The Impact of Context in Understanding the Relationship between Post-Traumatic Stress Disorder and Psychotic Features in Survivors of Torture

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Abstract—The purpose of this paper is to argue that the sociopolitical context in which a survivor of torture shapes his or her worldview prior to the persecution and torture can have a major influence on the symptomatology expressed afterwards and in particular, the expression of post-traumatic stress disorder with psychotic features. It is argued that becoming aware of the characteristics of the context which foster these post-traumatic reactions is crucial in understanding the pathways through which this comorbidity develops with greater intensity in survivors of torture and in shaping our interventions in ways that they take into consideration the impact of prior context. Some of the factors which are also considered important in this aetiology are pre-morbid personality factors and stressors that the survivors face during the immigration process. An integrative model of the possible factors shaping psychotic manifestations of traumatic stress is proposed which can be used in clinical practice for the accurate assessment of complex symptomatology in survivors of torture.

Index Terms—post-traumatic stress reactions, psychotic symptoms, survivors of torture, context.

I. INTRODUCTION

Both trauma and psychosis are intense human experiences that affect the core of the relationship to oneself, others, and the world. Recent research has drawn comparisons between symptoms attributed to schizophrenia and PTSD symptoms and to the fact that both symptoms of psychosis and PTSD can be categorized into positive and negative clusters [1], [2]. For example, intrusive thoughts, images, and flashbacks show similarities with the hallucinations and delusions associated with psychosis. Increased levels of hyperarousal and hypervigilance resemble the agitation seen in psychosis, the disturbed sleep patterns and nightmares of PTSD may appear as the disturbed sleep often seen in psychosis. Negative symptoms of PTSD, such as emotional numbing, affective constriction, concentration difficulties, social functioning difficulties, derealization, detachment and neglect of self also overlap significantly with negative symptoms of psychosis [1], [3], [4], [2].

It has been supported that PTSD and psychosis exist together as comorbid disorders and are part of a spectrum of responses related to a traumatic event [1], [2]. This phenomenon has been called postpsychotic-PTSD or post-traumatic stress disorder with secondary psychotic features (PTSD-SP). PTSD-SP is a syndrome that comprises of PTSD-symptoms followed in time by the additional appearance of psychotic features. According to studies, these individuals have no history of schizophrenia prior to the traumatic event and psychotic symptoms emerge after the onset of PTSD [5]. It has been described that after the presentation of a full-blown PTSD, hallucinations and delusions are then reported. Hallucinations are generally related to traumatic events but often accompanied by non-trauma related content, while the content of delusions is mainly persecutory/paranoid. Formal thought disorders, such as flight of ideas and loose associations are almost never reported [6]. The intensity of paranoid thinking and agitation is much higher in patients with PTSD-SP than in patients with PTSD without psychosis or patients with psychotic disorder without PTSD [7]. The nature and severity of the traumatic events are not associated with the presence or absence of psychotic features following PTSD [5]. There are no disturbances of affect (e.g. inappropriate affect) in patients with PTSD-SP. Ethnicity could be a confounder. Reference [8] and [9] were amongst the first to note that veterans with PTSD and auditory hallucinations were more likely to be Hispanic than other ethnicities. In another study, African Americans were found to have increased risk of PTSD-SP suggesting that cultural factors may be relevant in the expression of psychosis secondary to trauma [7]. PTSD-SP’s diagnostic criteria are not available, a fact which causes heterogeneity in the groups that have been studied and makes comparison difficult. Many of these experiences may not be categorized as genuine delusions and hallucinations by clinicians, and hence may be more aptly called ‘psychotic-like’ experiences. Furthermore, most clinicians lack therapeutic success with this complex clinical condition [6], [10]. Regardless of the argument whether the diagnostic concept ‘post-psychotic PTSD’ is a valid separate diagnostic entity or not, there are also differences in opinion regarding the exact relationship between trauma, PTSD and psychosis.

