SciMedCentral

Annals of Psychiatry and Mental Health

Review Article

Trauma, Dissociation, Schizophrenia, and the Split Mind of Professionals

Judit Harangozó[1], Bernadett Szita[2], Bálint Bese[1]*, Zsolt Mérey[1] and István Gallai[1]

[1]Awakenings Foundation and Community Psychiatry Centre of Semmelweis University, Hungary

[2]Department of Gynecology, Semmelweis University, Hungary

*Corresponding author

Bese Bálint, Awakenings Foundation and Community Psychiatry Centre of Semmel weis University, Hungary, H-1089, Budapest, Kálvária tér 5. Hungary; Tel: 36 20 825 0222; Email: besebalint@gmail.com

Submitted: 31 August 2015

Accepted: 11 September 2015

Published: 14 September 2015

Keywords

- Trauma
- Dissociation
- Schizophrenia
- Hearing voices approach
- Family therapy

Abstract

One original schizophrenia concept, created by Eugen Bleuler and Carl Gustav Jung, integrated the biological vulnerability and the trauma-induced complexes that are responsible for splitting, many practitioners in modern psychiatry have lost the human aspects of this diagnosis and its humanistic viewpoints. Although schizophrenia figures several diagnostic categories away from trauma-induced disorders in DSM-V some research strongly supports that trauma and dissociation is part of the pathogenesis of psychosis and dissociative symptoms may be very close to those of psychosis. By the outstanding approach of Judith Herman, the authors of this report analyze some aspects of the widespread neglect of traumas by professionals.

After describing the development of the concept of schizophrenia and a short review of the research on trauma and dissociation in schizophrenia, the authors describe their preliminary experiences of their innovative practice at Awakenings Foundation in Hungary. With community- and family- based care as a backdrop, Hearing Voices Self-Help Groups were implemented with the involvement of users and family members. It helps patients and families give sense to and catch the symbolic meaning of the psychotic experiences and move away from hopelessness – often generated also by current psychiatry – towards a meaningful way of recovery.

We typically find traumas and victimization of patients and also often family members are found which leads back to family history concealed by collective dissociation. Psychosis might appear as an inflammation which helps toxic abscesses (the forgotten trauma) open, which leads to purification and renewal, and to the catharsis of facing the past and the birth of a new family identity.

INTRODUCTION

Case 1

Erika had a physical disorder at the childhood age of 8 and she was not able to participate in sports and other physical activities. In addition, she also had a disharmonic family. When she travelled to school every day she began to experience dreamy states that amused her. She saw pictures and heard voices. After the bus arrived, she would "come back" and do her daily activities. Later when she became a university student, she read an esoteric book that she felt to be real. She "moved into" this "new reality" and suddenly wanted to jump out of the window. She was involuntarily hospitalized and got antipsychotic treatment. She recovered soon, but later she had smaller relapses and needed a small dose of clozapine (25mg) to stay stabilized. She is symptom-free now, married and employed. Dreamy states no longer occur.

Case 2

Albert Alfred had a difficult childhood. His father abused his mother and they lived in a one room flat. When Albert Alfred was 4 years old, his mother managed to divorce but subsequently became very poor and she had to work long hours to keep their flat. She often left Albert Alfred home alone and told him not to do anything dangerous and to be careful. Albert Alfred had a sleeping loft in their flat and stayed there most of the time. At this point, he started to hear the voice of a brother-like individual "Alfred" which was a good company for him. He also watched Japanese cartoons and filled the whole wall with drawings of their characters. Currently age 19 he looks like a romantic, dreamy young man and still hears "Alfred" who is quite angry and rude. Social isolation and difficulties in partner relationships impair his

life. He started to abuse benzodiazepines in order to overcome his suffering. Antipsychotic medication did not help him.

Case 3

Daniel was the first son of his parents who themselves were both traumatized in their childhood. Both had difficulties in expressing negative emotions. Daniel had a life threatening infectious disease at the age of 2. His parents could not stay with him in the hospital. At that time in Hungary, parents were not allowed to stay with their children in hospitals. Daniel fully recovered, but at the time of his release from the hospital he was so stressed that he did not let anyone touch him. His mother did not experience any negative emotions during and after this episode, later saying she "excluded" them. She managed things without emotions. Daniel was a good son, very clever, and often had ideas to "make things" better (just like her mother). When he went to school he was seriously bullied by his classmates. The family found "technical" solutions: Daniel changed schools and started having karate lessons but everybody in the family had difficulties speaking about their emotions and listening to Daniel speaks about his emotions. Daniel was able to defend himself after the age of ten, but never felt comfortable in school and did not have friends. At the university this changed. He found that he could open up at parties with excessive alcohol consumption and later cannabis which reduced his anxiety. He had girlfriends. He had and still has a perfectionist attitude. For example, he feels that he should be faultless in his performance, physical appearance and sexual performance. 2 years later he developed a psychotic episode with manic features. He felt he could understand messages of car registration numbers and that there existed a great power which played with people. He believed that we are all part of an experiment about children growing-up. Daniel had two hospital admissions and is currently prescribed olanzapine and lithium. He is now symptom free and is provided family care in our community service with psycho education and stress management. His childhood traumas have also been explored. Initially, he turned out not to have any memories about his childhood, only a few "pictures" could be recalled, e.g. once he was put in a box by his classmates who then did not let him out. Thus we started to work on "picking up" lost memories of the past with the help of the family members. During this process it was learned that Daniel's parents also had problems with recalling "the past". His therapist thinks that Daniel's psychotic concept of "big brothers" making experiments on the process of children's growing up is a symbol of his traumatic childhood experiences and his parents "over-rationalized" and emotionless world.

