SUMMARY. Schizophrenia is a chronic terror syndrome. In World War II there were battlefield traumas that always produced classic schizophrenic symptoms. However, if the patients were healthy before the trauma, they spontaneously recovered. The myth of the incurability of schizophrenia led to the belief that these individuals could not be schizophrenic if they recovered. But all schizophrenics are the victims of lives filled with trauma, sometimes subtle but usually obvious. Examples are described. Professionals have tried not to listen. But if one investigates, most of the bad things patients talk about or symbolize in their symptoms are not delusional, but real traumas. It helps to face the truth.

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In World War II, every soldier who underwent a particular battlefield experience developed schizophrenic symptoms. The soldier was under fire. He was in danger of being killed. He dug a foxhole under fire as quickly as he could, one just barely big enough to get into. He crawled into it and stayed there. He did not eat or drink. He urinated and defecated on himself because there was no other place to urinate or defecate without being killed. If the situation lasted for several days, every single soldier appeared classically schizophrenic when the shooting stopped, and his buddies came up to him. That is, when these patients were finally rescued, they exhibited Bleuler’s (1911) primary symptoms—thought disorder (inability to think logically when he wanted to), autism (inability to relate to other people), and apparently no affect or apparently inappropriate affect—plus hallucinations, delusions, and/or catatonic symptoms.

While these patients looked very severely schizophrenic, they recovered with safety and rest if they were reasonably healthy before this trauma. The term *schizophreniform psychosis* was invented to describe these patients, people who look in every way as if they are classic schizophrenic types, but who have a very good prognosis for spontaneous recovery (Bellak, 1948; Grinker & Spiegel, 1965). It was then believed that no schizophrenic patient ever recovered—a recurring myth in psychiatry—hence, a recovered patient must have been suffering from something else. Now we see these patients as simply one example of schizophrenic symptoms that occur in people who are reasonably healthy but subjected to unusual terror.

The true meaning of schizophrenia might have been discovered at that time if we had taken these observations seriously. Schizophrenia is primarily a chronic terror syndrome. Human beings are intended to be terrified for minutes, possibly for hours, so that emergencies can be dealt with. We are not intended to be terrified for days, weeks, or months. The only physiological findings with respect to persons with schizophrenia that can be replicated are those which are components of terror in non-schizophrenic individuals, or which are side effects of medications. The medications, which are helpful in the short run, are all medications which dampen down affect, including terror.

Eugen Bleuler’s primary symptom of no affect is only apparently no affect, since terror masks weaker affects. All symptoms of schizophrenia are either manifestations of terror (e.g., not being able to think clearly, not being comfortable with people), defenses against terror (e.g., avoiding people, obsessive symptoms), or symbolic acts. Catatonic stupor is not a specifically human symptom, but the response of al-
most all animals as the last stage of defense when under attack by a predator (Ratner, Karon, VandenBos, & Denny, 1981), a stage in which they are conscious of everything that is going on, but do not flinch even when great pain is inflicted. The predator usually acts as if the prey is dead, and will leave it for later unless hungry, frequently saving the prey’s life. This biological finding coincides with the clinical report by Fromm-Reichmann (1950) stating that catatronics know everything that is going on around them, even though they do not overtly react even to pain. The patients told her that when they were catatonic they had felt they would have died if they moved. As is so often the case, good laboratory research and good clinical observations coincide. There is, after all, only one real world.

The term schizophrenia was eventually abandoned, and then resurrected with an entirely different meaning in DSM-IV-TR (American Psychiatric Association, 2000) as schizophrenic symptoms that have lasted more than one month but less than six months. The myth of the incurability of schizophrenia, however, still echoes in DSM-IV-TR in the statement, “Complete remission (i.e., a return to full premorbid functioning) is probably not common in this disorder” (p. 309). This ignores the most important research findings on schizophrenia in the last 25 years: the 10 long-term, follow-up studies starting with Manfred Bleuler (1978), continuing with Luc Ciompi (1980), and the others from Switzerland, Scandinavia, Italy, Germany, and the United States (Harding, 1995; Harding, Zubin, & Strauss, 1987). Until Manfred Bleuler, no one had included patients who were not rehospitalized in studying the long-term course of schizophrenia. The general findings are that approximately a third of schizophrenics completely recover within 25 years irrespective of treatment, and this has been so since 1900. Another third of patients have social recoveries, that is, are able to function, work, and be self-sufficient, with some residual symptoms. Only approximately one-third has the classic morbid course still described in many textbooks.