II. CAN PSYCHOSIS BE A TRAUMATIC EVENT?

Recently, investigators have began to examine the possible traumatic effects of psychosis, and in particular whether the experience of living with schizophrenia (or other psychotic spectrum disorders) and subsequent hospitalization can lead to PTSD-type symptoms. Studies also show that the experience
of hospitalization can cause emotional, cognitive, and behavioral responses which can meet diagnostic criteria for PTSD in people with psychosis [4], [11]. This viewpoint argues that the traumatogenic effects of hospitalization in some cases can be as severe as those caused by a traumatic event itself.

III. CAN TRAUMA CAUSE PSYCHOSIS?

Another viewpoint proposes that trauma can induce psychosis. This viewpoint is drawn from research showing that trauma survivors diagnosed with PTSD reported to be experiencing symptoms of psychosis. This has been observed in studies mostly conducted with veterans [7]. The view that psychosis can be trauma-induced is also supported by research indicating that childhood trauma is a risk factor for psychotic experiences in the general population [12], [13]. There are high levels of trauma in the histories of psychotic populations, and the similarity between themes expressed in delusions and auditory hallucinations and the characteristics of traumatic events experienced before onset [14].

Reference [13] found that hallucinatory experiences in a sample of 200 sexually abused victims were related to the abusive traumatic event. However, an alternative view would be that psychotic symptoms are always related to the person’s developmental history, therefore if this contains traumas then this would explain the development of atypical experiences [2].

Despite these findings, it is still unclear whether the trauma is an etiological factor in psychosis or if the psychosis seen in PTSD is merely reflective of an underlying psychotic disorder. There is also still debate as to whether these ‘psychotic reactions’ can be mediated by environmental (e.g. culture, family, immigration, social support structures, reaction to health services), developmental (e.g. personality, psychopathology, coping), and cognitive factors (e.g. attributional style, pre-existing beliefs). More importantly, research has so far not addressed the role of the wider sociopolitical environment in which a survivor has shaped his/her primary experiences as a possible influencing factor in the development of these reactions after persecution and torture. Following, the relevance of context in the development of psychotic symptoms in traumatized individuals will discussed through the few studies which have dealt with this issue.

IV. THE RELEVANCE OF CONTEXT: EXAMPLES FROM OTHER SETTINGS

Traumatic events often occur embedded in a context, therefore this context can have a significant influence on the meaning the individual derives from traumatic events and the individual’s unique response to them. It has been noted in several studies that cultural factors may be relevant in the expression of psychosis secondary to trauma [10], [9]. Yet, an understanding of how this process works is still in the early stages [15].

Reference [16] in a study of severely traumatized Ethiopian immigrants who immigrated to Israel, they found out that severe stress and traumatic experience take the form of a brief reactive psychosis and not the form of the ‘classical post-traumatic stress disorder’. They noted that in the Ethiopian culture, it is normative for individuals to exhibit somatic symptoms, dissociative phenomena, and a belief that they are possessed by a spirit. In this culture, an individual with predisposing personality traits would react to extreme stress by exhibiting an exaggeration of the culturally accepted response in the form of reactive brief psychosis.

Reference [17] in their account of the impact of context in South African torture survivors they describe the unique cultural, political, and historical context in which the survivors are located. This context, they argue, is likely to shape the nature and extent of psychological sequel among this population. The nature of psychological distress experienced by torture survivors in South Africa is likely to be different from that of persons affected by trauma who live in comparatively peaceful, economically prosperous and stable countries. Distress among Black South Africans is less individualistically constructed and may be more intimately tied with perceptions of family, community, and societal well-being [18].

Reference [19] in her paper ‘Living Danger: On not knowing what we know’, describes the problematic matrix of political authoritarianism, the state’s use of torture, and the psychological responses of citizens during the Argentine Dirty War from a psychoanalytic standpoint. She identifies denial as the main psychological response of perpetrators, victims, and bystanders in order to protect themselves from anxieties that might otherwise overwhelm them. Many individuals disavowed significant aspects of the self as a means of dealing with persecutory anxiety. The traumatogenic political environment drove citizens to disavow not only their identities but often their capacities to believe and act on their perceptions of reality. A profound mechanism of dissociation of a part of one’s personality is also evident as a way to protect that part of the personality which identifies with the politics and values of the unfortunate victims of the arbitrary and unjust repression.

