

REVISÃO NARRATIVA/NARRATIVE REVIEW

Trauma e Psicose: Uma Análise Crítica da Literatura Trauma and Psychosis: A Critical Analysis of the Literature

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RESUMO

O conhecimento acerca do trauma, nomeadamente da sua relação com a psicose, tem sido objeto de estudo intensivo nos tempos recentes. Com o objetivo de apresentar o estado da arte sobre a interação entre trauma e psicose, realizou-se uma revisão narrativa da literatura sobre o tema, procedendo-se a uma subsequente análise crítica dos construtos fenotípicos que se crê serem marcadores de risco ou intermediários na relação bidirecional entre trauma e psicose. Eventos e perturbações traumáticas são frequentemente reportados em indivíduos com psicose, podendo as duas condições estabelecer-se segundo quatro tipos de relação: psicose como resultado de experiências traumáticas; perturbação de *stress* pós-traumático (PSPT) pós-psicótica; psicose como uma dimensão da PSPT; e PSPT e psicose comórbidas. A interação entre trauma e psicose supõe-se mediada através de disfunções nos domínios cognitivo, emocional, socioambiental e neurobiológico. O conhecimento aprofundado da complexa interação entre trauma e psicose permitirá aos serviços de saúde mental desenvolverem estratégias preventivas e terapêuticas mais dirigidas.

ABSTRACT

Knowledge about trauma, namely its relationship with psychosis, has been the subject of intensive study in recent times. To present the state of the art on the interaction between trauma and psychosis, a narrative review of the literature on the subject was carried out, followed by a critical analysis of the phenotypical constructs that are believed to be risk markers or intermediaries in the bidirectional relationship between trauma and psychosis. Traumatic events and disorders are frequently reported in individuals with psychosis, and the two conditions can be established according to four types of relationship: psychosis as a result of traumatic experiences; post-psychotic post-traumatic stress disorder (PTSD); psychosis as a dimension of PTSD; and comorbid PTSD and psychosis. The interaction between trauma and psychosis is thought to be mediated through dysfunctions in the cognitive, emotional, socio-environmental and neurobiological domains. In-depth knowledge about the complex interaction between trauma and psychosis will enable mental health services to develop more targeted preventive and therapeutic strategies.

Palavras-chave: Acontecimentos que Mudam a Vida; Perturbações Psicóticas; Perturbações de Stress Pós-Traumático; Trauma Psicológico

Keywords: Life Change Events; Psychological Trauma; Psychotic Disorders; Stress Disorders, Post-Traumatic

INTRODUCTION

Trauma results from an event (or series of events) experienced by the individual as threatening to their physical

or emotional integrity, leading to enduring consequences in their mental, physical, social, and existential functioning, significantly affecting overall well-being.¹ Exposure

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to traumatic events is a common human experience, with 60.7% of men and 51.2% of women reporting at least one traumatic experience in their lifetime, averaging 3.5 events per individual.^{2,3} However, only in the past three decades has research begun to systematically examine the short-, medium-, and long-term impacts of trauma, revealing lifetime prevalence rates of post-traumatic stress disorder (PTSD) between 7% and 12%.²⁻⁴

Recent literature suggests that exposure to adverse events not only increases the risk for trauma-related disorders but also for other clinical conditions, particularly psychotic disorders.⁵⁻⁸ Conversely, individuals with psychosis are highly susceptible to trauma, both through victimization and the potentially traumatic nature of psychotic symptoms and certain treatment practices.⁹ Although still in an early phase, our understanding of the trauma-psychosis interaction has significantly evolved in recent years. This article aims to provide a critical review of the literature regarding the nature and extent of the trauma-psychosis connection, highlighting the main epidemiological data, clinical presentations, explanatory mechanisms, and therapeutic approaches.

METHODOLOGY

A narrative review of the literature was undertaken to synthesize current evidence on the relationship between trauma and psychosis. The search was conducted using the PubMed/Medline databases, incorporating the following keywords: (trauma OR “post-traumatic stress disorder” OR PTSD) AND psychosis. Only articles published in English or Portuguese up to November 1 2024, were considered, ensuring inclusion of both foundational and contemporary research.

