Could Schizophrenia be a Dissociative Disorder?:
*Three historical enigmas (and one contemporary one)*

Andrew Moskowitz, Ph.D.
*Zwolle, The Netherlands*
21 May 2015

Perspectives on the relation between dissociation and psychosis

1. Historical and current *meaning* of the terms *dissociation* and *psychosis*
2. A role for dissociation in some/all *psychotic symptoms*
3. Evidence for a mental *disorder* characterized by an admixture of dissociation and psychosis
   - ‘Dissociative psychosis’ or ‘Dissociative schizophrenia’
4. The concept of *schizophrenia* and its relation to dissociation
Sources

- Based on:

---

Could *schizophrenia* be a dissociative disorder?

<table>
<thead>
<tr>
<th>Ego ( Experienced identity)</th>
<th>cohesive</th>
<th>cohesive</th>
<th>cohesive</th>
<th>multiple</th>
<th>fragmentation/ annihilation</th>
</tr>
</thead>
<tbody>
<tr>
<td>integrated</td>
<td>integrated, but with many personality facets</td>
<td>integrated, but with loosening of the cohesion of subselves</td>
<td>multiple personality</td>
<td>schizophrenia</td>
<td></td>
</tr>
</tbody>
</table>

Psychopathology: `-` `-` `possibly +` `++` `+++`

Christian Scharfetter’s (2008) *continuum of dissociation*
Scharfetter (2008) Ego pathology in schizophrenia and the dissociative disorders

- But schizophrenia is not DID
- ‘I assume that a highly unstable and fluctuating ego-self [in DID] is less disposed to ego-fragmentation – the most severe form of dissociation. It is even possible that the very unstable fluctuating ego-self protects it from fragmentation (i.e., is schizo-preventive). This would mean that the precondition for a schizophrenic dissociative ego-disorder would be a more rigid ego, disposed for fragmentation rather than fluctuation. One can imagine schizophrenia syndromes as glass and dissociative identity disorders as quicksilver: the rigid glass fragments split apart and do not reassemble easily, whereas the quicksilver glides smoothly apart into globes – little wholes – but quickly unites without splitting apart’ (p. 61).
- This is a unique view; most do not see the disturbances of self or ego in schizophrenia as dissociative in nature
- So, ‘Is schizophrenia a dissociative disorder?’ remains a provocative question

Enigmas around schizophrenia and dissociation

If schizophrenia is unrelated to dissociation/dissociative disorders, how do we understand these puzzles?

Historical

1. Bleuler’s schizophrenia and dissociation theory
   - Why was the historical concept of schizophrenia so influenced by the ideas of Pierre Janet and dissociation theory?
2. Schneider’s 1st rank symptoms of schizophrenia and dissociative identity disorder (DID)
   - Why were/are the 1st rank symptoms, frequently present in DID, considered highly predictive for schizophrenia?
3. Bateson’s double-bind theory of schizophrenia and disorganized attachment (DA)
   - **SLIDES NOT INCLUDED**

Contemporary

4. Auditory verbal hallucinations (‘voices’) and dissociation
   - Why are voices so common in schizophrenia, when they appear to be dissociative in nature?
**Enigma 1:** Eugen Bleuler and the creation of *schizophrenia*

Bleuler at the Rheinau asylum (1886-1898)

---

Bleuler, Carl Jung and the birth of schizophrenia (1900-1911)

Burghölzli in 1910

© A. Moskowitz
Dissociation and schizophrenia

In the years prior to 1908, dissociation was emphasized by others seeking alternative terms for Kraepelin’s *Dementia Praecox* (Scharfetter, 2001)

- Wernicke’s *Sejunktionspsychosis*, Zweig’s *Dementia dissecans*, Gross’s *Dementia sejunctiva*

Jung at Burghölzli (1900 - 1909)

- Jung strongly influenced Bleuler’s concept of schizophrenia
- 1902 – completes medical thesis on the possession states of a medium, supervised by Bleuler, *On the Psychology and Pathology of so-called Occult Phenomena*
- 1902-1903 – attends lectures of Janet in Paris for 4 months, on the impact of emotions on the ‘mental level’ (*l'abaissement du niveau mental*)
- 1903-1904 – returns to Burghölzli, begins developing word association test with Franz Riklin
- 1904-1906 – important publications on word association test, development of concept of *emotionally-charged complex*
- 1907 – publishes *On the Psychology of Dementia Praecox*, referencing Janet more than Freud
Jung, Freud, Bleuler and Janet