Dissociation and psychosis are very far from each other in the DSM classification system. In DSM-V., dissociation is in the cluster of trauma-related disorders [1] and traditionally thought to be close to hysteria which is the "furthest" category from schizophrenia in the psychopathology spectrum. The cases above show that sometimes it is easy (case2.) but many times it is hard to differentiate dissociative problems from psychosis as the symptoms often co-occur (case 3.) or change from one to the other (case 1.) and "classical" psychotic patients and their families may have dissociation and trauma history too (case 3.) just like in the cases of DSM-V trauma-disorders. In the following paragraphs the authors give an overview of these contradictions and show some current initiatives on trauma therapies in psychosis.

The history of the development of trauma-origin in diagnostic concepts – integration and splitting of professional minds?

Pierre Janet developed one of the original concepts of hysteria and dissociation. He also carried out research on hallucinations and made distinction between the psychological mechanisms related to hysteria (dissociation) and schizophrenia [2].

Breuer and Freud in his early period also described the trauma-origin [3] of hysteria; however, Freud later withdrew this concept and stated that patients suffer from their oedipal fantasies.

According to Judith Herman, Freud had to face the enormous frequency of traumatization of women, which was taboo in the society of his time. He may have (perhaps unconsciously) judged the risk of becoming a revolutionary deviant too great if he confronted the public with his findings. Trauma is frequent in society and, in a process similar to the dissociative amnesia of trauma survivors; society also seems to be "amnestic" about traumatized people and their stories. Herman commented that the realization of the trauma-origin of mental disorders needed strong emancipatory movements, like feminism and Vietnam veterans" movement.

These actions have made it possible to involve post-traumatic stress disorder in the diagnostic systems and to raise the focus on trauma in psychotherapies [4].

At the beginning of the 20th century an important team worked in the Zurich Burghölzli Hospital on the development of the concept of schizophrenia (Eugene Bleuler and Carl Gustav Jung worked together [5] in contact with Janet and Freud). When developing their concept of schizophrenia, they integrated biological vulnerability (emphasized by Bleuler) and the splitting which is not really different from the concept of dissociation described originally by Janet in cases of hysteria. Jung developed the concept of complexes. Moskowitz and Heim [6]:

"There is little reason to believe that Jung and Bleuler's definition of complexes differed. Echoing Jung's ideas, Bleuler defined complexes in his 1911 book as "a shortened term for a complex of ideas which are strongly affectively charged so that it permanently influences the content of the psychic process … (and) strives to obtain a kind of independence.' Furthermore, Bleuler and Jung co-authored an article entitled, "Komplexe und Krankheitsursachen bei Dementia praecox" ("Complexes and etiology in dementia praecox"), in which they expressed broad agreement, arguing only about the extent to which dementia praecox itself (and not just its symptoms) might be psychologically caused."

These pioneers did an important job by integrating the biological and psychosocial approach (the viewpoints of natural science and human sciences), which was then and still is very difficult for the followers. Psychiatry has lost this complex approach for decades and dominantly used the simple and static biological model of schizophrenia while psychosocial approaches were split into social psychiatry and antipsychiatry, not really disturbing the uncontrolled proliferations of biological psychiatry implicitly fed by the interests of the pharmaceutical

industry. Thoughts create themselves and our simple biological concepts have made us blind to the human side of schizophrenia and enhanced the dehumanization of our practice. We were also too unaware of the great environmental sensitivity of psychotic problems and the need to reach and influence these factors in therapies and care. This idea was born again by gene-environment interaction research [7,8]. At present, there is an emerging focus on the low validity of current diagnostic criteria of schizophrenia. Some comment on the possible trauma origin and dissociative mechanisms in schizophrenia [9-12].

An overview of recent studies on schizophrenia, trauma and dissociation

Some studies published over the past decade (Table 1) have reported that schizophrenia patients experience dissociative phenomena more often and to a higher degree than non-clinical individuals [13,14]. Furthermore, significant relationships were found between emotional, physical, sexual abuse and the development of dissociative symptoms in schizophrenia patients [15-19]. According to research findings dissociation is closely related to traumatic stress, which is consistent with the influence of stress-related events and dissociation in the pathogenesis of schizophrenia [20,21]. Also, Kocsis-Bogár et al. [22] found significant correlations between the number of adverse life events and schizophrenia spectrum disorders in a non-clinical sample.

