

Trauma and Serious Mental Illness

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Understanding Trauma

The image features a solid blue background. A thick orange border frames the central text. The text "Understanding Trauma" is written in a bold, white, sans-serif font and is centered horizontally and vertically. Two orange arrows are present: one starts at the bottom-left corner of the orange border and points horizontally to the right; the other starts at the top-right corner and points vertically downwards.

Traumatic Events

→ Rape/Sexual Abuse

→ Physical Abuse

→ Robbery

→ Accidents

→ Human Trafficking

→ Emotional Abuse

→ Combat

→ Natural Disasters

→ Sudden Death or Traumatic
Experience of Loved One

PTSD Criteria

- Exposure to Actual or Threatened Death, Serious Injury, or Sexual Violence
- Intrusive Symptoms (May not appear distressing in children; may be reenacted in play)
- Persistent avoidance of Stimuli Associated with the Traumatic Event(s)
- Negative Alterations in Cognitions and Mood Associated with the Traumatic Event(s)
- Alterations in Arousal and Reactivity
- Disturbance Causes Clinically Significant Distress or Impairment

Understanding Serious Mental Illness (SMI)



Severe or Serious Mental Illness (1)

- Diagnosable mental, behavioral, or emotional disorder
- Substantially interferes with person's life and ability to function
- Within the past year
- Over 18 years old
- Under 18 years old: "Serious Emotional Disturbance"

SAMHSA

Severe or Serious Mental Illness (2)

Typically

- Bipolar Disorder
- Schizophrenia
- Schizoaffective Disorder
- Treatment-Resistant Major Depression

Sometimes

- Some Personality Disorders (BPD and Schizotypal)
- Severe/Chronic Anxiety Disorders
- PTSD

SMI and Substance Use Disorders

→ Substance Use Disorders

→ Considered a “psychiatric disorder”

→ Not typically included as an SMI when occurring alone

→ Substance Use Disorder often co-occurs with SMI

Bipolar Disorder

- Clear shifts in mood, energy, activity levels, and concentration
- Often experience periods of extremely “up,” elated, irritable or energized behavior and periods of feeling “down,” sad, indifferent or hopeless
- Psychotic symptoms (hallucinations and/or delusions) may or may not be present

Schizophrenia

- Significant impairments in perception of reality and changes in behavior
- Disorganized Behavior
- Disorganized Thinking
- Negative Symptoms
- Extreme Agitation or Slow Movements
- Cognitive Difficulties
- Persistent Delusions
- Persistent Hallucinations
- Experiences of Influence, Control, or Passivity

Treatment-Resistant Depression

- Subset of Major Depression that does not respond to traditional and first-line treatments
- Symptoms may be more severe
- Depressive episodes may last longer
- May have more episodes throughout the lifetime

Schizoaffective Disorder

- Delusions
- Hallucinations
- Disorganized Thinking
- Depressed Mood
- Manic Symptoms

Prevalence Rates



What we know...

- 14.6 million American adults or 5.7% reported having SMI in the past year.
 - Via SAMHSA 2023 National Survey on Drug Use and Health
- Prevalence of specific disorders can be difficult to determine
 - Symptom overlap
 - Complexity of diagnoses
 - Varying methods for determining diagnoses

Prevalence by Type

- Schizophrenia and Related Psychotic Disorders – 0.25% - 0.64% (NIMH)
- Schizoaffective - 0.3% (less common than Schizophrenia)
- Bipolar Disorder – 4.4%
- Major Depression – 8.3%
 - 30% Treatment Resistant Depression (Zhdanova et al 2021)
- Borderline Personality Disorder – 1.4% - 5.9%
- Schizotypal Personality Disorder – 0.6% to 4.6%

Trauma Prevalence Estimates

General Population

- 50 – 70% have experienced at least one traumatic event

People with SMI

- Far exceeds the general population
- Multiple traumas
- People with Psychotic Disorder have experienced at least one traumatic event

Adult Trauma and SMI

SMI – Physical Abuse

→ Women – 75%

→ Men – 79%

SMI – Sexual Abuse

→ Women – 57%

→ Men – 25%

Domestic Violence

- Both men and women with SMI receiving psychiatric services are 2 – 8 times more likely to experience sexual and domestic violence
 - Khalifeh et al (2014)
- Both men and women with Bipolar Disorder are more than 8 times more likely to report ever experiencing partner violence than people with no mental disorder
 - Trevillion et al (2012)