Four thousand, four hundred and thirty-one (4431) articles were found. Two independent reviewers (JB and SM) conducted the screening process. Titles and abstracts were assessed for relevance, and potentially eligible articles were retrieved for full-text evaluation. Articles were included if they met the following criteria: (1) a primary focus on the association between trauma and psychosis, especially addressing comorbid presentations or trauma history in individuals at risk for, or diagnosed with, psychotic disorders; (2) clinically relevant contributions to the organization of mental health services or to treatment and prevention strategies; and (3) methodological clarity, appropriate study design, and publication in peer-reviewed journals. No restrictions were imposed regarding study design, and thus systematic reviews, meta-analyses, randomized controlled trials, cross-sectional and cohort studies, case-control studies, qualitative research, and clinical guidelines were all eligible for inclusion. Disagreements between reviewers at any stage of the selection process were resolved through discussion and consensus, with a third reviewer (MP) available for adjudication when necessary. The reference lists of included articles were also screened to identify additional relevant studies.

During full-text assessment, articles were excluded when they did not focus on the trauma-psychosis link, lacked

methodological clarity, or presented insufficiently relevant findings. Following this process, 52 studies were included in the final analysis. During the screening process, particular attention was given to the methodological characteristics of the studies, given the heterogeneity of designs found in the initial search. Methodological quality was considered in a pragmatic and narrative way by: (i) conducting an independent double screening of all records; (ii) prioritizing studies that presented clearly defined samples, validated assessment instruments, and transparent analytic procedures; and (iii) taking into account common methodological limitations, such as retrospective trauma measures or cross-sectional designs, when determining relevance and suitability for inclusion in the review.

The findings of the 52 studies were organized according to key themes identified in the literature: etiological links between trauma and psychosis, clinical aspects, and treatment/intervention approaches.

The information obtained from the literature review was organized and is presented across the following thematic domains: epidemiological data regarding the association between trauma and psychosis; explanatory models and underlying mechanisms; clinical approaches, with emphasis on trauma recognition and trauma-informed practice; treatment strategies, including interventions targeting different symptom profiles; interventions focused on mediating mechanisms between trauma and psychosis; and prevention strategies.

EPIDEMIOLOGICAL DATA

The prevalence of exposure to traumatic events among individuals with severe mental illness (including psychosis) ranges from 49% to 100%, with high rates observed at all stages of illness.^{8,10} Childhood trauma is highly prevalent not only in individuals diagnosed with schizophrenia (85%) but also in those with an at-risk mental state (ARMS) for psychosis or schizophrenia (86.8%).⁷⁻⁹ Between 75% and 98% of individuals with severe mental illness - most commonly in the schizophrenia spectrum - report multiple traumatic events, with an average of one to eight lifetime traumatic experiences.¹⁰

Regarding recent traumatic experiences, approximately one-third of patients reported being victims of physical assault and 13% of sexual assault in the previous year.¹¹ Additionally, the literature highlights that physical and sexual abuse are common occurrences during psychiatric hospitalizations and are associated with poorer prognosis and reduced engagement with healthcare services.^{12,13}

Unsurprisingly, trauma-related and psychotic disorders often co-occur, resulting in worse clinical outcomes and higher healthcare costs.^{10,14} Comorbid psychotic disorders have been reported in 20%-40% of war veterans with PTSD.¹⁵ Conversely, PTSD has an estimated prevalence of 30% among individuals with psychotic disorders - at least three times higher than in the general population - with higher rates of comorbidity observed in first-episode psychosis compared to chronic psychotic presentations.^{14,15} Recent research also suggests that most individuals with

psychotic symptoms and a history of trauma meet the diagnostic criteria for complex PTSD rather than simple PTSD.¹⁶ Nevertheless, the actual prevalence is likely underestimated, as trauma is frequently under-recognized in individuals with severe mental illness.