- Bleuler read and reviewed Janet’s works, and directly linked Janet’s *Psychasthenia* to his *Schizophrenia*
  - Bleuler did not, however, correspond with Janet or meet him
- Jung and Freud began their intense relationship in 1906, meeting in 1907
- A *Society for Freudian Researches* formed in Zürich in 1907, with Bleuler as the head
  - Jung and Bleuler struggle to apply Freud’s ideas on *infantile sexuality* to schizophrenia
- Jung’s allegiances torn between Freud and Janet
- Jung announces to Freud that he plans to visit Janet in June 1907, to discuss Freud’s ideas and the concept of schizophrenia with him
  - Returns disappointed (according to a letter to Freud), to which Freud responds with delight

First uses of ‘schizophrenia’ (literally, ‘split mind’): April, 1908

- ‘Kraepelin’s dementia praecox is not necessarily either a form of dementia or a disorder of early onset. For this reason… I am taking the liberty of using the word *schizophrenia* to denote Kraepelin’s concept. I believe that the tearing apart (“Zerreissung”) or splitting (“Spaltung”) of psychic functions is a prominent symptom of the whole group and I will give my reasons for this elsewhere.’
  (Bleuler at German Psychiatry Conference, Berlin)

- ‘We have borrowed from French psychology a similar concept which initially was true for hysteria – namely, “dissociation.” Today, the name means a “splitting of the self”… Hysteria is primarily characterized by dissociation and because dementia praecox also shows splitting (“Spaltung”), the concept of dissociation seems to blend into the concept of Schizophrenia.’
  (Jung at the *First International Congress of Psycho-analysis, Salzburg*)
Bleuler’s *Dementia Praecox or the Group of Schizophrenias* (1911/1950)

- ‘I call dementia praecox “schizophrenia” because… the “splitting” of the different psychic functions is one of its most important characteristics… In every case we are confronted with a more or less clear-cut splitting of the psychic functions. If the disease is marked, the personality loses its unity; at different times different psychic complexes seem to represent the personality… one set of complexes dominates the personality for a time, while other groups of ideas or drives are “split off” and seem either partly or completely impotent’ (pp. 8-9).

  - Clearly, this sounds like ‘dissociation’. But we must ask: ‘What is meant by splitting and what is meant by complexes?’

Splitting (‘Spaltung’)

- Prior to 1911, Bleuler extensively used the term ‘dissociation’. From *Consciousness and Associations* (1905):
  - ‘(D)issociation of the personality is fundamentally nothing else than the splitting off of the unconscious…’

- From the 1911 book:
  - ‘It is the splitting which gives the peculiar stamp to the entire symptomatology’ (p. 362).
  - ‘What Gross understands by his term “fragmentation”… of consciousness corresponds to what we call “splitting”. The consciousness, however, cannot fragment itself, but only its contents… The term “dissociation” has already been in use for a long time to designate similar observations and findings. But dissociation also designates more: for example, the constriction of the content of consciousness… [and] may thus give rise to misunderstandings’ (p. 363).
  - ‘The affectively charged complex of ideas continues to become isolated and obtains an ever increasing independence (splitting of the psychic functions)” (p. 359).
Complexes, according to Jung

- Concept of complexes developed out of word association task
  - Latencies, strange associations, disruptions of attention, forgetting of prior responses

- From On the Psychology of Dementia Praecox (1907/1960).
  - Complexes are described as clusters of ideas ‘cemented’ together by a powerful affect (p. 28), and accompanied by ‘somatic innervations’ (p. 41). Jung described a complex as a ‘being, living its own life and hindering and disturbing the development of the ego-complex’ (p. 47).

- In Jung’s later writings:
  - ‘Especially in those states where the complex temporarily replaces the ego, we see that a strong complex possesses all the characteristics of a separate personality. We are, therefore, justified in regarding a complex as somewhat like a small secondary mind…’ (Jung, 1911).
  - ‘Today, we can take it as moderately certain that complexes are in fact “splinter psyches.” The etiology of their origin is frequently a so-called trauma, an emotional shock or some such thing, that splits off a bit of the psyche’ (Jung, 1934/1960, pp. 97-98).

Complexes, according to Bleuler

- From ‘Consciousness and associations’ (1905):
  - ‘Independently of the conscious personality, wishes and fears regulate ideas to their liking and combine them in a compact complex, whose expressions emerge as “hallucinations”; these appear to be so… deliberate that they simulate a third person… But it is merely a piece of the split-off personality…’ (p. 279)
  - ‘There is… no difference in principle between unconscious complexes and these several personalities endowed with consciousness. When an unconscious complex associates to itself an increasing number of the elements of the ordinary ego, without linking itself with the ego as a whole, it becomes finally a second personality.’ (p. 291).