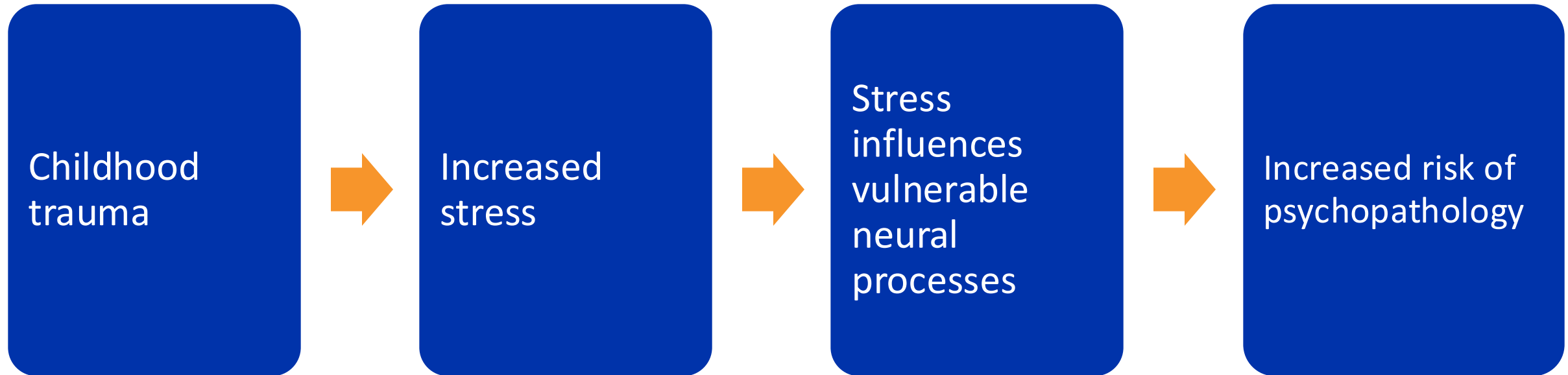
Relationship Between Trauma, Stress and Severe Mental Illness



Stress-Vulnerability

- Genetic or biological vulnerability to psychosis and BPD
- People can withstand a certain amount of stressors
- Once someone's stress threshold is reached, stress influences their neural processes
- Possible increased risk of psychosis and BPD

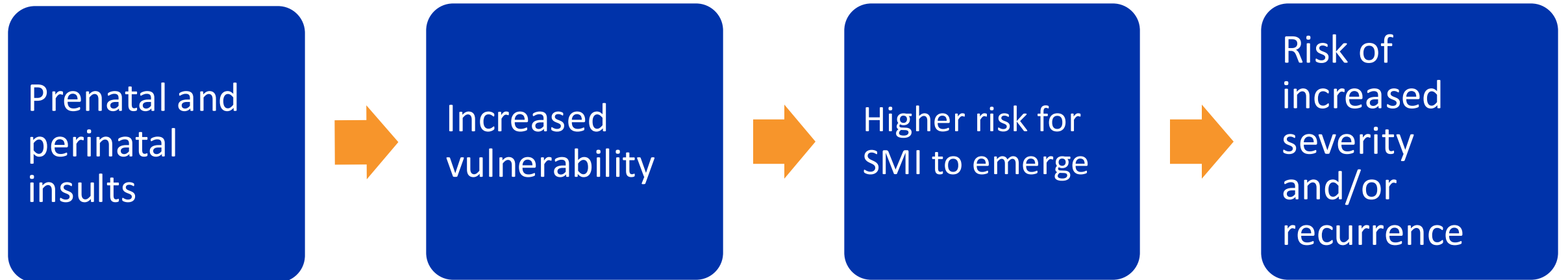
Stress-Vulnerability Model



Stress-Sensitization

- Genetic or biological vulnerability and major stress may cause psychosis or BPD to emerge
- CT may intensify preexisting neurobiological vulnerability
- Less stress needed for recurring psychopathology and/or increased severity

Stress-Sensitization Model



Trauma and SMI

People with SMI

- Physical Abuse – 45%
- Sexual Abuse – 35%

General Population

- Physical Abuse – 21%
- Sexual Abuse – 23%

Childhood Trauma and SMI

SMI – Physical Abuse

→ Women – 54%

→ Men – 58%

SMI – Sexual Abuse

→ Women – 49%

→ Men – 29%

Childhood Trauma and Psychosis

- Childhood Trauma linked to:
 - Increased occurrence of psychosis
 - More persistent psychosis
 - Subclinical psychotic experiences

