Psychosis, Trauma and Dissociation
Contents

Foreword xiii
Alexander C. McFarlane

List of contributors xvii

Introduction 1
Andrew Moskowitz, Ingo Schäfer and Martin J. Dorahy

PART 1 Connecting trauma and dissociation to psychosis: Historical and theoretical perspectives 7

1 Historical conceptions of dissociation and psychosis: Nineteenth and early twentieth century perspectives on severe psychopathology 9
Warwick Middleton, Martin J. Dorahy and Andrew Moskowitz
1.1 Dissociation: Mesmerism, multiple personalities and hysteria 10
1.2 Psychosis: Insanity, dementia praecox and schizophrenia 12
1.3 Dissociation, psychosis and schizophrenia: The merging of constructs 15
1.4 Conclusion 17
References 18

2 Hysterical psychosis: A historical review and empirical evaluation 21
Eliezer Witztum and Onno van der Hart
2.1 Early literature on hysterical psychosis 22
2.2 Hysterical psychosis in Pierre Janet's dissociation theory 22
2.3 The decline of hysteria 24
2.4 The return of the diagnosis of hysterical psychosis 25
2.5 Systematic and empirical studies 27
2.6 Hysterical psychosis and reactive psychosis 28
2.7 Integration and concluding remarks 29
References 30
CONTENTS

3 Association and dissociation in the historical concept of schizophrenia 35

Andrew Moskowitz

3.1 The birth of schizophrenia 37
3.2 Splitting, dissociation and the unconscious 39
3.3 Complexes and fixed ideas 41
3.4 Loosening of associations 43
3.5 Summary and conclusions 45

References 47

4 Ego-fragmentation in schizophrenia: A severe dissociation of self-experience 51

Christian Scharfetter

4.1 Schizophrenic syndromes as self-disorders 52
4.2 The construct of ego-pathology 52
4.3 Clinical elaboration of ego-pathology 53
4.4 Empirical assessment of ego-pathology 57
4.5 Ego-fragmentation, association and the dissociation model 59
4.6 Dissociative mechanisms: What and where? 60
4.7 The continuum of dissociative mechanisms: The spectrum of dissociation 62

References 64

5 Delusional atmosphere, the psychotic prodrome and decontextualized memories 65

Andrew Moskowitz, Lynn Nadel, Peter Watts and W. Jake Jacobs

5.1 Multiple memory systems and the hippocampus 66
5.2 Phobias, panic attacks and post-traumatic stress disorder 67
5.3 A summary of relevant research findings in schizophrenia 68
5.4 The psychotic prodrome 70
5.5 Delusional atmosphere, the psychotic prodrome and decontextualized memories 74
5.6 Freud's 'The Uncanny' (1919) 75
5.7 Summary and conclusion 75

References 76

6 The complex overlap between dissociation and schizotypy 79

Timo Giesbrecht and Harald Merckelbach

6.1 Introduction 79
6.2 Overlap between measures of dissociation and schizotypy 80
6.3 Why dissociation and schizotypy overlap 81
6.4 Conclusion 85

References 86

7 Pierre Janet on hallucinations, paranoia and schizophrenia 91

Andrew Moskowitz, Gerhard Heim, Isabelle Saillot and Vanessa Beavan

7.1 Historical overview 92
7.2 Important Janetian concepts 93
7.3 Schizophrenia 95
CONTENTS

7.4 Paranoia 97
7.5 Hallucinations 98
7.6 Assessment and implications 101
References 102

8 From hysteria to chronic relational trauma disorder: The history of borderline personality disorder and its links with dissociation and psychosis 105
Elizabeth Howell
8.1 Historical overview 106
8.2 Theoretical analysis 109
8.3 Summary 113
References 113

9 An attachment perspective on schizophrenia: The role of disorganized attachment, dissociation and mentalization 117
Giovanni Liotti and Andrew Gumley
9.1 Attachment disorganization and dissociation 118
9.2 Trauma and loss in the lives of primary caregivers of psychiatric patients 120
9.3 Dissociation, schizotypy and psychotic experiences 122
9.4 Metacognition and mentalization deficits 124
9.5 Summary and theoretical integration 126
9.6 Concluding remarks 127
References 128

PART 2 Comparing psychotic and dissociative disorders: Research and clinical perspectives 135