Reference [20] makes an important contribution to the understanding of social context and its influence on the emergence of psychotic symptoms. He notes that beliefs about the self are not only formed by the closer family knit, but are also reinforced by the societal/cultural context. Previous beliefs about the self are essential in contributing to the emergence of paranoid symptoms, especially if embedded within the framework of a severe traumatic experience. Living in a context where freedom of expression as well as the expression of individual needs and desires is restricted can lead to the formation of negative beliefs about the self but also of others around. Reference [20] describes the increased risk of psychotic symptoms as the response to a chronic, long-term experience of ‘social defeat’. Individuals experience social defeat when they have an encounter with another person who demeans, humiliates and subordinates them. In addition, chronic and long-term experience of social defeat may activate
the individual’s underlying genetic vulnerability to schizophrenia [20]. Understanding the experience of social defeat could explain the increased vulnerability of survivors of torture to psychotic presentations as a response to repeated feelings of humiliation and helplessness created by their torturers in an attempt to defeat them morally.

V. THE ROLE OF CONTEXT AND SURVIVORS OF TORMURE

Survivors of torture often form their primary beliefs and values in contexts which seek to gain dominance by control and repressive measures. The objective of these measures is usually to isolate, contain, destroy, or to politically remake citizens who most seriously challenge the state’s claims to political and ideological legitimacy. Prison and torture are used to break individuals accused of opposing a political regime and for the same purposes of obtaining information, cooperation, and public repentance [21], [22], [23]. These contexts foster characteristics such as hypervigilance and constant avoidance of threatening cues as mechanisms of protecting one’s self from physical and emotional harm. Individuals raised in these contexts repeatedly witness the loss of family members and friends who become active in the fight against the repressive regime and learn to live in a constant state of fear. Living in a constant state of hypervigilance leads to physiological overarousal which can then contribute to the inability to accurately assess possible threat, but also the misreading of what constitutes a threatening cue. Therefore, the paranoid thinking and persecutory beliefs often expressed by survivors of torture towards their treatment providers derives from what may seem as ‘exaggerated response against possible threat’.

It has to be noted that some symptoms also serve as adaptive functions and help the person survive. For example, in situations characterized by severe threat and danger, such as the interrogation context, symptoms such as hyperarousal, hypervigilance, enhanced auditory acuity, and restlessness [24] are adaptive rather than pathological.

With the development of post-traumatic stress reactions these responses become accentuated. These previously adaptive reactions often persist even if the threat is no more present. Survivors of torture carry this internalized mistrust and fear of persecution into any other context they encounter. The expression of somatic symptoms and dissociative phenomena is a way of externalizing the internalized threat. On the one hand, the variety of symptoms they are experiencing are integrated and interpreted within a subjective logic that introduces some coherence within their disintegrating internal world. On the other hand, it also reinforces the patient’s sense of being entrapped within a persecuting world.

Beliefs about human relationships formed in their societal context are being carried forward to their view of human relationships after the trauma. Their beliefs about human nature are not only formed by the repressive context, but also by their torture experiences. During their torture, survivors face humiliation and abuse by people from the same context. Both perpetrators and bystanders are peers. Thus, the ability to trust others is severely disrupted. Severe torture, may lead the person to believe that other people cannot be trusted which would make paranoid interpretations of ambiguous events more likely. Traumatic events which contribute to the development of faulty self and social knowledge and influence the nature of interpretations of intrusions possibly explains the link between trauma and the development of a psychotic presentation [25].

In reviewing the role of context in creating a pre-disposition towards the expression of psychotic-like features in survivors of torture in particular, one can conclude that context can have a dynamic impact on the meaning the individual derives from the traumatic event and the unique expression of response towards this event. It is argued that contexts in which authority is gained by control and repressive measures, psychotic-like reactions are formed as a response against this control, but also as a way of assigning meaning to a chaotic internal world dominated by threat. Reactions such as hypervigilance, paranoia, the expression of persecutory beliefs and mistrust may be viewed as ‘exaggerated responses against possible threat’ which served in the past as adaptive functions and helped the person survive. The experience of social defeat, helplessness, and demoralization that these survivors were subjected to repeatedly during their torture has shaped their beliefs about human relationships which are carried forward towards their relationships after the trauma. This is evident in their withdrawal from meaningful social relationships and the general social isolation they experience.