Ciompi (1980) followed patients for 40 years in Switzerland. Ciompi reported that the “disease” of schizophrenia does not seem to follow the course of a physiological disease, but rather the order of the social crises in a human being’s life experiences. No improvement has been shown in long-term outcome, with the introduction of modern medication, in any of the long-term studies. However, the best of the American long-term studies (Harding, 1988) found that 50% of schizophrenic patients stop taking their medication against medical advice, and the 30% who fully recovered in the long run were from that “non-compliant”
50%. No patient who continued to take their medication indefinitely as required by their psychiatrists had a full recovery, suggesting either that the healthier patients felt freer to stop against medical advice or that the medications, helpful in the short run, interfere with full recovery.

Every therapist who has ever listened to a person with schizophrenia has heard of a life filled with traumas. John Read and his colleagues (e.g., Read & Ross, 2003; Read, Goodman, Morrison, Ross, & Aderhold, 2005) have documented most carefully the frequency of histories of traumas in persons with schizophrenia as compared to both normal individuals and to patients with less severe diagnoses. This differential frequency is found even in the records of biologically oriented hospitals that make no effort to discover traumas.

These traumas have often been explained away either as delusional (i.e., as if the trauma never occurred), or as being the result of the illness (i.e., as if the patient arranges to be traumatized). Early in my career, when schizophrenic patients described traumatic events, particularly child abuse, I tended to consider them delusional until the evidence forced me to the conclusion that almost always the traumatic events had really occurred. In those few instances where the traumatic events are not real, they always represent a real problem that is distorted either in its recall or its description.

Evidence that the traumatic experiences were real was usually to be found in the recollections of members of the family, or sometimes in hospital records. In the 1950’s and 1960’s, families trusted mental health professionals to keep information confidential and to be concerned with helping their patients. Families were not as concerned as they are today about being reported for prosecution for having committed criminal acts or about being sued for damages. Of course, even then, most perpetrators lied. However, other members of the family did not often lie. In addition, some perpetrators told the truth because they regretted what they had done and hoped the mental health professional might be able to help the victim undo the bad effects.

Even harmful or abusive parents would often say, in private, that they were not proud of what they did, but that they had, in fact, done it. They might even say that they were ashamed of what they did while requesting us to help the child, “For God’s sake, help the child.” Although most of my patients have been adults, I have worked with a few schizophrenic children and have insisted that both parents be seen in therapy. I would see the child individually and then I would see each parent. Under those circumstances, it was easy to validate the reality of the bad events. (While I would still insist that both parents be in therapy, there
are advantages and disadvantages to each of the alternatives: the same therapist working with child and parents, different therapists working with each person, or a family therapist working with the whole family in addition to individual sessions for the designated patient. In any case, someone must work with the parents if the child is to really get better.)

One eleven-year-old schizophrenic boy reported an anxiety dream: “I was looking at a picture of a machine consisting of a needle and a bowl. Then an ape was chasing me. And I woke up.” In his next session, the father stated that when the patient was small, his crib was in the parents’ room.

“But he used to stand up and look at us.”

“Was it annoying?”

“It sure was. He used to make noise.

“Did you hit him?”

The father hesitated and then stated that he used to hit his son and felt guilty about it. “Was that when you were having sex?” The father was startled at the question, but then said that in fact he felt guilty when he hit the child because it was embarrassing. The father stated that it had happened many times and he was ashamed of it now.