10 Childhood trauma in psychotic and dissociative disorders 137
Ingo Schäfer, Colin A. Ross and John Read
10.1 Childhood trauma in patients with psychotic disorders 138
10.2 Childhood trauma in patients with dissociative disorders 141
10.3 The relationship between dissociation and psychosis 142
References 144

11 Dissociative symptoms in schizophrenia 151
Ingo Schäfer, Volkmar Aderhold, Harald J. Freyberger and Carsten Spitzer
11.1 Empirical studies on dissociation in patients diagnosed with schizophrenia 153
11.2 Dissociation and psychosis – what is the relationship? 158
11.3 Conclusion 160
References 160

12 Psychotic symptoms in complex dissociative disorders 165
Vedat Şar and Erdinç Öztürk
12.1 Hallucinations 166
12.2 Grossly disorganized behaviour 167
CONTENTS

12.3 Impairment in reality-testing: Trance-logic or psychotic breakdown? 168
12.4 Conditions mimicking formal thought disorder 169
12.5 Schneiderian symptoms: Are they nonspecific? 169
12.6 Psychopathogenesis of psychotic symptoms in dissociative disorders 170
12.7 An interaction (duality) model 171
12.8 Conclusions and recommendations for future research 172
References 173

13 Advances in assessment: The differential diagnosis of dissociative identity disorder and schizophrenia 177
Marlene Steinberg and Harold D. Siegel
13.1 Dissociative identity disorder and schizophrenia: Overlapping and diagnostically distinct symptoms 178
13.2 Distinguishing between schizophrenia and dissociative identity disorder: Assessment of dissociation 181
13.3 Clinical implications 185
References 186

14 Cognitive perspectives on dissociation and psychosis: Differences in the processing of threat? 191
Martin J. Dorahy and Melissa J. Green
14.1 Trauma and threat in dissociative and psychotic individuals 192
14.2 Attention and working memory 194
14.3 Conclusion 201
References 202

15 Depersonalization disorder and schizotypal personality disorder 209
Daphne Simeon and Holly K. Hamilton
15.1 Phenomenology of depersonalization and schizotypy 210
15.2 Neurocognitive profiles of depersonalization and schizotypy 211
15.3 Neurobiology of depersonalization and schizotypy 212
15.4 Clinical vignettes 215
15.5 Conclusion 216
References 217

16 Contributions of traumatic stress studies to the neurobiology of dissociation and dissociative disorders: Implications for schizophrenia 221
Eric Vermetten, Ruth Lanius and J. Douglas Bremner
16.1 Introduction 221
16.2 Differentiation of abnormal thought processes in dissociative disorders and schizophrenia – vignettes 222
16.3 Schizophrenia research: From psychosocial events to traumatic stress 223
16.4 Effects of traumatic stress on psychobiological systems 224
16.5 Pharmacologically induced dissociation 226
16.6 Neurotransmitters in dissociation and psychosis 227
16.7 Different neural circuits in schizophrenia and dissociative disorders 228
CONTENTS  ix

16.8 Heterogeneity of trauma response: Neural circuits in dissociative disorders and other trauma-related disorders 230
16.9 Vulnerable phenotypes 231
16.10 Concluding remarks 232
References 233

17 Treating dissociative and psychotic disorders psychodynamically 239
Valerie Sinason and Ann-Louise S. Silver
17.1 Historical background 240
17.2 Clinical vignettes 242
17.3 Treating dissociative states 248
17.4 The role of trauma in creating psychopathology 249
17.5 Conclusion 251
References 251

PART 3 Assessing and treating hybrid and boundary conditions: Clinical and existential perspectives 255

18 Dissociative psychosis: Clinical and theoretical aspects 257
Onno van der Hart and Eliezer Witztum
18.1 Dissociative psychosis and Pierre Janet’s dissociation theory 258
18.2 Dissociative psychosis and the theory of structural dissociation of personality 259
18.3 Discussion and conclusion 267
References 268

19 Trauma-based dissociative hallucinosis: Diagnosis and treatment 271
Barry Nurcombe, James G. Scott and Mary E. Jessop
19.1 Psychotic symptoms in post-traumatic stress disorder (PTSD) and complex PTSD 272
19.2 Hallucinations in children and adolescents 272
19.3 Clinical vignettes 274
19.4 Dissociative hallucinosis 275
19.5 The treatment of dissociative hallucinosis 276
19.6 Conclusion 277
References 278