VI. OTHER IMPLICATING FACTORS

While the purpose of this paper was to increase awareness regarding the contextual factors influencing the expression of traumatic reactions in survivors of torture, it is important to remember that the aetiology of this psychological disturbance is often considered to be multi-factorial. Some of the factors which are considered important in this aetiology include pre-morbid personality factors (unusual personality traits, coping, pre-existing negative beliefs) and stressors the survivors face during the immigration process.

A. Personality

Pre-morbid personality factors such as pre-existing unusual thought processes and idiosyncrasies in personality (such as schizotypal, borderline, schizoid traits) are important factors to consider as a traumatic experience is more likely to make an impact on an already disturbed personality system. Neurocognitive explanations [26] propose that individuals with unusual thought processes (such as schizotypal personality traits), have a vulnerability to having reduced capacity to integrate information when confronted with traumatic experiences.

Reference [8] hypothesized that vulnerability factors contributing to the likelihood of developing psychosis interact with mediating factors such as stress, coping skills of the person, developmental factors and thinking mechanisms.
PTSD mediates the relationship between trauma and increased psychotic symptoms. Increased stress arises from the avoidance of trauma-related stimuli and over-arousal related to the re-experiencing of the trauma. If the person is particularly vulnerable and stress overrides his or her ability to cope, this leads to an exacerbation of a psychotic symptom [27].

It has been argued that pre-existing negative beliefs about the self (e.g. as vulnerable, weak, unlovable) may combine with appraisals of others as dangerous or untrustworthy which then lead to anxiety and contribute to the emergence of feelings of threat and paranoia. The formation of persecutory delusions falls under this schema [28]. Reference [29] have shown that negative schematic beliefs about the self and others may be a mediator of the relationship between trauma and paranoia. In particular, interpersonal traumatic events experienced were a key factor in levels of paranoia, and was in some cases more important than the type of trauma. Re-experiencing symptoms may increase negative beliefs which in turn precipitate higher levels of paranoia.

B. Immigration/Social support structures

During the immigration process, a long and arduous process which causes a great amount of stress, the survivors are confronted with the dilemma of trusting others again in a context which is largely foreign and hostile to them. Thus, their internalized pessimistic view about human nature is often carried towards their interpersonal relationships in this new context. These internalized views form the interpersonal expectations of these individuals.

For many survivors, the lack of meaningful social support structures after a traumatic event influences the adaptation to trauma and development of any secondary reactions to it. Social support is an environmental variable that interacts with symptoms of PTSD and the search for support in the environment is considered an active stress management strategy. Social support may have an impact on the victim’s emotional states (fear, panic, grief, guilt, and shame) and coping strategies, such as degree of avoidance of thoughts and behaviors either directly or through reappraisals of the event influenced by disclosure to others [30].

Lack of meaningful social support can increase the internalized hostility and forces the exaggerated response against threat to re-express itself dynamically in the new context. Therefore, every experience is contained within this mental framework which is dominated by hypervigilance, avoidance, and paranoid thinking. Individuals who interact with the survivors often react to this state with fear, hostility and avoidance which further confirms the survivor’s negative internalized views about human nature. This bi-directional process between survivor and social encounters often leads to isolation and exacerbation of symptomatology having concomitant other consequences such as withdrawal from social contacts, misdiagnosis, drop-out from services and lack of therapeutic continuity.

VII. An integrative approach

An integration of all possible implicating factors is presented graphically in Figure 1. This model proposes different variables in addition to the contextual factors which may mediate initial and subsequent reactions to persecution and torture in survivors of torture and possibly influence the diagnostic outcome. These variables and their potential impact on the symptomatology expressed in the aftermath of a trauma could be used when assessing the clinical presentation of a survivor and in understanding the unique reactions that each survivor may indicate. The model offers a multi-factorial understanding of PTSD with psychotic presentations.