An 18-year-old freshman woman from a small town left home for the first time to go to a small Catholic college at some distance from her home. She had a psychotic break apparently for no reason. Her family thought that leaving home seemed to have been too stressful for her. When she was hospitalized, the treating psychiatrist described her as a “totally uncommunicative patient,” and consequently recommended a course of electro-convulsive therapy (ECT).

On my recommendation, her parents withdrew permission for ECT, arranged for testing with a competent clinical psychologist, and a consultation with me. By the time of the consultation (three days later), her psychiatrist rethought his recommendation and told the patient and her parents that he now thought that ECT would be a mistake.

The psychologist (Mary Jane Keller) was able to relate to the patient so well that the patient took the tests without any problem, on the same day that she was to be interviewed by me. Dr. Keller relayed her findings to me over the phone, before I talked the patient. On the basis of the kindly relationship formed with the diagnostic psychologist during the
testing, it was much easier to relate to the patient. I let the patient know I wanted to help. I told her who I was, what I knew about what was going on, what had happened, and that she had been saved from the trauma of ECT by my recommendation, which even her psychiatrist now admitted would have been a mistake. I said I wanted to see what else I could do that might be helpful. (Since I was scheduled to go on sabbatical at the end of the term, I had only agreed to see her and make a recommendation.) I wanted to hear what had happened, and I took seriously what she told me. By the end of the hour she was talking freely, and it was clear to me that even in ten weeks we could get a lot of work done. We began psychotherapy with the understanding that we would interrupt therapy at that time.

The Thematic Apperception Test indicated a trauma that had precipitated the psychosis. This was confirmed by the patient. At college, she had met a boy and gone out with him. But he wanted sex and she did not. One evening, they were walking alone nearly a mile away from any building (the small college was in a rural area). The boy became frustrated and told her that he was going to rape her. This terrified her. Given their isolation, it would have been impossible for her to stop him. He did not rape her, so obviously he had no intention of actually raping her but of scaring her into compliance. But she believed he was going to rape her, and she was terrified. That was the precipitating trauma, and she fell apart. Interestingly enough, he had also dropped out of college. She never did find out anything about his later life. She tried to see a psychologist at the College who recommended that she return home. The patient saw a psychiatrist, who medicated her. This did not help, and the patient was hospitalized.

But she did respond to psychotherapy, without medication, with a therapist who listened. She was out of the hospital after 3 sessions, started living on her own, earned her living doing housework while she continued psychotherapy twice per week, and ended therapy as planned at the end of 10 weeks. At that time, she was making arrangements to return to college. She also knew that she could ask for and receive more psychotherapy at our University clinic if she asked for it, even if I was not there. She started college, ran into difficulty, and returned asking for therapy. She was seen in psychoanalytic therapy for a year by a graduate student under supervision. She dropped out college, took a brief secretarial course, started earning a better living, and got married. After a few years she returned to college to finish her education while her husband finished graduate school.
However, there were also longer lasting subtler traumas. It is my practice to allow immediate family members one confidential session. Her mother said in that confidential session that she had never been able to love the patient. There were many children in this family. Her mother said this was the only child she had never been able to love. The mother felt guilty about it. She had never told the patient this. But she was honest with me because she was afraid that it had something to do with her daughter’s problems. Indeed, that daughter was the only child in the family who ever had a psychotic break. Her mother’s honesty and concern made it easier for me to understand the patient’s feelings. (Of course, I never told the patient what her mother said, but it was easier to give credence to the patient’s feelings of not being loved. If I felt it was necessary to tell the patient, I would, of course, have gotten her mother’s permission first.)

A 32-year-old paranoid schizophrenic patient in his thirties had been hospitalized as psychotic for 16 years (Karon & Rosberg, 1981). He spent only half of those years in mental hospitals. He was never discharged, but he was a genius at escaping. His mother sent him money to live on until he got into difficulty and was rehospitalized. I treated him for a year in a residential treatment center, five sessions per week without medication. This was followed by a second year of treatment under Jack Rosberg, a colleague, and several years of outpatient therapy. Thirty years later he has lived a successful life with no relapses.