- From Dementia Praecox (1911):
  - ‘Complex’ is ‘a shortened term for a complex of ideas which are strongly affectively charged… (and) strives to obtain a kind of independence’ (p. 24)
  - ‘The complex which has here become unconscious behaves as a dissociative piece of the mind, gathering experiences and making use of them’ (p. 284).
Bleuler’s schizophrenia and dissociation

- Delusions and hallucinations were not, according to Bleuler, core symptoms of schizophrenia
- ‘Loosening’ of associations (similar to Janet’s *reduction in psychological tension*) was important
  - *Splitting* is essentially *dissociation*
  - *Complexes* come very close to EPs, *emotional parts of the personality* (or Janet’s *fixed ideas*)
- Bleuler’s schizophrenia bears many similarities to dissociation and dissociative disorders
- Clearly, some cases described by Bleuler would today be called DID, but this does not explain why his *theoretical* explanations for schizophrenia link so closely to Janet’s ideas

Enigma 2: Kurt Schneider and the 1st rank symptoms of schizophrenia

- German psychiatrist in the tradition of Emil Kraepelin and Karl Jaspers
  - After Kraeplin, was committed to schizophrenia as a brain disease (of unknown etiology)
  - Following Jaspers, emphasized phenomenology and the ‘form’, not ‘content’, of symptoms
Genesis of the 1st rank symptoms

- In 1939, Schneider first proposed ‘1st rank’ symptoms for schizophrenia in a book for general physicians
  - As the most effective means of distinguishing schizophrenia from affective psychosis
  - These ideas were based on the examination of 5000 patients, known as the Schwabing cohort
- In 1950, they were incorporated into his book, Clinical Psychopathology
  - Translated into English in 1959
- First rank symptoms were specific to schizophrenia
  - ‘When we say, for example, that thought withdrawal is a first rank symptom, we mean the following. If this symptom is present in a non-organic psychosis, then we call that psychosis schizophrenia, as opposed to cyclothymic psychosis, or reactive psychosis’ (Schneider, 1959)

Impact on psychiatric diagnosis

- 1st rank symptoms incorporated into Wing’s Present State Examination, in 1967
  - Then into the Research Diagnostic Criteria in 1978
    - because of evidence they could be ‘reliably’ assessed
    - and because ‘delusions’ and ‘hallucinations’ were considered not specific enough
- Highly emphasized in DSM-III, III-R and IV, and in ICD-9 and 10 diagnostic criteria for schizophrenia
  - Only one 1st rank symptom required for a schizophrenia diagnosis
    - Eliminated from DSM-5 due to lack of evidence for diagnostic specificity(!)
    - Included, but de-emphasized (1 of 4 necessary symptoms), in proposed ICD-11 schizophrenia criteria
What are the 1st rank symptoms?

- Schneider’s description of symptoms from General Psychopathology (1959):
  - ‘Audible thoughts; voices heard arguing; voices heard commenting on one’s actions; the experience of influences playing on the body (somatic passivity experiences); thought-withdrawal and other interferences with thought; diffusion of thought; delusional perception and all feelings, impulses (drives), and volitional acts that are experienced by the patient as the work or influence of others. When any of these modes of experience is undeniably present, and no basic somatic illness can be found, we may make the decisive clinical diagnosis of schizophrenia’ (pp. 133-134)

1st rank symptoms as described by Mellor (1970)

1. Auditory experiences
   1. Hearing one’s own thoughts aloud
   2. Two of more voices discussing or arguing
   3. Voices commenting (in 3rd person) one one’s actions
2. Passivity experiences
   1. Imposed bodily sensations (somatic passivity)
   2. ‘made’ feelings - attributed to an external source
   3. ‘made’ impulses/drives - from an outside force
   4. ‘made’ actions - behavior controlled by an outside force (patient feels like an ‘automaton’)
3. Disturbances of thinking
   1. Thoughts withdrawn from mind by an external source
   2. Thoughts inserted into mind by an external source
   3. Thought diffusion or broadcasting
4. Delusional perception - a normally-experienced perception, followed by a delusional interpretation (delusions of reference)
Kluft’s (1987) 1st rank symptoms as a diagnostic clue to MPD