Recent theories of dissociative phenomena in schizophrenia

Some studies indicate that the relationship between childhood trauma and the development of disorders along the schizophrenic spectrum may be mediated by dissociation [23,24]. Allen et al. [25] suggested that dissociative detachment triggered by traumatic life events "undermines the individual's grounding in the outer world", thereby impairing reality-testing and disrupting the sense of identity. According to another theory, depersonalization could facilitate attribution of thoughts and intrusive memories to external sources, which may contribute to hallucinations [23]. This explanation suggests the possibility that hallucinations could be more a dissociative than a psychotic symptom [26]. Moreover, hearing voices, a common symptom of schizophrenia, is also very common in patients with dissociative identity disorder (DID) [27]. These observations indicate that there may be an overlap between schizophrenia and dissociative disorders related symptoms [28].

Ross and Keyes [29] proposed that a dissociative subtype of schizophrenia may occur in some cases, in their study they found that 60% of schizophrenia patients were high dissociations and had suffered more physical and sexual abuse in their early life. They hypothesize that dissociation and psychosis lie on a phenomenological continuum which involves DID, a dissociative trauma-related subtype, and a non-dissociative subtype of schizophrenia. In accordance with this concept, Şar et al. [19] identified a subgroup of patients with high dissociation and childhood trauma history in their sample of 70 subjects with a schizophrenic disorder. The dissociative subgroup was characterized by higher numbers of general psychiatric comorbidities, secondary features of dissociative identity disorder, Schneiderian symptoms, somatic complaints and extrasensory perceptions.

Scharfetter [30] suggested that disorders on the schizophrenic spectrum were on a continuum with other syndromes, such as DID and borderline personality disorder. They may represent a type of ego-fragmentation that can be understood as a special form of dissociation.

Other authors hypothesize an inverse relationship. Giese et al. [31] proposed that dissociation might arise as a defense mechanism against the disorganizing and deeply traumatizing experiences in schizophrenia patients, as the decline of dissociative tendencies have been reported after successful treatment of psychotic symptoms in several cases [16,17].

Inconsistency in research findings

While evidence for a close relationship between dissociation, trauma and psychosis is growing (Table 1), there are a great number of contradictions that need to be resolved. Inconsistencies in research findings may be due to heterogeneity in methodology and outcomes measured small sample sizes or short durations. Another explanation is that there is overlap between dissociative symptomatology, especially when measured by Dissociative Experiences Scale (DES), and psychosis. Indeed a couple of items in DES concern perceptual experiences such as hearing voices. Other authors propose that this relationship reflects a higher tendency to experience hallucinations in people responding to trauma with dissociation [15]. Schäfer et al. [32] suggest that it could at least partly be a measurement artifact due to shared item content. Some authors give a stigmatizing explanation that psychotic patients can have problems in understanding the items of the DES, and it can be difficult to distinguish dissociative phenomena from delusions [33].

In summary, newer research suggests that dissociative symptoms may be related to childhood trauma in patients with schizophrenia spectrum disorders. There is a high degree of phenomenological overlap and functional interplay between schizophrenic syndromes, post-traumatic conditions, and dissociative disorders [29] but cannot conceptualize the exact relationship. Recent interpretations of the findings still show the strong belief in the validity of categorical diagnoses and mostly exclude the possibility of trauma-origin of schizophrenia itself (without dissociative disorder comorbidity) as was described first by the "magical Burghölzli team".

The Hearing Voices Movement of users helps professionals to overcome splitting of concepts and find the humanistic viewpoints

Hearing Voices Approach [34-37], elaborated in 1987 by Dutch psychiatrist Marius Romme and colleague Sandra Escher is an efficient alternative to the bio-medical mainstream psychiatry establishment, under the wings of Intervoice – International Hearing Voices Network that harmonizes the 27 national hearing voices networks which also provides the emancipator power of a user's movement. The user inspired elaboration of the Hearing voices approach began in 1984, when one of Romme's patients insisted getting an answer to why the voice says what it says what it wants to communicate. He insisted that it does not talk

Table 1: Studies investigating the relationship between trauma and dissociation among patients with a psychotic disorder.