20 Dissociative schizophrenia 281
Colin A. Ross
20.1 A dissociative structural model of the psyche 283
20.2 The dissociative subtype of schizophrenia 287
20.3 A clinical case example of dissociative schizophrenia 289
20.4 Research data supporting the existence of dissociative schizophrenia 292
20.5 Research and clinical implications of dissociative schizophrenia 293
References 293
CONTENTS

21 The role of double binds, reality-testing and chronic relational trauma in the genesis and treatment of borderline personality disorder
Ruth A. Blizard
21.1 The effects of relational trauma on reality-testing
21.2 Caregiver pathology, double binds, disorganized attachment and dissociated self-states
21.3 Treating the effects of dissociative, psychotic or sociopathic caregivers on reality-testing
21.4 Conclusion: Borderline psychotic traits stemming from relational trauma require relational treatment
References

22 Pharmacotherapy in the collaborative treatment of trauma-induced dissociation and psychosis
Thom Rudegeair and Susie Farrelly
22.1 A brief overview of psychopharmacologic philosophy
22.2 The complex presentation of people who dissociate
22.3 Overview of a ‘good enough’ medical approach to the treatment of dissociative/psychotic phenomena
22.4 Some specific recommendations for the use of psychotropic medications in the treatment of persons with dissociative symptoms
22.5 Summary
References

23 Accepting and working with voices: The Maastricht approach
Dirk Corstens, Sandra Escher and Marius Romme
23.1 The history of the Maastricht approach and of the hearing voices movement
23.2 Relevant research findings
23.3 Assessment: The Maastricht hearing voices interview
23.4 Formulation: Making the construct/breaking the code
23.5 Case vignette: Maureen
23.6 Making a treatment plan
23.7 Talking with the voices
23.8 Recovery
23.9 Summary
References

24 Dissociation, psychosis and spirituality: Whose voices are we hearing?
Patte Randal, Jim Geekie, Ingo Lambrecht and Melissa Taitimu
24.1 A cosmic battle: Patte’s story
24.2 Maori perspectives
24.3 Shamanic crisis
24.4 A cosmic battle – Part 2
24.5 The subjugation of other cultural perspectives
24.6 Dissociation and psychosis as states of consciousness
## CONTENTS

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>24.7 A cosmic battle – Part 3</td>
<td>341</td>
</tr>
<tr>
<td>24.8 From victim to victor – a new model</td>
<td>342</td>
</tr>
<tr>
<td>24.9 Conclusion</td>
<td>343</td>
</tr>
<tr>
<td>References</td>
<td>343</td>
</tr>
</tbody>
</table>

## Index

Index 347
Foreword

_Time is the substance I am made of. Time is the river that carries me away, but I am the river._ (Borges, 1964 p. 17).

Oliver Sacks commenting on Jorge Luis Borges:

_Our movements, our actions, are extended in time, as are our perceptions, our thoughts, the contents of consciousness. We live in time, we organize time, we are time creatures through and through._ (Sacks, 2004, p. 41).

The human capacity to hold the present in the context of past experience, while reacting flexibly and appropriately to the current environment, is one of the miracles of biological evolution. It is not surprising that such a complex process of holding and organizing the present is subject to the risk of major disruption and disaggregation. This volume edited by Moskowitz, Schäfer and Dorahy is a fascinating and scholarly miscellany of works that brings together two perspectives of how human consciousness is disrupted. In modern psychiatry, the dominance of the phenomenological perspective, combined with the ascendancy of biological psychiatry, has tended to marginalize the psychodynamic perspectives of mental life. The neurobiological approach, while rich in detail, at times can be simplistically mechanistic and distract from concepts about the mind. However, any clinician who deals with patients readily understands the limitations of the strict phenomenological approach as a method of understanding a patient’s distress and the circumstances that evoke or intensify their symptoms.

This exploration of the link and disjunctions between dissociation and psychosis is a welcome and rich addition to the psychiatric literature, serving to counterbalance the relative poverty of psychodynamic thinking in current clinical opinion, which tends to be driven by empirical observation dependent upon statistical analysis with computers. The subtleties and nuances of mental life, which this book explores in a rigorous and thoughtful manner, are not so readily subjected to reductionist observation. Rather, a book such as this embraces the richness of the experience of the human mind with its fragility, particularly when it becomes overwhelmed with environmental and internal inputs.