THE LINK BETWEEN TRAUMA AND PSYCHOSIS

a. Explanatory models

Although existing explanatory models remain a subject of debate, the relationship between trauma and psychosis appears to be complex and multifactorial. Some authors propose dividing the relationship between trauma and psychosis into four subtypes (Fig. 1)^{4,17}:

i. Psychosis as a result of traumatic experiences

Exposure to adverse events - especially those that are early, intense, and repeated - can not only result in trauma-related disorders but also increase vulnerability to psychotic symptoms, ranging from attenuated experiences to established psychotic pathology.^{7,8,18,19} This association seems to follow a dose-response relationship: a greater number of exposures to traumatic events (notably physical abuse in childhood, but also emotional abuse and neglect) results in an increased risk of psychosis in adulthood.⁵ The presence of traumatic experiences in childhood (compared to recent events) appears to predict the transition to psychosis among individuals with clinical presentations considered ARMS.⁸ The mechanisms through which traumatic experiences may lead to the development of psychotic symptoms are detailed later in the text.

ii. PTSD induced by psychosis (post-psychotic PTSD)

PTSD develops following a psychotic episode, where the negative experience with the treatment received (such as involuntary hospitalization, coercive practices, etc.) or the psychotic experience itself constitutes the traumatic event.²⁰

iii. Psychosis as a dimension of PTSD (PTSD with psychotic symptoms)

PTSD may present with diverse phenomena such as obsessive, phobic, depressive, dissociative, and psychotic symptoms.^{20,21} Although the latter may be confused with dissociative symptoms or re-experiencing phenomena (such as flashbacks), in PTSD with psychosis, psychotic symptoms appear to be more pervasive and frequent.²² In this regard, auditory hallucinations and delusional ideation of guilt or persecution may occur in up to 40% of individuals with severe PTSD.^{4,24} The content of these phenomena is often, though not always, related to trauma.²⁵ Despite the similarities, one study with adolescents suggests that imperative and derogatory hallucinations are more common in PTSD than in schizophrenia and are associated with greater emotional distress, self-harm, and suicidal

ideation.²⁶ Some authors argue that PTSD with psychotic symptoms should be conceptualized as a distinct entity, given that important differences seem to exist not only at the level of clinical presentation but also in genetic load, approach, and response to treatment, compared to PTSD without psychotic symptoms.²⁷

iv. PTSD and psychosis as comorbidities

Individuals with psychotic illness (or vulnerability to it) present a higher risk of victimization. In these cases, PTSD may arise as a comorbid disorder that conditions the increase in symptom severity and the use of acute care services. The deleterious effect of PTSD and re-traumatization on the course of psychotic illness occurs directly (through avoidance, hyperarousal, and distress symptoms resulting from traumatic re-experiencing) and indirectly (through the use of psychoactive substances, re-victimization, and poor therapeutic alliance with service providers, among others).²⁸

With the exception of the first subtype, in the last three, the clinical presentation is characterized by the coexistence of psychotic and post-traumatic symptoms, which should always be considered in the differential diagnosis when comorbidity is present.

b. Underlying mechanisms

The mechanisms involved in the transition from traumatic experiences to psychosis are not yet fully understood, and several models have been developed to explain this relationship. The most consensual are the stress-vulnerability and stress-sensitivity models, which combine neurobiological concepts with cognitive processes.^{10,29} According to these models, individuals whose genetic/biological heritage predisposes them to psychosis can sustain a certain allostatic load, beyond which the risk of transition to psychosis increases. The crossing of this individual threshold in reaction to a traumatic experience (especially if it occurs at an early age or is associated with a greater traumatic load) seems to condition not only chronic stress levels but also increased sensitivity to minor stressors in the future, further potentiating the risk of emergence of psychotic symptoms.

The trajectory between trauma (early, intense, and/or multiple) and the onset of psychosis is complex and can be explained through interrelated changes in cognitive, affective-emotional, socio-environmental, and neurobiological domains (Fig. 1)^{30,31}:

i. Cognitive domain

Cognitive biases: Adverse experiences can lead to maladaptive changes in information processing, generating negative cognitions about the world, others, and the self, with thoughts of shame, guilt, and worthlessness. Exposure to stressors in adulthood will trigger feelings of inferiority and the search for an explanation external to the individual, often leading to false interpretations of reality, with a tendency toward paranoia and self-reference. In some cases, defense and coping mechanisms may assume the form of psychotic symptoms, such as delusions or hallucinations.^{30,31}

Dissociative symptoms: Some authors postulate that the dissociative symptoms of PTSD, when interpreted as being generated externally, resemble hallucinatory experiences. Some have even proposed the category of a dissociative subtype of psychosis, which might respond better to trauma-focused psychotherapy.³²

b. Affective-emotional domain

Early or intense adverse experiences can lead to emotional dysregulation, hypersensitivity to daily events, and the development of anxiety and depressive symptoms.