When he started treatment with me, he insisted, “my mother was nice, my father was nice, my family was nice, and nothing happened in my childhood.” According to both him and his mother, the precipitating event was the death of his father. When the patient was 12 years old, his father died from what may have been an accident. Certain circumstances, however, strongly pointed to the possibility of suicide. But his mother never told him how his father died “to spare his feelings.” (Of course, the fantasies generated by keeping things mysterious are usually more traumatic than any unpleasant event, but his mother did not know that.) His mother described the family situation before the death of his father and, in fact during his whole childhood as “happy.” After his father’s death, the boy began to hear the voices of drowned people when riding a car by a river or a lake. He developed a strong interest in spiritu-alism and heard the spiritual world, that is, dead people talking to him.

With these hallucinations, which obviously had the reassuring meaning that death was not real, that it did not matter if you were alive or dead, he was able to function in school and other situations for years. During this period, his mother took him to a Park Avenue psychiatrist to
have the psychiatrist talk to him about sex. During the interview, the patient was continuously hallucinating, but at the end of the interview the psychiatrist told the patient’s mother that the patient was the best adjusted teenager he had ever seen. According to the patient, “You just tell a psychiatrist you know nothing about sex, and they say you are well adjusted.”

Eventually, he complained about a conspiracy against him in which his mother was involved. He was then hospitalized, and began his career as a patient. During his latest treatment his mother, supposedly to save money, started living with him in the residential treatment house where he was treated, helping to take care of it. Their informal interactions were thus observable during this time. His mother had been psychoanalyzed. She consciously tried to be helpful, but was actually destructive, by insistently repeating to the patient the more or less classical interpretation of death wishes towards his father. In fact, there was nothing in the patient’s behavior or conversation outside the therapeutic hour which seemed related to such feelings. Nor was there any material in the therapy hours related to such feelings.

Literally hundreds of times with no provocation, the mother asked the patient, “Do you think you killed your father? You didn’t kill your father. Nobody blames you for killing your father.” Eventually, the patient revealed that 6 months before the death of his father, his mother had left, saying she wanted a divorce and later returned “because she needed money.” Eventually, the patient was able to recall the “civil war” he felt inside him when having to choose between his mother and father, he chose his father.

The father had been a weak ineffectual character, nevertheless loving as compared to his mother, and hence a sustaining force in the patient’s life. The patient recalled having had his first hallucination when he learned that his father was dying. He prayed to God to save his father’s life, and a voice told him that his father would be spared. The next day, his father died. The patient felt that his mother had killed his father and would kill him too if he ever got her mad.

There were anal problems. His mother described him as having been completely toilet trained before the end of the first year, which can only be done traumatically. Just how strong the resultant fears of his own feces were in this patient was shown in the fact that he would periodically fast insofar as the therapists and attendants would allow it, even after his fears of being poisoned (which will be discussed below) were resolved. These fasts were not terminated until the patient was explained that if he could stop eating he would “not have to shit.” The therapist actually ac-
companied the psychotic patient to the bathroom when he defecated and continued talking with him to indicate that his feces were not repulsive, discussing later in therapy the meanings of toilet training and feces.

The importance of these anal pressures to the patient was shown when he was asked in a therapy hour to talk about the envy he felt for his younger brother. He immediately said:

“There is no envy about shit.”

“Do you remember anything about shit?”

“My brother shit in the bathtub when he was five years old and my mother cleaned it up.”

“If you had shit in the bathtub at that age, what would have happened?”

“I don’t know.”

“Would your mother clean it up?”

“No.”

“Would you be punished?”

“Yes.”

“How would they have punished you?”

“I don’t know. But it would be awful.”

We see that the patient’s feeling about his brother being more loved than him was, in fact, based on preferential treatment. Moreover, when his brother was born, the patient, who was four years old, suffered from whooping cough, and was tended by his mother personally while he was confined to bed. Suddenly, his mother left him to have the second child and did not come near him for almost two months, a minor eternity to a sick 4-year old. No wonder he felt that his mother loved his younger brother more.