Childhood Trauma and Bipolar

→ Childhood Trauma linked to:

→ Increased Occurrence

→ Earlier Age of First Episode

→ Increased Severity

→ Increased Rapid Cycling

→ More frequent shifts between mood episodes

→ Increased Risk of Suicidal Behavior

Childhood Trauma and Major Depressive Disorder (MDD)

→ Childhood Trauma may:

→ Produce symptoms earlier

→ Create cycles that last longer and happen more frequently

→ Increase risk of morbidity

Increased Trauma Risk and SMI

→ Social Isolation

→ Impulsivity

→ Emotional Instability

→ Emotional Vulnerability

→ Homelessness

→ Difficulty Recognizing Risks

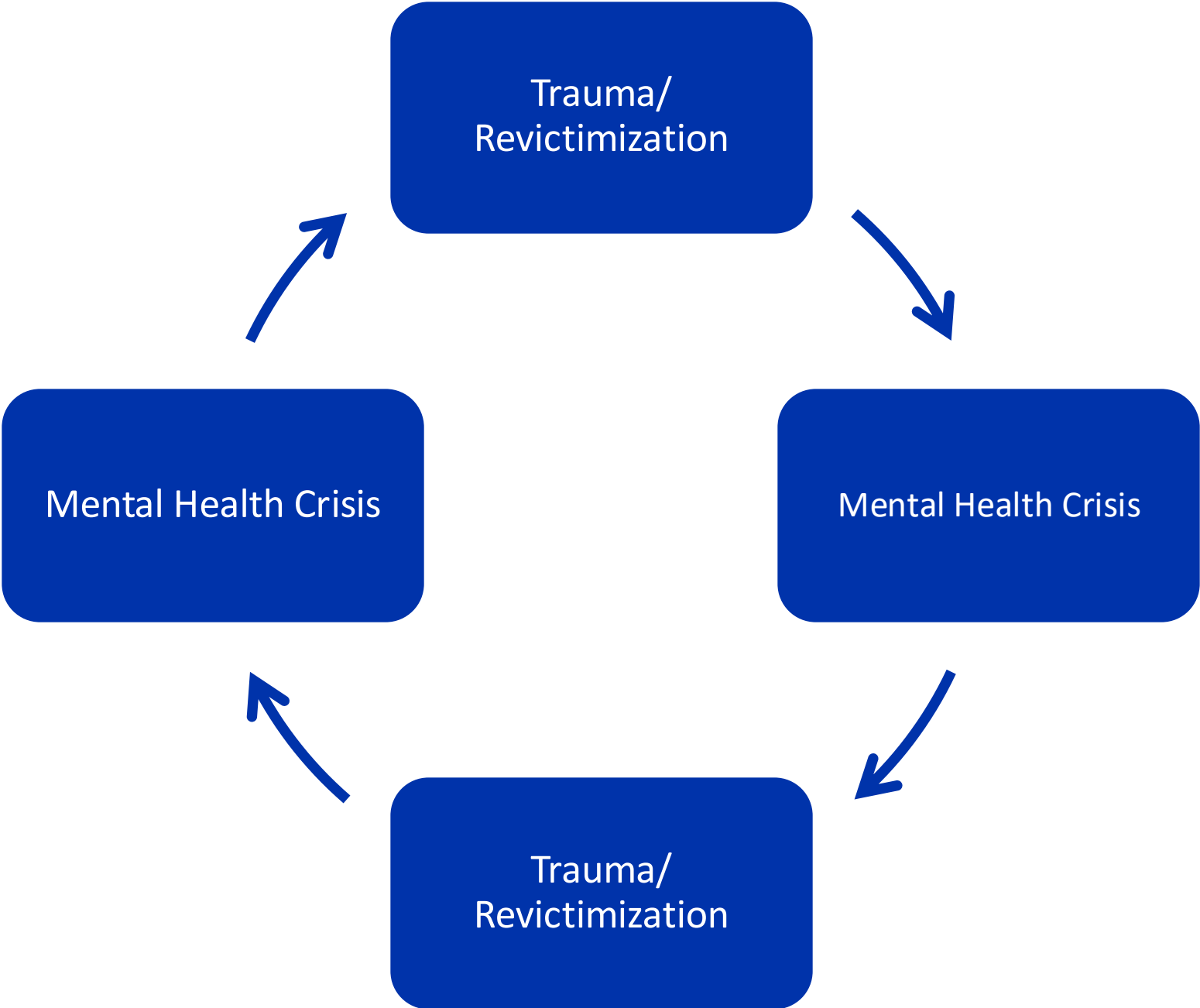
→ Substance Misuse

→ Emotional and/or Financial Abuse Related to the SMI

Trauma of SMI

- Experiencing SMI may be traumatizing
 - Family Distress and Loss of Friends
 - Social Stigma and Discrimination
 - Interpersonal Challenges
 - Unemployment
 - Treatment and Hospitalization
 - Intersection of Systems of Oppression