c. Socio-environmental domain

Early trauma can lead to difficulties in establishing healthy relationships, via insecure attachment styles that condition feelings of rejection and inferiority and increase the risk of psychoactive substance use.

d. Neurobiological domain

Changes in this domain include hyperactivation of the hypothalamic-pituitary-adrenal (HPA) axis and subsequent brain changes in stress-related structures such as the amygdala and hippocampus, increased dopaminergic sensitivity, inflammation, and oxidative dysregulation. Dysfunction of these stress response mechanisms appears to favor the long-term development of psychosis.³²

CLINICAL APPROACH

a. Identification

Without effective treatment, psychosis and trauma have a significant impact on patients' lives and their prognosis. In this sense, the first step in initiating treatment is the recognition of trauma in the narrative and history of each patient. Nevertheless, traumatic experiences are frequently undervalued in individuals with severe mental illness (and in psychosis in particular).³³ This underdiagnosis is due, at least in part, to the fact that the experience of psychosis masks other diagnoses or is considered more relevant by clinicians. Other barriers include the difficulty some patients may have in recalling past events and the difficulty clinicians have in distinguishing whether the experiences reported by patients are delusional. In addition, most mental health services do not routinely screen for these symptoms.³⁵ A multicenter study revealed that, although 42% of patients with severe mental illness met the criteria for PTSD, only 2% had a formal diagnosis.³⁵

It is therefore essential to promote the active investigation and empathic discussion of potentially traumatic events among people with psychosis. Although there may be some initial reluctance on the part of the patient to address these topics, qualitative studies demonstrate that, if given the appropriate time and space, patients feel comfortable discussing these issues.³⁶ Moreover, one study showed that 86% of patients showed improvement in PTSD and psychotic symptoms after talking about trauma, with all participants reporting that sharing these experiences was beneficial and important in the therapeutic process.³⁷ It is fundamental that the clinician

asks what has happened to the patient, focusing on their socio-familial context, avoiding blaming the patient for their situation, and understanding the relationship between past traumatic events and the phenomenological expression of the illness. This recognition strengthens the therapeutic relationship, improves case formulation, and opens the possibility of new therapeutic responses, promoting rehabilitation and post-traumatic growth.³⁸ To support more systematic detection of traumatic events, scales and semi-structured interviews such as the PTSD Checklist can be used³⁹; some trauma assessment instruments, such as the CAPS-S, have already been adapted for patients with psychosis, allowing the distinction between psychotic symptoms unrelated to trauma and PTSD symptoms.¹⁶

b. Trauma-informed practice

Trauma-informed practice is a model that aims to view trauma holistically, generating a comprehensive understanding of how exposure to trauma affects individuals' neurological, biological, psychological, and social development. This approach aims to contribute to the creation of safe environments, the thoughtful integration of symptom phenomenology into the patient's biographical history, and the reduction of re-traumatization processes, thereby aiming for better clinical outcomes. Although it lacks high-quality empirical evaluation, trauma-informed practice has been recommended and is progressively integrated into service organizations, particularly in mental health.⁴⁰ The concept of trauma-informed practice, as postulated in 2014 by the Substance Abuse and Mental Health Services Administration (SAMHSA), is based on four principles¹:

- Recognition of the impact of trauma, often understanding people's behaviors as coping strategies to overcome adverse experiences;
- Recognition of the main signs and symptoms of trauma in patients, families, and other stakeholders involved in the therapeutic process;
- Response to the problem through the integration of current knowledge about trauma into the development of policies, procedures, new practices, the training of service providers, and leadership sensitive to this topic;
- Active resistance to re-traumatization, avoiding the maintenance of stressful and toxic environments that may reactivate memories of past trauma. This is especially relevant in psychiatric services where mechanical or physical restraint is used, which may be retraumatizing and interfere with the treatment and recovery process.