Study	Sample	Measures	Results	Further findings
Holowka et al. (2003) [39]	Schizophrenia (n=26)	DES, CTQ, SCID-I	Significant correlations between DES scores and emotional, physical, sexual abuse and physical neglect.	After controlling for the four other forms of abuse and neglect, emotional abuse remained significantly correlated with dissociative symptoms
Ross & Keyes (2004) [29]	Schizophrenia (n=60)	DES, DDIS, SAPS, SANS	High dissociators had more severe trauma histories, more comorbidity and higher scores for both positive and negative symptoms.	60% of patients scored > 25 in DES. 44% of the patients fulfilled criteria for DID.
Hlastala & McClellan (2005) [40]	Schizophrenia (n=27) Atypical psychotic symptoms (n=20) Bipolar disorder (n=22)	DES, DICA Structured Clinical Interview for DSM-IV,	Higher rates of abuse and dissociative symptoms among patients with atypical psychotic symptoms than among subjects in the two other groups.	Patient with atypical psychotic symptoms were significantly more likely to receive a diagnosis of PTSD than patients in the two other groups.
Kilcommons & Morrison (2005) [15]	Schizophrenia spectrum (n=32)	DES, THQ, PANSS, PCTI, PSS-SR	Physical abuse was associated with positive psychotic symptoms and sexual abuse was specifically related to hallucinations. Dissociative processes were associated with Psychotic experiences.	94% of the sample reported at least one traumatic event. The prevalence of current PTSD was 53%. Severity of trauma was associated with severity of PTSD and psychotic experiences.
Schäfer et al. (2006) [16]	Schizophrenia spectrum female (n=30)	DES, CTQ, PANSS	Significant correlations between physical neglect and emotional abuse with dissociative symptoms.	Dissociative symptoms were not stable over time.
Vogel et al. (2006) [13]	Schizophrenia spectrum partly remitted (n=87) Healthy controls (n=297)	DES, SCL-90-R, PDS	Significantly higher DES scores in patients with trauma and PTSD than in patients without trauma.	Schizophrenia patients even without trauma or PTSD symptoms had significantly higher scores in all three DES subscales than controls.
Modestin et al. (2007) [41]	Schizophrenia spectrum outpatients in remission (n=43) Personality disorders (n=47) Healthy controls (n=42)	DES, TQ, MPT, SCL-90-R	No significant differences between the groups in DES scores.	A set of five variables was identified as the strongest contributors to the occurrence of ―schizoidia‖: TQ broken home, MPT neuroticism, schizophrenia spectrum and personality disorder diagnoses and SCL aggressivity.
Lysaker & Larocco (2008) [42]	Schizophrenia spectrum (n=68)	TAA, TSI, PANSS	Clinically significant trauma symptoms including dissociation in two thirds of participants. Significant correlations between greater levels of depression and disturbance of volition with greater levels of dissociation.	Significant correlations between delusions and intrusive experiences, dissociation, and number of significantly elevated trauma scales.
Vogel et al. (2009) [43]	Schizophrenia (n=80)	DES, CTQ, SCL-90-R	Childhood traumatic experiences were frequent. Physical neglect was associated with high dissociation, whereas abuse was not.	Significant association of physical neglect with psychopathological distress not fully accounted for by dissociation.
Şar et al. (2010) [19]	Schizophrenia spectrum (n=70)	DES, DDIS, CTQ, SAPS, SCID-II	Significant correlations between CTQ scores and DES scores, but not with core symptoms of the schizophrenic disorder. Only physical abuse and physical neglect predicted dissociation.	A subgroup of patients with high dissociation, childhood trauma history and secondary features of dissociative identity disorder was identified.

Vogel et al. (2011) [44]	Schizophrenia (n=25) Patients with non-psychotic disorder (n=35)	AMDP, PDS, CTQ,SAPS, SANS, SANS, MADRS	All forms of childhood abuse showed significant associations with PTSD and dissociation. Dissociation predicted high scores on SAPS.	Positive symptoms were more closely related to dissociation than to PTSD and were not specific to schizophrenia. Negative symptoms were linked to dissociation and childhood trauma.
Perona-Garcelán et al. (2012) [22]	Psychotic (n=71)	DES, TQ, PANSS	Significant correlations between childhood trauma and dissociation, hallucination and delusion scale scores.	Depersonalization showed a mediating relationship between childhood trauma and hallucinations.
Schäfer et al. (2012) [17]	Schizophrenia spectrum (n=145)	DES, CTQ, PANSS	Positive symptoms were the best predictors of dissociation at admission and childhood sexual abuse when patients were stabilized.	Dissociative symptoms and their relationship with psychotic symptoms were not stable over time.
Varese et al. (2012) [23]	Schizophrenia spectrum (n=45) Healthy controls (n=20)	DES, PANSS, LSHS-R, CATS, The Ammons QT The auditory signal detection task	Significantly higher dissociative tendencies and childhood sexual abuse among hallucinating patients.	Dissociation mediated the effect of childhood trauma (particularly sexual abuse) on hallucination-proneness.
Braehler et al. (2013) [14]	First-episode psychotic (n=62), Chronic psychotic (n=43) Non-psychotic controls (n=66)	DES, CTQ	Chronic patients reported the highest level of dissociation. More severe childhood trauma was associated with greater dissociative symptoms in all groups.	Emotional abuse showed the strongest associations with dissociation. Stronger association between physical neglect and dissociation among men than women.
Álvarez et al. (2014) [28]	Schizophrenia spectrum (n=45) Healthy controls (n=78)	DES, CTQ-SF	More childhood trauma and a higher average dissociation score in the patients' than in the controls' group. The presence of childhood trauma was related to the intensity of the Dissociation.	The risk of developing a disorder on the schizophrenic spectrum was 4.23 times greater in the presence of polytraumatization.
Pec et al. (2014) [45]	Schizophrenia (n=31) Borderline Personality Disorder (n=36)	DES, TSC-40, HONOS	Significant correlations between DES scores and symptoms of traumatic stress. Significant correlations between levels of antipsychotic medication and DES scores.	Significant correlations between antipsychotic medication and the depersonalization/derealization component of the DES in BPD patients.