Clinicians readily understand how psychotic experience arises from the failure of the brain to screen, prioritize and symbolize environmental inputs. These misperceptions, combined with the disorganized internal mechanisms of language, which are core elements of the psychotic experience, are directly reflected in the phenomenology of the psychotic
disorders. There is an intuitive logic in the surgical and minuscule dissection of these phenomena and their careful definition as reflected in the phenomenological tradition. On the other hand, the nature of dissociation, by the fact that it is often reflecting on the absence of registration of relevant memories or environmental experiences (e.g. amnesia or conversion), is a far more demanding field of investigation. These constructs have been treated with considerable suspicion historically and have often evoked the possibility of suggestion, mimicry, or malingering. The subtlety and fluidity of dissociative phenomena also make them much more difficult to observe systematically and document. These are phenomena that demand that the clinician have a sensitive awareness of the interface between the patient’s external world and its mental reflection. The fragmentation or disruption of this process is at the core of the dissociative experience.

This book is masterful in the way that it brings together the concepts of psychosis and dissociation, using the link of traumatic experiences. The flourishing of interest in the field of psychological trauma in the last three decades following the inclusion of post traumatic stress disorder in DSM-III has provided a bridge for the reconsideration of many of these constructs. The field of trauma has taught us about how overwhelming experience can disaggregate the registration systems of the brain and disrupt the normal processes that go into laying down memories that can be flexibly accessed and utilized for determining future behavior. Rather, traumatic memories that are stored in more primary sensory representations without the same degree of linguistic transformation as normal memories come to have an autonomy and dominance in an individual’s mental life. These memories have the capacity to disrupt the integration of an effective reaction to subsequent events and experiences. Dissociative mechanisms play a core role in the maladaptive attempts of an individual to mitigate against his or her overwhelming distress.

This volume reminds clinicians that psychosis, of itself, is a highly traumatic experience and that significant elements of the phenomenology of these conditions represent the patients’ secondary adaptation at minimizing their overwhelming sense of confusion and disorganization. The various contributions further highlight the complexity of these adaptations and alert clinicians to the dynamic processes that go into the individual’s attempts to modulate and limit the over-stimulation driven by changing and rich environments.

By taking an historical perspective, we are also reminded that generations of highly sophisticated and observant clinicians have been aware of the importance of dissociative mechanisms as being a central element in the psychotic experience. However, as is so often the case in human knowledge, conceptual approaches tend to be dichotomized and the value of observations, in one domain, is diminished by any competitor. Psychiatry in the late 19th and early 20th centuries was a battleground between the strict phenomenologists and the emerging world of psycho-analysis, and the discipline has struggled to find a balance between these two important perspectives. In some regards, DSM-III represented the final rejection of the dominance of Freudian views of psychopathology, again re-asserting the importance of empirical phenomenology in clinical science. Unintentionally, this re-orientation significantly disenfranchised psychodynamic thinking in clinical practice. The field of traumatic stress has been one area that has built and championed this bridge. This current volume is a landmark work, demonstrating the importance of holding a sophisticated knowledge of the phenomenological perspective whilst being informed by the dynamic perspective, which is richly embodied in the symptoms and nature of dissociation. By bringing these two perspectives together and re-visiting the historical debates that have existed, we are given an opportunity to reconsider these highly sophisticated and reflective
FOREWORD

accounts of patients’ symptoms and psychopathology, in the light of modern advances in neuroscience. One would hope that such a volume will stimulate an exploration of these subtle phenomena which lie at the core of the psychopathological experience.

The challenge ahead is to use this body of knowledge and integrate it with the findings of many neuroimaging studies that tell us a great deal about the functional circuitry of the brain. Interestingly, these modern technologies have highlighted the subtlety of interaction with the environment and how one of the great challenges of evolution was the development of systems that could hold consistent representations of the external environment. It is not surprising that these complex neurophysiological processes are disrupted, either because of an abnormality of the brain circuitry, as is the case in psychotic symptoms, or by the external environment and the arousal it provokes. Ultimately the individual who struggles to hold a reflection of reality will then be overwhelmed by any further impingements from their environment. In this way we can only really understand the nature of psychosis by incorporating an understanding of dissociative processes.

This volume is recommended to clinicians and researchers alike and, by drawing from the past, provides an unusual insight into the future.