- Richard Kluft, a dissociative disorders (and hypnosis) expert, begin noticing 1st rank symptoms in his MPD(DID) patients after Mellor’s (1970) paper
- For about 10 years, he systematically assessed these symptoms in his MPD patients
  - Only included those who had been integrated/fused to reduce possible ‘misdiagnosis’

Prevalence of 1st rank symptoms in MPD/DID

1. Auditory experiences
   1. Hearing one’s own thoughts aloud
   2. Two of more voices discussing or arguing
   3. Voices commenting (in 3rd person) one one’s actions

2. Passivity experiences
   1. Imposed bodily sensations (somatic passivity)
   2. ‘made’ feelings - attributed to an external source
   3. ‘made’ impulses/drives - from an outside force
   4. ‘made’ actions - behavior controlled by an outside force (patient feels like an ‘automaton’)

3. Disturbances of thinking
   1. Thoughts withdrawn from mind by an external source
   2. Thoughts inserted into mind by an external source
   3. Thought diffusion or broadcasting
   4. Delusional perception - a normally-experienced perception, followed by a delusional interpretation (delusions of reference)
1st rank symptoms in DID and schizophrenia

- Others (e.g., Colin Ross et al., 1989, 1990; Dorahy et al, 2009) replicated Kluft’s findings
  - 1st rank symptoms as or more common in DID than in schizophrenia
  - Dorahy (2009) found voices commenting 2x more common, and voices conversing 5x more common in DID than in schizophrenia

- In schizophrenia, 1st rank symptoms not associated with poor outcome. Some evidence for the opposite:
  - positive outcome in 1st episode schizophrenia over 2 years (significantly shorter hospitalizations, Thorup et al, 2007)
  - shorter duration of illness \( (r = -.29) \) and fewer hospitalizations \( (r = -.40) \) in a more chronic schizophrenia sample

**Enigma 2: What was Schneider thinking?**

- We don’t know!
  - Limited information on the Schwabing cohort (what kind of patients?)
  - Schneider also worked as a military psychiatrist and with prostitutes

- 1st rank symptoms highly consistent with DDNOS diagnosis (proposed ICD-11 Complex Dissociative Intrusion Disorder)
  - One primary part of the personality
  - Persistently intruded into by other parts of the personality

- Intrusions and withdrawals between parts of the personality can explain the 1st rank symptoms common in DID/DDNOS (‘made’ feelings, actions, impulses; thoughts withdrawn or inserted; and voices commenting or conversing)
  - ‘Indeed, it is a clinical commonplace for personalities to state that they have made another see or hear something, influenced another’s perceptions, caused a sensation, impulse, or action in some other alter, or taken away the alter’s memory’ (Kluft, 1987, pp. 297-298)

- But not thought broadcasting or delusional perception (genuine delusions), which appear to be very rare in dissociative disorders (and BPD)
Enigma 3: Voice hearing and dissociation

- ‘Each dissociative part of the personality minimally includes its own, at least rudimentary, first-person perspective. As each dissociative part, the individual can interact with other dissociative parts and other individuals, at least in principle.’ (Nijenhuis and Van der Hart, 2011)

Comparing voices in psychotic and non-clinical populations

- Daalman et al (2011) The same or different? A phenomenological comparison of auditory verbal hallucinations in healthy and psychotic individuals
  - 118 psychotic outpatients, 111 health voice hearers (heard at least 1 voice/month)
  - Voices not different on perceived location (external/internal), loudness, number of different voices (11 in patients, 7 in healthy controls(!)), and personification, ‘suggesting a similar phenomenon in both groups’ (p. 325)
  - But patient’s voices were more frequent, longer in duration, more distressing and, particularly, more negative in content
  - Onset of voice hearing in controls (age 12) much earlier than in psychotic disorders (age 21)
  - Dissociation and dissociative disorders not screened for
Dissociation and Psychosis in DID and Schizophrenia (Laddis & Dell, 2012)

- 40 DID patients and 40 schizophrenia
- DID were more female (92% vs 35%) and better educated (13.9 years vs 12.3) than schizophrenia patients
- Assessed with Multidimensional Inventory of Dissociation (MID, Dell, 2006)
- DID patients scored significantly higher on total score and on all subscales, except ‘voices arguing or conversing’
  - 85% DID, 65% Schizophrenia
  - Child voices more common in DID
- Schizophrenia patients’ scores on voices scale overwhelming correlated with total MID scores ($r = .96$)
  - Over 91% of variance in MID scores ‘explained’ by voices scores
- Suggests that dissociation in schizophrenia may be limited to auditory hallucinations