Abbreviations: AMDP: Arbeitsgemeinschaft Methodik und Dokumentation in der Psychiatrie; CATS: The Child Abuse and Trauma Scale; CTQ: Childhood Trauma Questionnaire; DDIS: Dissociative Disorders Interview Schedule; DES: Dissociative Experiences Scale; DICA: Diagnostic Interview for Children and Adolescents; HONOS: Health of the Nation Outcome Scales; LSHS-R: The revised Launay–Slade Hallucination Scale; MADRS: Montgomery–Åsberg Depression Rating Scale MPT: Munich Personality Test; PANSS: Positive and Negative Symptoms Scales; PCTI: Post-traumatic Cognitions Inventory PDS: PTSD Symptom Scale; PSS-SR: Posttraumatic Stress Disorder Symptom Scale – Self-Report; SANS: Scale for the Assessment of Negative Symptoms; SAPS: Scales for the Assessment of Positive Symptoms; SCL-90-R: Symptom Checklist-90-R; TAA: Trauma Assessment for Adults—Brief Revised Version
THQ: Trauma History Questionnaire
TSC-40: Trauma Symptom Checklist-40
TSI: Trauma Symptom Inventory
TQ: Trauma Questionnaire

nonsense and that it has to do with reality. Romme and Escher and their followers, along with users, have since found answers to these questions, which have led to the recovery of many users who have retaken their functioning and control over their lives. The approach then focuses not on healing per se but on the user's aspects of recovery, the latter being the world of a full life, ability of self-determination, and human dignity. "Hearing Voices" groups are often organized on a self-help basis and reject the dehumanizing concepts and practices of "classical psychiatry" that traumatize many patients and make them hopeless, thus working against recovery. They also fight for the acceptance of user's experiences as evidence for a good practice (besides professional research evidence). Romme et al. published the volume "Living with voices – 50 stories of recovery" in 2009 that is the evidence base of user experiences for the Hearing Voices Approach.

One of its basic hypotheses, drawn from recovery stories, is that the appearance of voice hearing may be connected to a series of traumatic life events that make the personality vulnerable and undermines self-esteem. The voice hearer may become aware what moments of his/her life, or who exactly, have shaken his/her trust in the world, his/her self-esteem and self-acceptance, and what has led to his/her disability in staying in control of his/her own life.

The leading motif of the approach is that voices promote

recovery even if their message is most often offending, depreciating, abusing, and commanding. This paradox may be resolved by dialogue with the voice. Instead of rejecting the voice (and other so called psychotic experiences), observing it and expounding its symbolic message (just like at Case 3.) may appropriately contribute to being able to identify points in life where one did not succeed in adapting to changes and challenges. Many times patients became unaware victimized and lost normal negative feelings, enabling stress to overcome them. This work with the message of the voices ultimately helps identify what kind of changes have become necessary on the road of recovery and also what one needs to change about him/herself so that these pitfalls become avoidable. Romme and colleagues also suggest finding and expressing negative emotions which are often "placed outside" and voice hearers often feel that emotions are provoked by the voices. As Eleanor describes in the book: "Everyone has their private demons and his (the voices) demonic aspects were the unaccepted aspects of my self-image. The contempt and loathing that he expresses is actually to do with me in that it reflects how I feel about myself. He is like a very external form of my own insecurities, my own self-doubt." This opens the paths to recovering self-esteem mentally and by realizing one's dreams, to self-acceptance and self knowledge [36].

The Hearing Voices Approach encourages the person to have a "map" of subjectivities populating his/her mind and an active, rational, and fearless viewpoint on them that enables the non-psychotic subject to emerge even in the midst of what used to be called mere hallucinations. During this process, no particular interpretational framework or sentiment is enforced, which has just the effect that the true existential sense of the voices can appear. By not treating the voices as if existing in a separate sphere of madness, they are immediately verbalized as being in negotiable interaction with the patient.

Working with a consistent collaborative recovery-focused approach [38], Coleman's "non-method" entails working with traumatic experiences or events related to the emergence or change of voices, finding the relevant emotion – which is particularly hard in ways of coping that we perceive as psychotic – and creatively externalizing that emotion, making it available for description. Then the patient is asked about this present experience again, and so on, as associations (emotions and images) allow themselves to be explored as they are unfolding. All this may lead to the withdrawal of the voice (and other so called psychotic experiences) as it is not needed any more once its mission has been accomplished.