c. Treatment

The treatment of PTSD in individuals with psychosis is challenging and requires better definition compared to the treatment of the different entities separately. However, with current knowledge of the risk factors, mechanisms, and domains involved in the mediation and interaction between trauma and psychosis, together with existing evidence of the efficacy of some specific therapeutic approaches for comorbidity, the following therapeutic and preventive targets can be recommended:

i. Target a) – Traditional treatment of psychotic symptoms

The presence of psychotic symptoms in PTSD is associated with lower efficacy of conventional treatments, often requiring the initiation of antipsychotic therapy, either as monotherapy or as an add-on. There is no specific antipsychotic with demonstrated greater efficacy, with several studies showing good results with risperidone, quetiapine, and a smaller number with clozapine, amisulpride, olanzapine, or fluphenazine.³⁰ Early and effective treatment of psychotic symptoms, combined with a humane approach that fully respects the rights of people with mental illness (notably regarding the use of coercive measures), is essential for full patient recovery, minimizing the deleterious effect of re-traumatization and preventing the development of possible post-psychotic PTSD. As for the negative (anhedonia, avolition, alogia, social isolation, affective blunting) and cognitive symptoms of schizophrenia, these do not appear to arise in PTSD, and trauma-focused cognitive-behavioral therapy (CBT) has not shown any impact on them.⁴¹

ii. Target b) – Treatment of post-traumatic symptoms

Several types of psychotherapy have been studied in the management of patients with psychosis and PTSD, with growing evidence that interventions normally used for trauma can be adapted and used in people with psychotic illness.⁴² Gradual exposure therapy in CBT has demonstrated efficacy in reducing PTSD symptoms, notably irritability and emotional instability.⁴³ Eye movement desensitization and reprocessing (EMDR) has also been effective in reducing PTSD and psychotic symptoms, particularly auditory-verbal hallucinations and delusional ideation, as well as other comorbid conditions (depression and anxiety) and improvement in self-esteem.⁴⁴ CBT without exposure has not shown an effect on reducing PTSD symptoms in this population.⁴⁵ Some patients with intense PTSD symptoms may still benefit from pharmacological treatments such as selective serotonin reuptake inhibitors (SSRIs) or selective $\alpha 1$ -adrenergic receptor blockers.⁴⁶

In summary, gradual exposure therapy and EMDR can be used safely and effectively to reduce PTSD and psychotic symptoms in individuals with both comorbid conditions.⁴⁷ Despite evidence of efficacy and safety in psychosis, there is still some reluctance among clinicians to use these strategies, fearing they may be too stimulating for some patients and aggravate certain symptoms.¹⁰ The use of these strategies is not yet sufficiently validated in the early phases of psychotic illness.

As for complex PTSD, it appears to require a longer duration of treatment due to its association with greater dysfunction and the need to address the “disturbances in self-organization” (DSO) linked to this condition - namely emotional dysregulation, relational difficulties, or low self-esteem - with insufficient evidence currently available to support a specific type of psychotherapy for this new nosological entity.⁴⁸

iii. Target c) – Approach to the mediating mechanisms between trauma and psychosis

Despite the lack of evidence to date, there is a good theoretical rationale for targeting the signs and symptoms that appear to mediate the trauma-psychosis diathesis, to prevent the transition to psychosis³¹:

- Maladaptive cognitive biases through cognitive restructuring and behavioral interventions⁴⁹;
- Dissociative symptoms through sensory grounding techniques⁴⁵;
- Depressive and anxious symptoms through relaxation techniques, mindfulness, CBT, or the use of antidepressant medication (notably SSRIs)³¹;
- Loneliness and social isolation through social skills training and community interventions.³¹

The suggested techniques appear to be more effective in individuals with more severe symptoms.⁴²

iv. Target d) – Preventive strategies

Preventive mechanisms and interventions targeting traumatic situations, particularly (though not exclusively) in childhood, will undoubtedly play a crucial role in reducing all trauma-related presentations, including psychosis. There should be a focus on vulnerable groups, which include individuals with established mental disorders and members of the household - especially children (who share not only genetic risk but also exposure to environmental adversity, placing them at increased risk). Individuals with neurodevelopmental disorders, who are more susceptible to developing schizophrenia, are also at greater risk of exposure to traumatic experiences in childhood (such as peer bullying), which may foster the development of psychosis. Therefore, these individuals should be the target of specific protective strategies.⁵⁰⁻⁵²