Trauma – SMI Cycle



Trauma Assessment Challenges (1)

- Limited confidence in self-reports
- Fears of exacerbating SMI symptoms
- Individual may be retraumatized by initial trauma-related questions and shut down
- May avoid talking about traumatic experience unless directly asked

Trauma Assessment Challenges (2)

- Diagnostic Overshadowing
 - Highly distressing symptoms of SMI may block the importance of trauma symptoms for the clinician
 - Symptom Overlap/Misinterpretation

- Intersectionality, Bias. and Diagnostic Overshadowing
 - Race/Ethnicity
 - Ability
 - Gender Identity
 - Sexual Orientation

Symptom Overlap: PTSD vs. SMI (1)

- Flashbacks
- Memories of traumatic events
- Avoidance of trauma stimuli/reminders
- Over-arousal
 - Racing thoughts
 - Easily startled
 - Physical responses
- Hallucinations
- Delusions
- Negative symptoms
 - Lack of interest/enjoyment
 - Lack of motivation
 - Lowered emotional expression
- Mania

Symptom Overlap: PTSD vs. SMI (2)

- Psychotic symptoms including hallucinations, delusions, and paranoia can occur secondary to PTSD
- Not considered a “Psychotic Disorder”

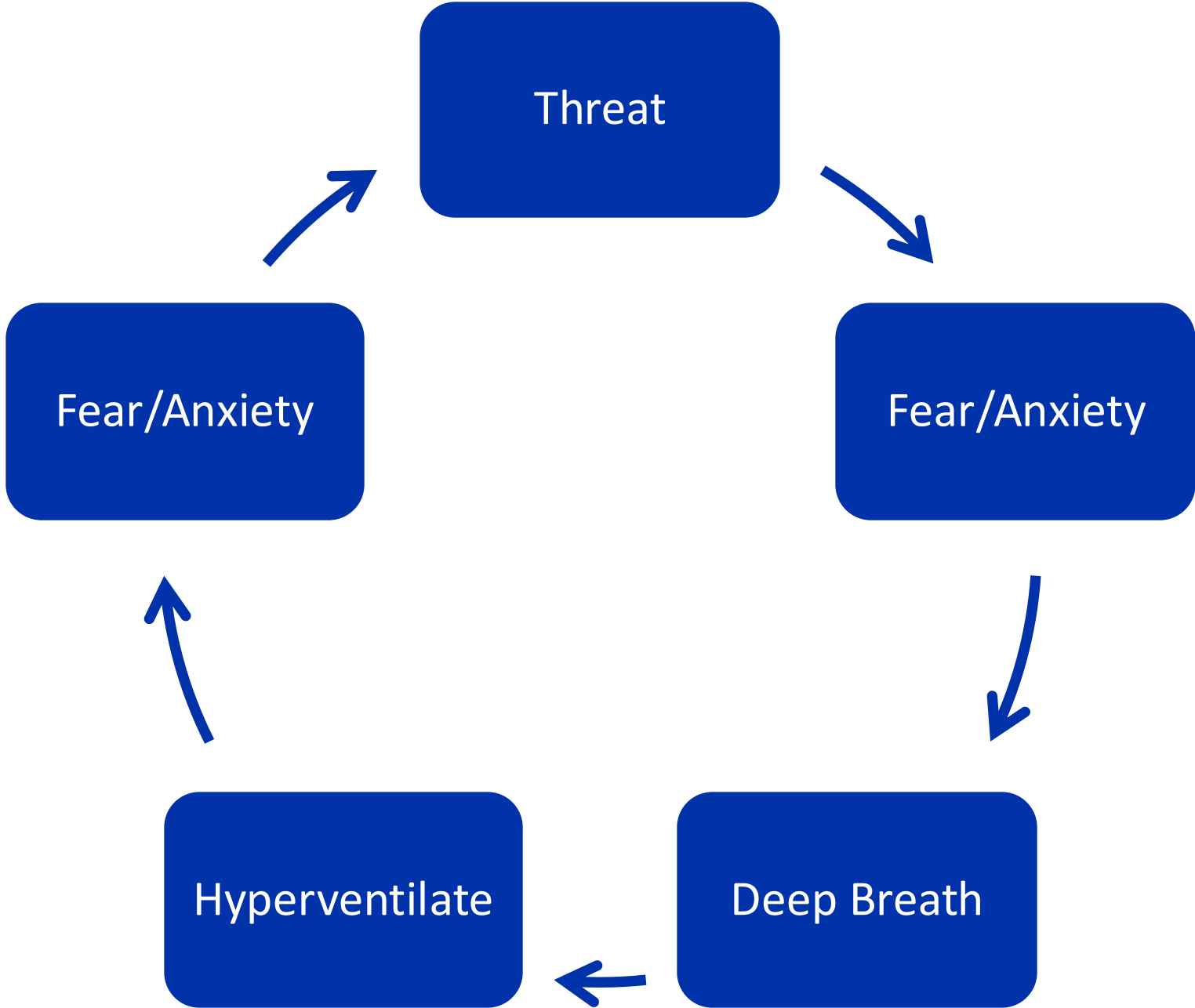
Trauma-Informed Care

- Evidence-based trauma treatments are not offered routinely to people with SMI, such as those with psychotic symptoms
- SAMHSA recommends all treatment programs implement a trauma-informed approach
 - Recognizes signs of trauma
 - May or may not include trauma-specific treatments
 - Policies and practices geared to avoid retraumatization

Helping Survivors Cope with Symptoms



Deep Breathing



Breathing Retraining

- Unless preparing for a truly dangerous situation we do not really need deep breaths
- What we really need is less air and slow breathing
- Decreases negative thoughts by being mindful of the present moment
- Paranoia - “Clear your head so you can think straight” rather than “relax”
- Early step in the Cognitive Restructuring (CR) for PTSD program
 - Mueser & Gottlieb (2025)

Benefits of Breathing Retraining

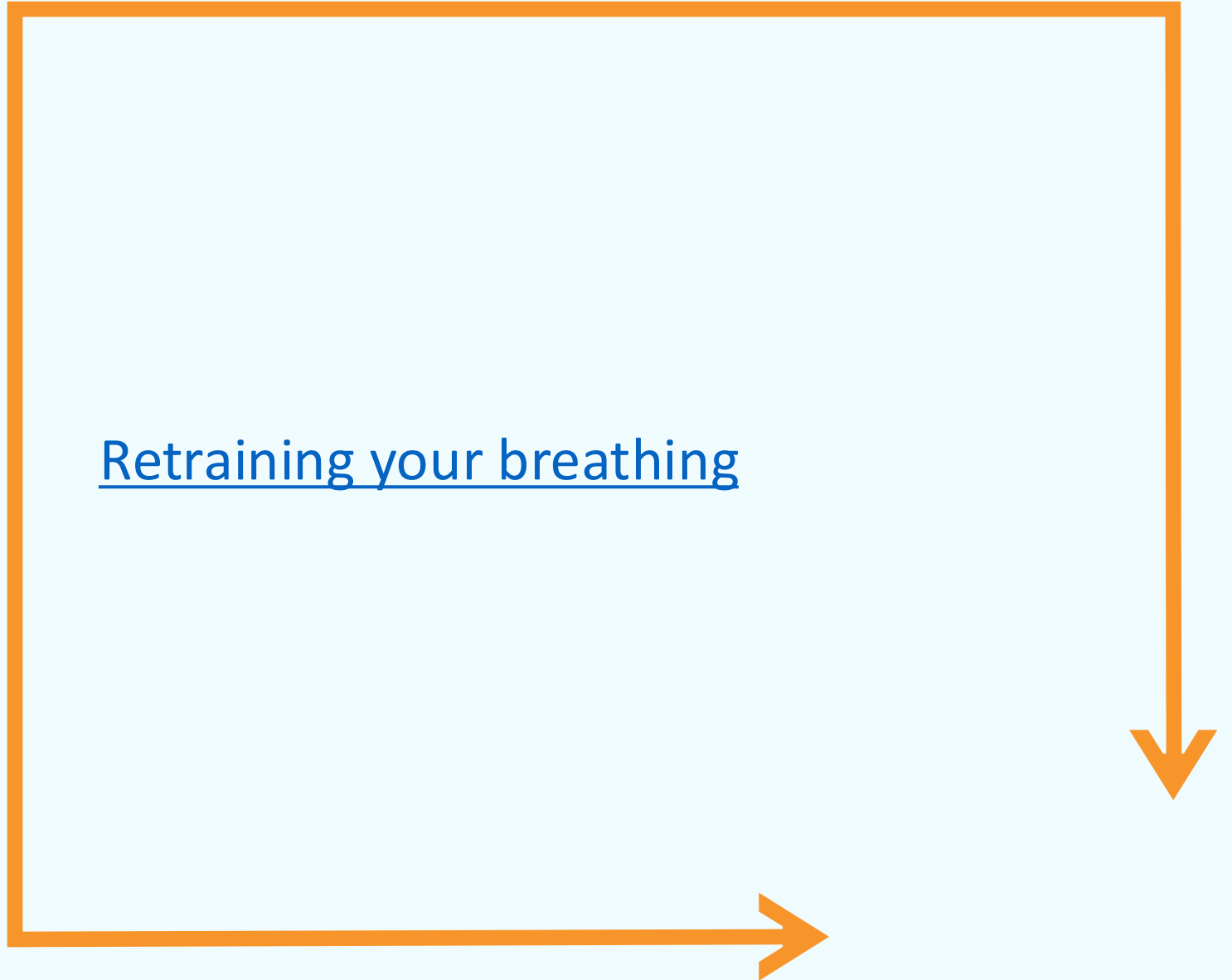
- Decreases arousal, anxiety and other PTSD symptoms
- Focuses attention when not anxious
- Relaxes the body, decrease fight/flight/freeze response
- Can be use in the moment or preemptively