Trauma therapies with families on the basis of the Hearing voices approach and community psychiatry practice at Awakenings Foundation in Budapest

When recording the characteristics of the voices and other psychotic experiences and also the life story of the patients and families in community based family settings, it is not difficult to find associations just like in Case 3. Sometimes the association is quite easy to find: e.g. Gabriel, a grandson of a holocaust survivor - who hides the history of the murder of great-grandparents from the (grand) children - produced a psychotic episode where he felt himself in a concentration camp where his grandfather killed the Jews in the house of the family.

In other cases we proceed slowly. Some families often have lost memories and emotions which are usually related to the parent's and grandparent's traumatic life events. With the involvement of psychotherapists and other members of the community psychiatry team, we can start to "find" the past, searching for old photo albums and memorial objects, visiting places related to the past (i.e. Holocaust museum, Jewish cemetery) and also keeping alive the communication about life events and the symbolic positive messages of voices and psychotic experiences. Of course traumas are very diverse and the symbolic meanings of psychosis are equally very diverse just as the connections of dreams to complexes. But what is similar, we often find that patients were the "good children" who did not protest and did not express and often did not realize their negative feelings earlier, and easily became unaware victims. They gave up their goals and dissociated (split) their negative aggressive feelings which later exploded in psychosis or during substance use.

From this point, results and methods of trauma therapies can be used similarly to other patients but we see that - beside the hearing voices self help groups - family work and community approach give a better context for this, compared to individual psychotherapy settings.

1. The practice allA search for life history relevance of psychotic experiences, also to find the positive function of them for the person and the family – Gabriel's psychotic experience is a testimony to the grand-grandparents‟ trauma that helps the whole family to retrieve their past and express their love and compassion towards the lost relatives and also towards Gabriel, and express the feeling of grief and anger

2. Atharsis through the rescue of the personal and family memories and personal (negative) feelings from the dissociative fog and the expression of them (in different ways)

3. Finding personal and family goals for recovery and for a positive new identity showing compassion towards victims and common family values. Gabriel's family deals now with their identity and gathers information about the Jewish culture and the role of the Jewish community in the Hungarian history

4. Teaching new skills to reach the goals (this is part of community-based rehabilitation), including communication and problem solving skills that helps patients and families to have coping mechanisms other than dissociation in cases of conflict.

The Hearing Voices Approach can be deployed within both traditional and community based framework of mental health care, in individual, family and group form. Hearing Voices Approach, however, proves to be a challenge for traditional psychiatry that on one hand does not engage in studying voices and on the other hand hardly believes in the possibility of recovery. Hearing Voices Approach, as a recovery based approach, builds on the personal resources of users and their families. Community psychiatry, in contrast to traditional psychiatry, offers a wider set of recovery-focused services and family involvement and multiplies the results of both trauma-therapies and rehabilitation.

The first self-help groups of voice hearing persons in Hungary appeared as results of the work of the authors particularly that

of the expert by accompaniment Zsolt Mérey and among others expert by experience István Gallai.

The Hearing Voices Approach helped the professionals of our team to:

1. learn not to be leaders of the recovery process but take part as professional experts in a self-help process

2. Find a human meaning of psychosis

3. Go on with overcoming split professional approaches, and stigma

4. Be partners of recovery and share the catharses in therapies which help both patients and practitioners to face and heal the wounds in our own lives.

SUMMARY

The tangible and immediate humanizing effect of self-help groups should help our "wartime psychiatry" become an evidently civilian practice. The work of experts by experience deconstructs delusional and delusion labeling (i.e. iatrogenic) effects. Developing confidence in life narratives emancipates authentic emotions and breaks dissociative modes; putting aside our dissociation generating and hardly validating practices patients are able to get the "weight of their words" and their "voice" back. Since routinely using trauma and coping related exploration and validation of psychotic phenomena, it is perceived that the latter improve the benefit for the patient. Psychotic experiences wait to help us create a winning situation for the patient.

Clinical experience and various research findings – including the gene-environmental studies and those studying dissociation, trauma and schizophrenia reviewed in this article – all support that the pure biological concept of schizophrenia should find its way back to an original diagnostic concept of Bleuler and Jung described in the 1910s. Judith Herman's approach [4] seems to work: we see nowadays that users Hearing Voices Movement might cure the split mind of professionals who deal with the human nature of psychosis with a certain "dissociative amnesia" in their approach. The principle of self-help is an important aspect of these groups, which helps patients set off on the road of recovery even where the professional approach is not yet ready for it. With the implementation of Hearing Voices Self-Help Groups in the authors" practice at Awakenings Foundation, treatment has made our practice more humanistic and effective. We proceed together on the road of personal and professional recovery with the experts by experience.