DISCUSSION

The study of the interaction between trauma and psychosis is still in its infancy, despite the high comorbidity between these two conditions. In current research, the relationship between trauma and psychosis is described as complex and bidirectional. In addition to a risk association (where the presence of one increases vulnerability to the development of the other), traumatic events also appear to influence the severity and content of delusions and hallucinations. The importance of exposure to adverse events in childhood has been particularly studied. Growing evidence reveals that early trauma (compared to more recent events) is an important cumulative risk factor for the emergence of trauma-related disorders (particularly complex PTSD) as well as psychotic disorders. This relationship appears to be mediated by complex interactions involving cognitive, emotional, socio-environmental, and neurobiological factors. These mechanisms represent, in part, different explanatory levels of the same pathophysiological phenomena (e.g., the experience of hypersensitivity to daily events corresponding to the emotional translation of HPA axis hyperactivation). On the other hand, they establish mutual causal relationships (anxiety may lead to threat perception

and paranoid interpretations or self-devaluation cognitive schemas, which in turn condition a sad mood), feeding back in a way that places the individual in a state of chronic stress and reduced resilience to future stressors.

Interestingly, the intermediate syndrome between trauma and psychosis presents important similarities (at least at the clinical-phenomenological surface), not only with the DSO associated with complex PTSD, but also with the clinical descriptions of ARMS. Indeed, the most recent studies point to a greater proximity between psychosis and complex PTSD (compared to simple PTSD), both being associated with similar types of early and persistent interpersonal trauma. It can therefore be hypothesized that DSO (or complex PTSD in its full expression) represents the most likely mediating link in the trauma-psychosis diathesis, or that it may share causal and maintenance psychological mechanisms with psychosis.

While these mechanisms provide a coherent and multidimensional framework for understanding how trauma may contribute to psychosis, the empirical support for each pathway varies considerably. As such, the strength of evidence supporting each proposed mechanism is uneven. Neurobiological models, such as HPA axis sensitization and dopaminergic dysregulation following early adversity, have growing empirical support, yet many findings remain correlational. Cognitive models - linking trauma to maladaptive threat appraisals, paranoia, and dissociation - are supported by experimental paradigms and mediation analyses, but inconsistencies persist regarding which cognitive pathways are necessary or sufficient for psychosis emergence. Socio-environmental explanations, including bullying, deprivation, and insecure attachment, show robust associations in population studies; however, their interactions with genetic vulnerability remain insufficiently clarified.

This variability in empirical support underscores the need to interpret mechanistic findings within the broader methodological limitations of the field. Consistent with this, the available evidence is limited by methodological constraints that require careful interpretation. Many studies rely on retrospective self-report measures of childhood trauma, which are susceptible to recall bias, particularly in individuals experiencing current psychopathology. Cross-sectional designs, common in the literature, preclude strong causal inferences and raise the possibility of reverse causality - that is, early manifestations of psychosis increasing exposure to traumatic environments rather than trauma being the initial precipitant. Prospective longitudinal studies, while more informative, remain relatively scarce and often rely on heterogeneous definitions of trauma and psychosis, limiting comparability across studies.

From the perspective of daily practice, it is not surprising that DSO are often identified, diagnosed, and addressed as ARMS. As specialized programs for early intervention in psychosis are more widespread - both nationally and internationally - than those dedicated to trauma, interpreting the syndrome as belonging to the ARMS spectrum provides easier access to specialized care. It is therefore important to

equip all services dedicated to psychosis intervention with the skills to identify and manage traumatic symptoms.

The difficulties in diagnosing trauma in psychosis may have several explanations, including an essentially biological focus in the conceptualization of psychosis. On the other hand, some clinicians are reluctant to ask about traumatic events in individuals with psychotic symptoms, fearing that this may aggravate their condition. However, it is important to remember not only the high prevalence of traumatic events in psychotic disorders, but also that their identification and consideration in a more comprehensive case formulation appear to be associated with better prognosis and patient satisfaction.

It would, however, be unrealistic to expect, at least in the initial phase of service development, that these services could be equipped on a large scale with all the necessary tools for trauma management, especially considering the high specificity of psychotherapeutic approaches and the resources required for their implementation. While the development of specialized trauma interventions should remain a long-term goal, implementing trauma-informed practice provides a realistic and valuable starting point. This model recognizes the role of traumatic experiences and their possible clinical manifestations, while avoiding overly reductionist interpretations of distress or the unintended assignment of a victim identity. Complementing this, a nuanced understanding of the complex pathways linking trauma to psychosis can help identify preventive and therapeutic strategies to interrupt a cycle of increased vulnerability and strengthen each patient's recovery project.