How to Retrain Breathing

- Choose a word you find relaxing (usually one syllable, ex. “Calm”)
- Take a regular breath (not deep)
- Exhale very slowly through the mouth while saying your relaxing word
- Pause before taking your next normal inhalation (count of four)
- Practice several times a day, 10 to 15 breaths

Let's Practice

Retraining your breathing



Coping with SMI and Trauma Symptoms (1)

Non-stressful actions requiring concentration

- Reading/Studying
- Sub-Vocalizing (ex. reading aloud or singing under your breath)
- Household Repairs
- Crafts

Coping with SMI and Trauma Symptoms (2)

Engage the senses

- Find and Point to 5 different objects in the room. Say the name out loud. 5 Rounds
- Hold a small object and focus on how it feels
- Sip a non-alcoholic beverage
- Listen to instrumental music
- Sensory Soothing – warm bath, weighted blanket
- Hum
- Insert one ear-plug

Coping with SMI and Trauma Symptoms (3)

- Distraction (ex. do an easy chore)
 - Does not tend to be effective long-term
- Do something constructive/self-esteem building
- Establish or re-establish structure and routine
- Address sleep hygiene

Coping with SMI and Trauma Symptoms (4)

- Build upon healthy coping strategies already or previously used
 - Social contacts
 - Spirituality
 - Hobbies
 - Exercise

Coping with SMI and Trauma Symptoms (5)

- If receiving mental health services, follow established action plan
- Contact mental health provider or seek emergency services in accordance with action plan

Helping Others to Regulate (1)

- Acknowledge emotions without escalating them (ex. “It sounds like you are worried.”)
- Keep your language clear, simple and nonjudgmental
- Do not over-engage
- Adjust the environment (ex. increase or decrease lighting, offer distractions, attend to noise)

Helping Others to Regulate (2)

- Avoid arguing or challenging delusions and hallucinations while not buying into them
- Respond honestly
- If they are frightened offer calm reassurance (ex. “I’m here with you.”)
- Offer comforting touch if appropriate and with consent
- Maintain clear emotional and physical boundaries

Helping Others to Regulate (3)

- Encourage and assist in obtaining trauma-informed mental health care
- Assist in connecting with support groups through established organizations (ex. NAMI)
- **ALWAYS seek emergency assistance if symptoms create danger to self or others**

Q&A

The image features the text "Q&A" in a 3D, white, sans-serif font. Each character is suspended by a thin white vertical line from the top edge of the frame. The letters are set against a solid teal background. The "Q" is on the left, the ampersand "&" is in the middle, and the "A" is on the right. The letters have a slight shadow on the surface below them, giving them a three-dimensional appearance.