REFERENCES

1. Zelazny K, Simms LJ. Confirmatory factor analyses of DSM-5 posttraumatic stress disorder symptoms in psychiatric samples differing in Criterion A status. J Anxiety Disord. 2015; 34: 15-23.

2. Moskowitz A, Heim, G, Saillot I, Beavan V. Pierre Janet on hallucinations, paranoia and schizophrenia. Psychosis, Trauma and Dissociation: Emerging Perspectives on Severe Psychopathology. 2009; 91-103.

3. Breuer J, Freud S. Studies on Hysteria (1893-1895) in Standard Edition, vol 2. London: Hogarth Press. 1995

4. Herman JL. Trauma and Recovery. The Aftermath of Violence – from Domestic Abuse to Political Terror. Basic Books. New York. 1997.

5. Bleuler E, Jung CG. Komplexe und Krankheitsursachen bei Dementia praecox Complexes and etiology in dementia praecox. Zentralblatt für Nervenheilkunde und Psychiatrie XIX. 1908; 220-227.

6. Moskowitz A, Heim G. Eugen Bleuler's Dementia praecox or the group of schizophrenias (1911): a centenary appreciation and reconsideration. Schizophr Bull. 2011; 37: 471-479.

7. Van Os J, Rutten BP, Poulton R. Gene-environment interactions in schizophrenia: review of epidemiological findings and future directions. Schizophr Bull. 2008; 34: 1066-1082.

8. Kéri S, Kiss I, Seres I, Kelemen O. A polymorphism of the neuregulin 1 gene (SNP8NRG243177/rs6994992) affects reactivity to expressed emotion in schizophrenia. Am J Med Genet B Neuropsychiatr Genet. 2009; 1250: 415-420.

9. van Os J. A diagnosis of schizophrenia? In: Does Schizophrenia Exist. Maudsley Discussion Paper No. 12. 2003.

10. van Os J. Is there a continuum of psychotic experiences in the general population? Epidemiol Psichiatr Soc. 2003; 12: 242-252.

11. Kendell R, Jablensky A. Distinguishing between the validity and utility of psychiatric diagnoses. Am J Psychiatry. 2003; 160: 4-12.

12. Bebbington PE, Bhugra D, Brugha T, Singleton N, Farrell M, Jenkins R. et al. Psychosis, victimisation and childhood disadvantage Evidence from the second British National Survey of Psychiatric Morbidity. The British Journal of Psychiatry. 2004; 185: 220-226.

13. Vogel M, Spitzer C, Barnow S, Freyberger HJ, Grabe HJ. The role of trauma and PTSD-related symptoms for dissociation and psychopathological distress in inpatients with schizophrenia. Psychopathology. 2006; 39: 236-242.

14. Braehler C, Valiquette L, Holowka D, Malla AK, Joober R, Ciampi A, et al. Childhood trauma and dissociation in first-episode psychosis, chronic schizophrenia and community controls. Psychiatry Res. 2013; 210: 36-42.

15. Kilcommons AM, Morrison AP. Relationships between trauma and psychosis: an exploration of cognitive and dissociative factors. Acta Psychiatr Scand. 2005; 112: 351-359.

16. Schäfer I, Harfst T, Aderhold V, Briken P, Lehmann M, Moritz S, et al. Childhood trauma and dissociation in female patients with schizophrenia spectrum disorders: an exploratory study. J Nerv Ment Dis. 2006; 194: 135-138.

17. Schäfer I, Fisher HL, Aderhold V, Huber B, Hoffmann-Langer L, Golks D, Karow A. Dissociative symptoms in patients with schizophrenia: relationships with childhood trauma and psychotic symptoms. Compr Psychiatry. 2012; 53: 364-371.

18. Vogel M, Spitzer C, Kuwert P, Möller B, Freyberger HJ, Grabe HJ. Association of childhood neglect with adult dissociation in schizophrenic inpatients. Psychopathology. 2009; 42: 124-130.

19. Sar V, Taycan O, Bolat N, Ozmen M, Duran A, Oztürk E, Ertem-Vehid H. Childhood trauma and dissociation in schizophrenia. Psychopathology. 2010; 43, 33–40.

20. Read J, van Os J, Morrison AP, Ross CA. Childhood trauma, psychosis and schizophrenia: a literature review with theoretical and clinical implications. Acta Psychiatr Scand. 2005; 112: 330–50.

21. Bob P, Mashour GA. Schizophrenia, dissociation, and consciousness. Conscious Cogn. 2011; 20: 1042-1049.

22. Kocsis-Bogár K, Miklósi M, Forintos DP. Impact of adverse life events on individuals with low and high schizotypy in a nonpatient sample. J Nerv Ment Dis. 2013; 201: 208-215.