Alexander C. McFarlane

The Centre for Military and Veterans’ Health

The University of Adelaide, Australia

References


List of Contributors

Volkmar Aderhold
Institute for Social Psychiatry, Ernst-Moritz-Arndt University, Ellernholtzstr. 1-2, D-17487 Greifswald, Germany
v.aderhold@gmx.de

Vanessa Beavan
St Lukes CMHC, 615 New North Road, Morningside, Auckland, New Zealand
vbeavan@adhb.govt.nz

Ruth A. Blizard
PO Box 4562, Boulder, Colorado 80306, USA
www.ruthblizard.com; info@ruthblizard.com

J. Douglas Bremner
Departments of Psychiatry and Behavioral Sciences and Radiology, and Emory Clinical Neuroscience Research Unit, Emory University, Emory Briarcliff Campus, 1256 Clifton Road, Atlanta GA 30306, USA
www.dougremner.com; jdbremn@emory.edu

Dirk Corstens
RIAGG Maastricht, Parallelweg 45–47, 6221 BD Maastricht, The Netherlands
www.hearingvoicesmaastricht.eu; d.corstens@riagg-maastricht.nl

Martin J. Dorahy
Department of Psychology, University of Canterbury, Private Bag 4800, Christchurch, 8041, New Zealand
martin.dorahy@canterbury.ac.nz

Sandra Escher
Dreesch 11 B, 3798 °S Gravenvoeren, Belgium
a.escher@skynet.be

Susie Farrelly
Cornwall House, Building 16, Greenlane Clinical Site, Greenlane, Auckland, New Zealand
SuzieF@adhb.govt.nz
LIST OF CONTRIBUTORS

Harald J. Freyberger
University of Ernst-Moritz-Arndt Greifswald, Rostocker Chaussee 70, D-18437 Stralsund, Germany
freyberg@uni-greifswald.de

Jim Geekie
St Lukes CMHC, 615 New North Road, Morningside, Auckland, New Zealand
JGeekie@adhb.govt.nz

Timo Giesbrecht
Maastricht University, PO Box 616, 6200 MD Maastricht, The Netherlands
T.Giesbrecht@psychology.unimaas.nl

Melissa J. Green
School of Psychiatry, University of New South Wales & Black Dog Institute, Prince of Wales Hospital, Randwick, NSW, 2031
melissa.green@unsw.edu.au

Andrew Gumley
University of Glasgow, 1055 Great Western Road, Glasgow G12 0XH, UK
aig2r@clinmed.gla.ac.uk

Holly K. Hamilton
Mount Sinai School of Medicine, Box 1230, One Gustave L. Levy Place, New York, NY 10029, USA
holly.hamilton@mssm.edu

Gerhard Heim
Düppelstrasse 29, D-12163 Berlin, Germany
gjheim@t-online.de

Elizabeth Howell
817 Broadway, 9th Floor, New York, NY 10003, USA
www.drelizabethhowell.com; efhowell1@earthlink.net

W. Jake Jacobs
University of Arizona, 1503 E. University Blvd., Tucson, AZ 85721, USA
wjj@email.arizona.edu

Mary E. Jessop
Royal Children’s Hospital, Brisbane, Queensland 4000, Australia
mejessop@tpg.com.au

Ingo Lambrecht
Segar House, Level 3, 126 Khyber Pass Road, Grafton, Auckland, New Zealand
IngoL@adhb.govt.nz

Ruth Lanius
Department of Psychiatry and Neuroscience, University Western Ontario and London Health Sciences, 39 Windermere Road, London, Ontario, Canada, N6A 5A5
Ruth.Lanius@lhsc.on.ca
LIST OF CONTRIBUTORS

Giovanni Liotti
Scuola di Psicoterapia Cognitiva, Viale Castro Pretorio, 116, 00185 Roma, Italy

Harald Merckelbach
Maastricht University, PO Box 616, 6200 MD Maastricht, The Netherlands
H.Merckelbach@Psychology.Unimaas.Nl

Warwick Middleton
Suite 4D, 87 Wickham Terrace, Brisbane 4000, Australia
warmid@tpg.com.au

Andrew Moskowitz
University of Aberdeen, Clinical Department of Mental Health, Division of Applied Health Sciences, Royal Cornhill Hospital, Aberdeen AB25 2ZH, Scotland, UK
a.moskowitz@abdn.ac.uk

Lynn Nadel
University of Arizona, 1503 E. University Blvd., Tucson, AZ 85721, USA
nadel@u.arizona.edu