As previously noted, the context plays an important role in creating a predisposition towards developing what may be diagnosed clinically as ‘psychotic-like reactions’. Survivors of torture often develop their worldview in repressive contexts where torture policies become a central component of the authoritarian rule. The interpretation of internal reality in relationship to external events and others is shaped by these experiences. The repressive context fosters the conditions for the development of a mental state which shares many features of the frightened, over-aroused, vigilant state characteristic of a traumatized state. When the traumagenic context becomes a traumatic experience, i.e. torture, these reactions are intensified and may contain psychotic features. These presentations which cannot be diagnosed clinically as psychotic reactions because of their transient nature and lack of clear-cut diagnostic criteria are being conditioned in the context in which the survivor forms his/her worldview, including their self-beliefs and coping skills.

Pre-morbid personality factors, pre-existing psychopathology, individual coping mechanisms, internalized self-beliefs, stress induced during the immigration process and characteristics of the new context will determine the form and intensity of PTSD symptomatology. If most of these factors are positive, e.g. the survivor has no pre-existing psychopathology, possesses solid coping skills and carries positive self-beliefs then it will be easier to form meaningful social relationships and interpret new experiences within a positive frame. This survivor will be more committed to receive supporting services and assistance from professionals. However, it is also important that the new context is supportive and contains reparative features.

In a different case, if the survivor has pre-existing psychopathology, negative self-beliefs and lack of coping skills, then traumatic experiences intensify these elements and create a further vulnerability for other symptomatology to surface. When the immigration process is stressful and support in the host country is missing, previous maladaptive responses intensify. Exaggerated responses against threat can manifest in the form of psychotic symptoms. This survivor will interpret new experiences within a paranoid frame of mind and will be hypersensitive to any cues he/she perceives as threatening. Lack of trust towards professionals, drop-out from services and isolation are some of the characteristic outcomes of these responses. If the new context cannot contain these responses and interpret them accordingly then it will replicate elements of the old, repressive context, creating anti-therapeutic elements.
VIII. Clinical implications

The paper introduces an integrative model through which clinicians can assess whether psychotic symptoms secondary to trauma are mediated by previous context and other predisposing factors. Until now, the role of context in explaining this particular clinical presentation has not been investigated. The difficulty in investigating this phenomenon quantitatively makes it even more difficult to draw definitive conclusions. However, it is argued that understanding the role of context is important in order to pre-maturely avoid labeling these reactions as pathological and that a focus only on overt symptoms elicited in the context of a diagnostic interview represents a unidimensional and decontextualized understanding of the survivor’s experience.

It has been indicated that traditional psychopathology models which have been applied in societies undergoing or coming to terms with a history of political and social turbulence [31], [23] have neglected to view the victim of political and social turmoil as a complex and dynamic aggregate of political, social, cultural, and individual factors, who continually creates meaning of his or her experiences [32].

By framing distress and suffering following a traumatic event as a psychiatric condition, and not taking into consideration the sociopolitical and cultural context in which this distress has occurred, researchers and clinicians risk to convey an expectation of continued psychopathology in the aftermath of the event and a lack of understanding regarding the experiences which led to their current state. In addition, the meaning ascribed to the traumatic experience is often influenced by proximal and distal factors in the person’s personal history and experience [33].

It has been indicated that the normative treatment for schizophrenia in our culture may make things significantly worse, and possibly even turn psychotic reactivity (the possibility for a brief psychotic reaction) into chronic clienthood, and that it may do so by repeatedly creating the conditions for social defeat [20].

It is also important to open a dialogue and address issues that may be related to conflicting beliefs/values and identities, because these may cause additional doubts and confusion about one’s personal and social/interpersonal functioning.

The integration of social support concepts in the study of PTSD is a challenging one and still in its infancy. However, considering the evidence for a link between social support and PTSD, it is important that psychotherapies integrate social support intervention.

Understanding the stressors added by the immigration process is essential as the host country becomes the new context which will either become the starting point for a safe and trusting experience or will replicate elements of the old context through the rejection and marginalization that these individuals experience. The more quickly the social fabric and a sense of normalcy is restored, the sooner the reduction in distress and psychopathology.

REFERENCES

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Figure 1. Integrative model-Factors shaping psychotic manifestations of traumatic stress.