The patient talked about oral problems (Karon, 1960) including the fear of being poisoned, which sometimes caused him not to eat. Nonetheless, his mother, who consciously wanted to be helpful, was proud of the fact that she had breast-fed the patient for a full year, and had gradually weaned him. Where, then, could there have been an oral trauma?
During the early weeks of therapy, the patient refused to drink milk. He finally told the therapist, “The Athenian girls are laughing at me. They say their breasts are poisoned.” The therapist reassured the patient that the therapist was stronger than the Athenian girls and that the milk was not poisoned. The patient then asked for and received a large glass of milk which he drank, asked for another glass which he also drank, and showed no specific distaste for milk afterwards.

One day while sitting down, the patient was approached by a woman with a rather well endowed bosom. He made frantic wiping gestures from his side. Afterwards, he told the therapist, “She approached me with her breast and I got hurt in the side.” One day while sitting at breakfast, the patient’s mother, who was knowledgeable about psychoanalysis, asked him, “Didn’t I have enough milk? Didn’t I give you enough to drink?” The patient replied, “The cow gave her calf milk and then kicked it. She shouldn’t do that. It’s something that happened hundreds of times in the history of the world.” During therapy, the therapist reminded the patient of this statement. The patient steadfastly denied that the statement had anything to do with him, “It’s just something that happened. The cow gave her calf milk and kicked him. It has nothing to do with me.” The milk or food seemed to be poisoned not by any characteristic of the milk but by the fact that his mother had resented any demands upon her to feed the infant, so that after feeding him, she would become immediately angry. Then, the child would feel her hostility and get hurt. To an infant, an angry mother is a trauma. The trauma did not happen once but over and over. This problem continued even after the patient became an adult. Whenever the patient’s mother cooked a meal and he ate it, there was a quarrel afterwards. If the patient did not eat (sometimes he was on a fast or hunger strike) or if the mother did not cook (often the attendants cooked), there was no quarrel. The attendants reported that the problem went on, in this sequence and without exception, for six months. The quarrel would be neither about cooking nor about food, but about something different each time. Apparently, the demand to feed made the mother angry; and when she became angry, anything would turn into a quarrel. The mother was not consciously aware of this sequence. The patient would also deny, even during therapy hours, being consciously aware of this, although his delusion of the cow clearly reflected it, and our discussion on the meaning of that delusion led to the disappearance of his fear of being poisoned.

Patients often resist the idea that their parents were involved in a trauma or that they were not above reproach. Once, a patient told me how lucky he was to have had such good parents, especially such a good
mother. However, even before becoming psychotic, the patient had not been able to remember anything about his life prior to the middle of high school. The patient had not thought this abnormal. After unsuccessful “psychotherapy,” combined with multiple medications in increased dosages, and inpatient treatment, all of the patient’s psychiatrists diagnosed him with an “incurable schizophrenia.” Electro-convulsive therapy (ECT) was recommended as his only hope. His wife was told that although ECT would probably not help, it was his only hope.

On my advice, his wife withdrew permission for ECT and removed him from the hospital. At that point, the patient was not eating or sleeping, and was continuously hallucinating. He was seen in psychoanalytic therapy, without medication, seven days on the first week, six days on the second week, and five days on the third week. He was very gradually reduced to four times per week, and then to three. After the third year, the patient was seen on a once-per-week basis. The patient began eating after three days, began working at a complex job after six months, and eventually had a successful and creative career while becoming a good husband and father.