Building on this, therapeutic recommendations should differentiate between well-established interventions and those for which evidence remains preliminary. For instance, trauma-focused CBT and EMDR have demonstrated efficacy in selected patients with comorbid PTSD and psychosis, yet their applicability in early-phase psychosis and in individuals with marked instability remains debated. Potential risks (such as transient symptom exacerbation during exposure-based work) require careful monitoring and clinical judgment. Emerging interventions targeting dissociation, attachment insecurity, or social disconnection are promising but require more rigorous evaluation before being widely implemented (Table 1).

Table 1. Strength of evidence and clinical implications of interventions at the trauma-psychosis interface.

Level of evidence	Intervention / Mechanisms	Clinical Implications	Limitations and Risks
Robust evidence	• Trauma-focused CBT with graded exposure (psychosis + PTSD). • EMDR (in stable patients with comorbid PTSD and psychotic symptoms).	• Can reduce PTSD symptoms and may alleviate some psychotic phenomena. • Should be considered in clinically stable patients with clear traumatic triggers and preserved capacity to tolerate affective activation.	• Not evaluated sufficiently in early-phase psychosis or in clinically unstable patients. • Risk of transient symptom exacerbation during exposure. • Requires careful monitoring and clinician expertise.
Moderate evidence	• Cognitive interventions targeting appraisals of threat, paranoia and dissociation. • Social skills training and structured psychosocial interventions for trauma-related social withdrawal.	• Useful for modifying cognitive biases implicated in trauma-psychosis interactions. • May reduce distress associated with hallucinations or paranoia.	• Effects are inconsistent across studies. • Mechanisms of change remain incompletely understood. • Benefit depends on patient insight, cognitive capacity and engagement.
Emerging / Controversial evidence	• Interventions targeting dissociation • Approaches addressing attachment insecurity. • Programs reducing social isolation • Early trauma-focused interventions in ARMS populations.	• Conceptually promising given the role of dissociation, attachment and social disconnection in trauma-psychosis pathways. • Potential preventive benefits, especially in at-risk mental states.	• Empirical evidence remains limited. • Many studies are preliminary, small or uncontrolled. • Risk of destabilization if implemented without clinical readiness. • Unclear which patient subgroups benefit most.

Finally, the integration of peer-led movements may allow the incorporation of experiential elements into the biomedical model, helping patients make sense of their psychotic experiences. An approach that promotes the understanding of phenomena such as hallucinations and delusions in light of the patient's narrative thus allows recentering the experience, giving it meaning, justification, and an entity with which the individual can interact, and opening the possibility for new therapeutic opportunities.

LIMITATIONS AND FUTURE DIRECTIONS

Regarding the limitations of this work, as it is a narrative review, there is likely a selection bias. On the other hand, the fact that a systematic methodology was not followed may result in biased and superficial analyses. Finally, the inclusion of studies with different methodological quality levels compromises and hinders the generalization of the present conclusions. In the future, more and higher-quality studies are needed to better delineate the boundaries between disorders classically linked to trauma and psychosis (in its different manifestations), in order to seek more

differentiated (and more adapted) responses and treatments for the different groups of patients with these pathologies.

CONCLUSION

Traumatic experiences increase the risk of developing psychosis and influence its expression and prognosis. The relationship between trauma and psychosis is complex and still poorly understood, probably mediated by cognitive, emotional, social, and neurobiological factors, which are expressed through potentially intermediate presentations diagnosed as DSO or ARMS. Furthermore, individuals with psychosis exhibit a high prevalence of post-traumatic symptoms, most of which remain neglected. Although some interventions, such as CBT and EMDR, are effective in cases of comorbidity, individuals with psychotic disorders rarely benefit from them due to the underdiagnosis of trauma in this population. It is therefore important to increase scientific knowledge about the importance of trauma in psychosis, as well as to translate these findings into clinical practice to expand appropriate preventive and therapeutic measures.

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JB: Conceptualização, metodologia, análise formal, redação e revisão.

MP: Conceptualização, investigação, redação e revisão.

SM: Conceptualização, análise formal, redação e revisão.

JC: Redação e revisão.

Todos os autores aprovaram a versão final a ser publicada.

CONTRIBUTORSHIP STATEMENT

JB: Conceptualization, methodology, formal analysis, writing, and editing.

MP: Conceptualization, research, writing, and editing.

SM: Conceptualization, formal analysis, writing, and editing.

JC: Writing and editing.

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