Comparing voices in DID and schizophrenia

- Dorahy et al, 2009
  - 34 patients with schizophrenia, 29 with DID
  - Significantly more DID patients than schizophrenia
    - Heard voices before age 18 (90% vs 32%)
    - Heard multiple voices (90% vs 31%)
    - Heard child voices (along with adult voices; 97% vs 6%)
    - Voices commenting (2x more) or conversing (>5x more)
  - No difference between the groups on perceived location (primarily inside in both groups) and congruence between one’s mood and the ‘mood of the voices’ (mood of voices was rated overwhelmingly as different from one’s mood at the time and in general)
Does dissociation mediate between childhood trauma and auditory hallucinations?

Perona-Garcelán et al (2012), *Dissociative experiences as mediators between childhood trauma and auditory hallucinations*
- 71 outpatients with a psychotic disorder (90% schizophrenia)
- 45% reported childhood traumatic experiences
- Childhood trauma correlated $r = .37$ with PANSS hallucinations & $r = .32$ with delusions
- Depersonalization (from DES)
  - significantly mediated between childhood trauma and hallucinations (direct effect of trauma became non-significant)
  - but not childhood trauma and delusions (direct effect of trauma remained significant)

Varese et al (2011) *Dissociation mediates the relationship between childhood trauma and hallucination proneness*
- 45 schizophrenia patients & 20 healthy controls
- DES/hallucinations proneness (whole sample) $r = .70$ ($p < .001$)
  - Stronger correlation that childhood trauma variables
- ‘The relationship between childhood trauma and hallucination-proneness was positively mediated by dissociative tendencies. The mediational role of dissociation was particularly robust for experiences of sexual abuse…’ (p. 8)
The enigma of dissociation and voice hearing: Summary

- Dissociation strongly and consistently "predicts" auditory hallucinations in psychotic, clinical (including PTSD) and non-clinical populations.
- Dissociation predicts AH while controlling for a wide range of variables, including schizotypy, mood disturbance, negative self cognitions, thought suppression and trauma history.
- While childhood trauma is linked to delusions, dissociation predicts delusions as strongly as hallucinations in only one study (of non-psychotic patients) and
- The relationship between dissociation and voice hearing may be stronger than the relation between voice hearing and delusions!
- Does this mean that all voices are dissociative? Do all voices include their own 'first-person perspective' and can they 'interact with other dissociative parts and other individuals'?
- Enigma: why is this apparently dissociative 'symptom' so common in schizophrenia?

Enigma 4: The double bind theory of schizophrenia and disorganized attachment

- Gregory Bateson (1904-1980)
- Trained as an anthropologist
  - Conducted fieldwork (with Margaret Mead) in New Guinea and Bali
  - Interested in mother/child communication and the construction of 'play'
- Developed concepts of feedback loops and self-regulating systems, within field of cybernetics
- Applied to the etiology of schizophrenia
Summary and conclusions

- The historical concept of schizophrenia connects with dissociation in at least 4 ways:
  - Bleuler’s original concept of schizophrenia is infused with dissociative concepts
  - Schneider’s 1st rank symptoms of schizophrenia are easily explained from a dissociation perspective
    - most are more common in DID than in schizophrenia
  - Auditory verbal hallucinations, a common symptom in schizophrenia, is strongly predicted by dissociation - in all clinical and non-clinical populations
  - Bateson’s double bind theory of schizophrenia…
Explanations?

- What does this all mean?
- The ‘group’ of schizophrenias includes a highly dissociative subgroup, which explains the numerous links - dissociative psychosis?
- ‘Schizophrenia’ itself is a form of dissociative disorder - DDNOS or Complex Dissociative Intrusion Disorder?
  - Psychotic symptoms - EP or EPs?
  - Negative symptoms - poorly functioning ANP?
- Psychotic symptoms ‘allow’ the expression of powerful emotions
  - Is psychosis a cure for the double bind?

How to solve the enigmas

- Careful longitudinal research, from before birth to adulthood
- Screening all schizophrenia/psychotic disorder samples for posttraumatic and dissociative disorders
- Developing more valid diagnostic criteria for schizophrenia or the ‘core’ psychotic disorders
Eugen Bleuler on trauma, dissociation and schizophrenia (1911)

- Unlike Jung, Bleuler generally thought of schizophrenia as an organically-based brain disease
  - But sometimes he too wondered

- ‘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’ (p. 300)