23. Perona-Garcelán S, Carrascoso-López F, García-Montes JM, Ductor-

Recuerda MJ, López Jiménez AM, Vallina-Fernández O, et al. Dissociative experiences as mediators between childhood trauma and auditory hallucinations. J Trauma Stress. 2012; 25: 323-329.

24. Varese F, Barkus E, Bentall RP. Dissociation mediates the relationship between childhood trauma and hallucination-proneness. Psychol Med. 2012; 42: 1025-1036.

25. Allen JG, Coyne L, Console DA. Dissociative detachment relates to psychotic symptoms and personality decompensation. Compr Psychiatry. 1997; 38: 327-334.

26. Moskowitz A, Corstens D. Auditory Hallucinations: Psychotic symptoms in dissociative experience. J Psychol Trauma. 2008; 6: 35–63.

27. Ross CA, Miller SD, Reagor P, Bjornson L, Fraser GA, Anderson G. Schneiderian symptoms in multiple personality disorder and schizophrenia. Compr Psychiatry. 1990; 31: 111-118.

28. Álvarez MJ, Masramon H, Peña C, Pont M, Gourdier C, Roura-Poch P, et al. Cumulative effects of childhood traumas: polytraumatization, dissociation, and schizophrenia. Community Ment Health J. 2015; 51: 54-62.

29. Ross CA, Keyes B. Dissociation and schizophrenia. J Trauma Dissoc. 2004; 5: 69–83.

30. Scharfetter C. Ego-fragmentation in schizophrenia: A severe dissociation of self-experience. In: Moskowitz A, Schäfer I, Dorahy MJ editors. Psychosis, trauma and dissociation: Emerging perspectives on severe psychopathology. 1st ed. West Sussex. Wiley-Blackwell; 2008.

31. Giese AA, Thomas MR, Dubovsky SL. Dissociative symptoms in psychotic mood disorders: an example of symptom nonspecificity. Psychiatry. 1997; 60: 60-66.

32. Schäfer I, Adenhold V, Freyberger HJ, Spitzer C. Dissociative symptoms in schizophrenia. In: Moskowitz A, Schäfer I, Dorahy MJ editors. Psychosis, trauma and dissociation: Emerging perspectives on severe psychopathology. 1st ed. West Sussex. Wiley-Blackwell; 2008.

33. Steinberg M, Cicchetti D, Buchanan J, Rakfeldt J, Rounsaville B. Distinguishing between multiple personality disorder (dissociative identity disorder) and schizophrenia using the Structured Clinical Interview for DSM-IV Dissociative Disorders. J Nerv Ment Dis. 1994; 182: 495-502.

34. Coleman, R. & Smith, M. Working with Voices II. Victim to Victor 2nd Ed. P&P Press Ltd. Dundee. 2005.

35. Soucy B, Bourque M. Vivre son rétablissement. Le Pavois. Québec. Canada. 2008.

36. Romme M, Escher S, Dillon J, Corstens, D. & Morris, M. Living with voices. 50 stories of recovery PCCS Books Ltd. Ross-on-Wye. 2009.

37. St-Germain A. Soucy, B. Mieux vivre avec les voix. Le Pavois. Québec. Canada

38. Coleman, R. Recovery: an alien concept? P&P Press. Port of Ness, Isle of Lewis. 2011

39. Holowka DW, King S, Saheb D, Pukall M, Brunet A. Childhood abuse and dissociative symptoms in adult schizophrenia. Schizophr Res. 2003; 60: 87-90.

40. Hlastala SA, McClellan J. Phenomenology and diagnostic stability of youths with atypical psychotic symptoms. J Child Adolesc Psychopharmacol. 2005; 15: 497-509.

41. Modestin J, Hermann S, Endrass J. Schizoidia in schizophrenia spectrum and personality disorders: role of dissociation. Psychiatry Res. 2007; 153: 111-118.

42. Lysaker PH, Larocco VA. The prevalence and correlates of trauma-related symptoms in schizophrenia spectrum disorder. Compr Psychiatry. 2008; 49: 330-334.

43. Vogel M, Schatz D, Spitzer C, Kuwert P, Moller B, Freyberger HJ, et al. A more proximal impact of dissociation than of trauma and posttraumatic stress disorder on schneiderian symptoms in patients diagnosed with schizophrenia. Compr Psychiatry. 2009; 50: 128-134.

44. Vogel M, Meier J, Grönke S, Waage M, Schneider W, Freyberger HJ, et al. Differential effects of childhood abuse and neglect: mediation by posttraumatic distress in neurotic disorder and negative symptoms in schizophrenia? Psychiatry Res. 2011; 189: 121-127.

45. Pec O, Bob P, Raboch J. Dissociation in schizophrenia and borderline personality disorder. Neuropsychiatr Dis Treat. 2014; 10: 487-491.

Cite this article

Harangozó J, Szita B, Bese B, Mérey Z, Gallai I (2015) Trauma, Dissociation, Schizophrenia, and the Split Mind of Professionals. Ann Psychiatry Ment Health 3(6): 1044.