE clearly shown as causation.

• What begins as a neutralizer, kills the body.
Sobriety – getting there – sends splinters through the adult
TRAUMA AND ALTERED SENSE OF SELF

A sense of an internal vacuum
All powerful yet helpless
A sense that no-one is like you
Perpetual challenge to sense of self and developmental tasks
Trauma creates unsolvable conflicts

The Clinician recognizes the, essentially unsolvable, trauma conflicts that have created and solidified coping skills, including substance use.
Unsolvable Conflicts Lead to Health Destroying Consequences

Anxiety
Addiction
Self-blame and Shame
Impulse Control Issues
Risky behaviors
Trauma Survivors have altered Schemas

- Traumatized children grow up to be adults.
- Traumatized adults approach the world with this knowledge:
  - The world is not safe.
  - I will always be in danger.
  - My needs will not be met.
  - Others are not to be trusted.

These learned lessons become hard wired principles, and as such are the framework from which the adult filters information, operates in relationships and makes decisions.
Trauma Detangler

Critical: Education about the unsolvable dilemmas that trauma presents us with

Education is neutral and does not challenge attachments
Education empowers the client to find solutions

- Young children solve attachment puzzles to survive
- The result is cognitive distortions and eventually, ANTs
- PTSD is the mind’s attempt to solve the puzzle, the fractured pieces of trauma
- Education can be overlaid on the story to help align the pieces, change the narrative
Hard Wired for Survival and High Risk

These learned lessons about self, others, world - become hard wired principles, and as such are the framework from which the adult filters information, operates in relationships and makes decisions.
Creating a Safe Internal World can lead to Trauma Spectrum Disorders

All ‘non-functional’ behavior can be recognized and described as survival, attempts at resilience and internal construction of a world that feels safer than real world experience.
Have respect for the internal world that has brought them this far........
Understanding Trauma vs Psychosis

This year there will be approximately 100,000 new cases of Schizophrenia in the U.S.
How many patients are misdiagnosed?

There are no official statistics on misdiagnosis or changed diagnosis.
ENTIRE SYSTEMS HAVE BEEN CREATED AROUND CONCEPT OF SCHIZOPHRENIA

CMH?
SSDI/SSI?
APU?
COURT? ATO’s?

Some of the systems we can name are based on old beliefs about assessment, diagnosis, treatment and recovery. These systems believe that PTSD is a soft diagnosis. Resources are not funneled into adequate assessment, supervision and training.
Co-Morbidity Complications

• Trauma related disorder and psychosis often co-exist.

• Both should be treated concomitantly, with the SUD receiving recognition as a very valuable early tool for survival.
What happens when you question diagnoses?

Comments from the audience?

A word about resilience: Human beings are capable of coping with significant psychological trauma without sustaining great psychological harm.
SCHIZOPHRENIA VS PTSD

It is important that clinicians understand that hearing voices is a common phenomena, especially in conjunction with chronic/severe PTSD.

60 – 70% of clients with PTSD hear voices

Meta-analysis, Brock Chisholm, MD
PTSD AND HEARING VOICES


Study by Columbia University – 5000 respondents – 52% experienced ‘positive symptoms’ including voices.

http://www.mentalhealthcare.org.uk/view_all_videos/dr_brock_chisholm_video_2
Trauma Spectrum

There are many other trauma based disorders.

The Clinician should consider all trauma based disorders when assessing, diagnosing and treating.

- Dissociative Disorder
- Dissociative Identity Disorder
- Borderline Personality Disorder
- Substance Use Disorders
- Attachment Disorders
We don’t get to tell the client about their reaction

The clients affectual interpretation of the trauma stimulus is what matters, and what mutates into PTSD, not a raters score of severity

*Note for group facilitators*
Multiple trauma responses exist and inform symptoms. Not just fight or flight. Freeze response (also replicated across the animal kingdom) creates profound long-lasting changes in neural pathways.
The Opioid Wash replicates death

- Numbing
- Avoidance
- Playing dead
- Safety
- Still = safe
- Movement incites an internal crash
Common Features of Trauma Spectrum

• The client has an extensive interpersonal trauma history beginning in childhood. PTSD cannot exist from genes alone?

• Age of onset. (trauma – PTSD: no known time cut off)

• The client has a normal range of affect at baseline (without medications). The affect may be ‘dysregulated’ or numbed due to frantic attempts to cope.

• The client is in hyper arousal.

• The client appears hyper vigilant.

• Perpetual fear and expectation of harm.

• Guarded and suspicious due to loss of trust.

• Somatization. Trauma is held in body memory and transforms into illness.

• Body Dysmorphism and issues around food.
Indicators of Trauma Spectrum

- **Super sense.** Sharpened. Sensory overload due to constant state of arousal (fight or flight). Poor tolerance of light/sound/objects on skin.
- Self-harm, infliction of pain – “the suicide protector”. Not the path to suicide.
- **Amnesia.**
- Depersonalization.
- Derealization.
- Exaggerated startle response. “Jumpy”.
- Fuzzy or frozen Cognition. Trouble thinking and making decis
It is both a blessing
And a curse
To feel everything
So very deeply.
Hypervigilance and Hyperarousal

The client has become finely calibrated for trauma

A demanding life situation calls for being on guard

Continues for many years after traumatic stimulus removed or DEAD
FOOD AND TRAUMA

✓ Food: a complex entity for many trauma survivors
✓ Co-morbid eating disorder is common
✓ Food is a suitable anesthesia
✓ Food camouflages sexuality and being
✓ Food is a channel for a blossoming self loathing
✓ Food can be withheld to self punish
✓ Food can channel defiance and outrage
✓ Many traumas happen around food (withheld, controlled, poisoned, violence at the dinner table)
Amnesia

All memory is subject to distortion..........