Barry Nurcombe
49 Highview Terrace, St. Lucia, 4067, Brisbane, Queensland, Australia
bnurcombe@uq.edu.au

Erdinç Öztürk
Istanbul Universitesi, Istanbul Tip Fakültesi Psikiyatri Klinigi 34390 Çapa Istanbul, Turkey
erdincozturk@klinikpsikoterapi.com

Patte Randal
Buchanan Rehabilitation Centre, 27 Sutherland Road, Pt. Chevalier, Auckland, New Zealand
PatteR@adhb.govt.nz

John Read
University of Auckland, Private Bag 92019, Auckland, New Zealand
j.read@auckland.ac.nz

Marius Romme
Dreesch 11 B, 3798 °S Gravenvoeren, Belgium
m.romme@skynet.be

Colin A. Ross
The Colin A. Ross Institute for Psychological Trauma, 1701 Gateway, Suite 349, Richardson, TX 75080, USA
www.rossinst.com; rossinst@rossinst.com

Thom Rudegeair
Auckland City Hospital, Grafton, Auckland 1023, New Zealand
ThomR@adhb.govt.nz

Isabelle Saillot
Institut Pierre Janet, 23 rue de La Rochefoucauld, 75009 Paris, France
institut@pierre-janet.com
LIST OF CONTRIBUTORS

Vedat Şar
Istanbul Üniversitesi, Istanbul Tip Fakültesi Psikiyatri Klinigi 34390 Çapa Istanbul, Turkey
www.vedatsar.com; vsar@istanbul.edu.tr

Ingo Schäfer
Department of Psychiatry and Psychotherapy, University Medical Centre Hamburg-Eppendorf, Martinistr. 52, D-20246 Hamburg, Germany
i.schaefer@uke.uni-hamburg.de

Christian Scharfetter
Psychiatric University Hospital Zürich, Post Box 1931, CH 8032 Zürich, Switzerland
christian.scharfetter@bluewin.ch

James G. Scott
Royal Children’s Hospital, Herston, Queensland 4029, Australia
drjamesscott@optusnet.com.au

Harold D Siegel
1061 Mirabelle Avenue, Westbury, New York, NY 11590, USA
Linkmets@aol.com

Ann-Louise S. Silver
4966 Reedy Brook Lane, Columbia, MD 21044–1514, USA
asilver@psychoanalysis.net

Daphne Simeon
Mount Sinai School of Medicine, Box 1230, One Gustave L. Levy Place, New York, NY 10029, USA
daphne.simeon@mssm.edu

Valerie Sinason
Clinic for Dissociative Studies, 815 Finchley Road, London NW11 8AJ, UK
vsinason@aol.com

Carsten Spitzer
University Department of Psychosomatic Medicine and Psychotherapy University Clinic Hamburg-Eppendorf and Klinikum Eilbek (Schön Kliniken) Martinistr. 52; 20246 Hamburg, Germany
cspitzer@uke.uni-hamburg.de

Marlene Steinberg
Northampton, MA, USA
www.drmsteinberg.com; steinberg@charter.net

Melissa Taitimu
PO Box 227, Tweed Heads, NSW 2485, Australia
mtaitimu@gmail.com

Onno van der Hart
Utrecht University, De Bosporus 46, 1183 GJ Amstelveen, The Netherlands
www.onnovdhart.nl; onnovdh@planet.nl
LIST OF CONTRIBUTORS

Eric Vermetten
Military Mental Health, Central Military Hospital, Department Psychiatry UMC Utrecht and Rudolf Magnus Institute of Neuroscience, Heidelberglaan 100, 3584 CX Utrecht, The Netherlands
e.vermetten@umcutrecht.nl

Peter Watts
P0 Box 101810, Wairau Park, North Shore City, 0745, New Zealand
wattspychology@orcon.net.nz

Eliezer Witztum
4 Revadium, Jerusalem 93391, Israel
elyiit@actcom.co.il
Introduction

Andrew Moskowitz, Ingo Schäfer and Martin J. Dorahy

In the 100 years since Eugen Bleuler introduced the term schizophrenia to describe the most disturbed of his hospitalized patients, the essential connection between traumatic life events, dissociative processes and psychotic symptoms has been lost. While Bleuler believed the core deficit underlying schizophrenia to be organic in nature, he felt that the symptoms arose understandably from emotional life experiences; occasionally, he wondered whether schizophrenia itself did as well:

The stronger the affects, the less pronounced the dissociative tendencies need to be in order to produce the emotional desolation. Thus, in many cases of severe disease, we find that only quite ordinary everyday conflicts of life have caused the marked mental impairment; but in milder cases, the acute episodes may have been released by powerful affects. And not infrequently, after a careful analysis, we had to pose the question whether we are not merely dealing with the effect of a particularly powerful psychological trauma on a very sensitive person rather than with a disease in the narrow sense of the word. (Bleuler, 1911: 300)\(^1\)

In this passage, Bleuler proposes an early version of a diathesis-stress model, in which a constitutionally-based diathesis (here dissociative tendencies; elsewhere, loosening of associations) requires the stresses of everyday life in order for schizophrenia to be expressed. But he also considers (though ultimately rejects) the possibility endorsed by his

\(^1\)Translated by Suenje Matthiesen.
INTRODUCTION

colleague Carl Jung that the intense affect of a traumatic experience could drive, all on its own, the splitting and deterioration seen in schizophrenia (Bleuler and Jung, 1908). And, around the same time, Morton Prince (1906) and others, heavily influenced by Pierre Janet’s theories (as was Jung), were also conceptualizing psychotic symptoms as dissociation-based.

Paradoxically, while late-nineteenth-century interest in linking dissociation and psychosis culminated in Bleuler’s work, he was also partly responsible for its demise. In his insistence on an organic basis for schizophrenia and, particularly, the astonishing breadth of his diagnosis – containing not only most forms of manic depression and personality disorder, but also the dissociative conditions of hysterical psychosis and multiple personality – Bleuler accelerated the loss of interest in the trauma-based disorders of dissociation, and helped to initiate the medicalization of schizophrenia.

This medicalization took centre stage in the latter part of the twentieth century, with the ascent and dominance of the biologically oriented neo-Kraepelinian movement, who called for a return to Kraepelin’s insistence on the discreteness of mental disorders, their biological and often genetic basis, and discontinuity between ‘normal’ and ‘abnormal’ functioning (Klerman, 1978). But these credos have become increasingly challenged. Ironically, the seed of their downfall – the Trojan Horse within the neo-Kraepelinian fort – was planted in their first creation, the DSM-III (APA, 1980). Two categories were included among the hundreds sanctioned – post-traumatic stress disorder (PTSD) and schizoaffective disorder – which undermined the assumptions of the neo-Kraepelinian model. PTSD (increasingly viewed as a form of dissociative disorder, e.g. Van der Hart, Nijenhuis and Steele, 2006) allowed that severe life events could produce serious mental disorders, even in the absence of any presumed genetic or biological predisposition, and schizoaffective disorder challenged the discreteness of schizophrenia and bipolar disorder, the twin pillars of the neo-Kraepelinian edifice.

And indeed, by the end of the twentieth century, the house that Kraepelin built began to look increasingly shaky, and the neo-Kraepelinian credos increasingly suspect. Schizoaffective disorder, initially proposed without diagnostic criteria, is now considered a valid psychiatric disorder, and research suggests that schizophrenia and bipolar disorder blend into one another on a variety of biological, cognitive and phenomenological dimensions (Marneros and Akiskal, 2007). Retrospective studies demonstrating that persons diagnosed with psychotic disorders (and dissociative disorders) report high levels of childhood trauma have been supplemented with prospective studies linking early adverse experiences to the development of psychotic symptoms (Janssen et al., 2004). Many psychotic symptoms, particularly so-called ‘Schneiderian’ symptoms which form the basis for the current diagnosis of schizophrenia, are found commonly in persons with dissociative disorders, possibly even more so than in schizophrenia. Auditory hallucinations, strongly emphasized in contemporary diagnoses of schizophrenia (but not by Bleuler), are now recognized to be common not only in dissociative disorders and PTSD, but also in persons with no diagnosable mental disorder (Moskowitz and Corstens, 2007), and delusions are found with such frequency in PTSD – not always with obvious traumatic content – that some have called for a psychotic subtype of PTSD (Alarcon et al., 1997).

Thus, the neo-Kraepelinian edifice is beginning to crumble. The last several years have seen numerous publications – including half a dozen books or special journal issues – dedicated to the connection between trauma and psychosis. Clearly, there is a