Trauma memory
Loss of memories
Loss of time (hours, weeks, days, months, years)
Pre- or post-trauma
Precursor to a fragmented world/splintered self
Separated ego states
More trouble than others remembering daily tasks
Patchy, fragmented memory
Trauma memory is distressing

• Clients use numbing, avoidance, blocking to avoid trauma memory and its triggers

• It can be automatically re-experienced
The three D’s
Always assess via interview or standardized tool

• Dissociation – a technique that splits consciousness away from an unpleasant stimulus
• Derealization – altered perception of environment – world seems strange and unreal, objects may seem smaller or larger
• Depersonalization – altered perception of oneself
• Often accompanied by physical sensations:
  Fuzzy, floaty, out of body, zombie like, watching self from above, day walking, slow motion, blanking out, headache (particularly for dissociation).
Elements of Trauma Spectrum

- Distorted or fragmented memory.

- Poor response to medications for target symptoms. Poor tolerance for side effects.

- Medications look like they are providing some ‘glue’ to attach the client to more functional behaviors. ‘Take the edge off’.

- Strong reluctance to sleep and use sleep aids.

- Avoidance.
When Resonance and Intuition aren’t enough

• Widely accepted tools for assessment:
  • Clinical Interview with thorough history and symptom assessment. “The Gold Standard” – Ross, MD
  • PCL – PTSD Checklist
  • SCID-D
  • DAPS
  • DES II
  • MID
  • Genetic testing to assess efficacy/utility of medications
D does not stand for details
Do not Ask for Details!

- The key is not in the survivor telling the details.

- “The Slower you go the Faster you get there”. (Richard Kluft Axiom)

- Sandra Paulsen – “When the emotional pain exceeds the clients resources, trauma work cannot be done”.
Let’s Look At Why This Is Actually Difficult...

**Trauma Related Disorders**

- Etiology: Interpersonal Trauma.
- Slow to percolate: The person develops across childhood through adulthood with behaviors as adaptations.
- Trauma memory often impeded, embellished or non-existent.

**Psychosis**

- Trauma often triggers a psychotic episode but the connection is not always clear.
- Death of a parent and other profound life events appear to precede psychotic break.
- Real trauma experiences become wrapped around delusion.
### Trauma Related Disorder vs Psychosis

<table>
<thead>
<tr>
<th>Trauma Related Disorders</th>
<th>Psychosis</th>
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</thead>
<tbody>
<tr>
<td>Hyper vigilance (awareness) and suspiciousness</td>
<td>Paranoia</td>
</tr>
<tr>
<td>Frozen Cognition</td>
<td>Thought blocking</td>
</tr>
<tr>
<td>Obsessive behavior to address fear</td>
<td>Perseveration</td>
</tr>
<tr>
<td>Hyper arousal and super sense</td>
<td>Auditory and Visual Hallucinations</td>
</tr>
<tr>
<td>Poor Hygiene due to inability to acknowledge body/shower.</td>
<td>Poor hygiene due to lack of recognition of odor/appearance.</td>
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</tbody>
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Trauma Related Disorder vs Psychosis

• **Magical Thinking can look like psychosis!**
  - Early cognitive processes designed to manage discrepancies created by interpersonal trauma. Gives CONTROL to the thinker.
  - Magical thinking resolves the double bind
    – Example: *Daddy said I deserve it. I’m a bad, filthy girl and he is a good daddy.*

• Psychotic thinking makes ‘magical’ leaps!
  - Thought process is changed by psychosis.
  - Grandiosity, delusions, thought insertion, ideas of reference.
Psychotic thought process vs Trauma based thinking

Psychotic thinking can look very much like distorted trauma based thinking

Go back to listening........
Who are the players in the story?
Does the thinking or delusion serve a protective purpose?
Is the timeline right?
Is it hard/soft/residual?
Does it respond to reframe?
Is there a political or religious reference?
Magical Thinking

• Essentially narcissistic
• Protects the attachment
• Source of blame for trauma is “me” and I am all powerful to stop it.
• This looks like grandiosity until we dig deeper

The ‘DELUSION’ (?) of fear does not disappear when the trauma stimulus is removed.
Psychosis for reals........

• Classic symptoms of schizophrenia generally respond well to anti-psychotics.
• Schizophrenia is often thought as ‘organic’ and has a strong genetic component.
• Classic psychosis usually has a strong element of negative symptoms:
  ✓ Flattened/blunted affect
  ✓ Difficulty identifying physical complaints
  ✓ Limbic system tip-offs: religion, sex and politics
  ✓ Paranoia is often non-specific (the ‘others’)


Don’t pick favorites in assessment and treatment

Trauma Spectrum Disorder

Substance Use Disorder

Psychosis

“If a man does not know what port he is steering for, no wind is favorable to him.”

-- Seneca
Your practice impacts the story for years to come

• Clients feel heard

• Therapeutic resonance and alliance is strong

• Education frames the clients struggles in a way they can understand and gain perspective

• Removing blame in this way relaxes and detangles the recovery process

• Choices begin to be made out of the bins of trauma

• Early mortality is offset – you affect EPIGENETICS – how cool is that!