In one of his hallucinations, the client would feel the horrible experience of burning in Hell. A friend of the couple, who had suggested to the wife to talk to me and had asked me whether the patient might be treatable, asked me early in the treatment whether the patient had ever talked about the scar on his hand, suggesting that I ask the patient about it. When I asked the patient whether he had a scar on his hand, he told me that he did. The patient’s mother told me the story behind the scar. According to her, she took the patient to a store when he was five years old. Seeing him with a toy in his hand, the mother asked him where he had gotten it. He said that a lady had given it to him. The mother asked the lady, who stated that she had not given him the toy. The mother made him return the toy and apologize to the lady. Then, she took him by the hand, walked him home four or five blocks, took him up the stairs to the third floor where their apartment was, turned on a gas burner, and held his hand in the burner to teach him not to steal. Although the burn left a permanent scar, the patient sustained that the event had no effect on him because he could not remember it. I told the patient that I was of the opinion that what we cannot remember has the most profound effect on us. I added, “Most of us can only imagine what it would be like to burn in Hell. But you’ve actually been there.” His hallucination of burning in Hell disappeared after that session.

Another trauma that he recalled included being sent out to play dressed all in white when he was five years old, and receiving a beating.
if he got dirty, which of course, he did. The patient deemed this punish-
ment appropriate. I pointed out to the patient that any parent knows that 
a child of that age, dressed all in white, would get dirty within 30 min-
utes even in a hermetically sealed room.

The patient grew up in an Italian neighborhood in New York City. As 
he would go out to play, his mother would warn him not to play with 
Italian kids, “for his own good” because “those Italian kids” were dan-
gerous. Of course, in an Italian neighborhood in New York City, there 
are only Italian kids. Hence, he would have to either not make friend or 
do wrong (according to his mother’s dictates) by the friends he made.

The patient had always tried to be good enough to deserve his par-
ents’ love. As a child, the patient together with his brother would re-
ceive piano lessons. The patient worked hard to develop some skill. His 
brother apparently had little talent, so the piano teacher gave up and 
taught the brother a couple of pop tunes. The patient eventually became 
ready to show off to his parents the skill with which he had learned to 
play after considerable effort. But when he played the piano for them, 
the patient discovered that the parents did not like his classical music 
but enjoyed his brother’s pop tunes.

The patient had the fantasy that if only he were successful enough, 
his parents would eventually love him. However, whenever his parents 
talked to him on the phone or in person, they would only talk about how 
much money his brother (who had gone into business) was making. 
Similarly, when they talked to the brother, they would only talk about 
how brilliant the patient was. Both brothers felt like a failure before psy-
choanalytic therapy, which they both luckily undertook. I pointed out to 
the patient that both he and his brother were successful and that there is 
not enough time in life to do everything. If you are a college professor, 
you are not going to earn a great deal of money. If you are a business-
man, you are not going to write books. His parents were neither intellec-
tuals nor successful business people, but they were good at making both 
of their children feel inadequate despite their success. When the patient 
finally finished his PhD, he was given a raise and a promotion in his aca-
demic job. He called his parents to share his triumph and get the ap-
proval he now felt he had earned. His parents did not react, except to ask 
whether that was all the salary he got. “I’ve been telling people you 
make more than that already,” said his father. After that phone call, the 
patient’s defenses began to unravel, and he got sicker and sicker until 
his hospitalization.

The patient’s mother had produced in him the feeling that food out-
side the family was dangerous. The patient’s wife reported that when
they ate out, the patient would regularly ask, “Is it safe to eat this?” The patient reported that he had never eaten a meal without feeling nauseated. When we started psychotherapy, we focused on the fact that the patient was not eating at all, given that this symptom could become fatal in 30 days. I took him early in the morning to an all-night restaurant. He objected, “I can’t go in there. They’ll think I’m crazy.” I told him that, on the contrary, they would think he was drunk. “I’ll throw up!” I told him that he would not be the first drunk to throw up there that night. As I have recommended for patients who do not eat (Karon & VandenBos, 1981), I ate one meal a day with him, in this case, breakfast, and we talked about eating. Most important with psychotic patients who do not eat is the fear of being poisoned, which usually relates to the repetitive trauma in infancy and childhood of a mother who resents (usually unconsciously) having to feed and mother the child, consequently getting angry after each time she feeds the child and the child eats. As discussed before, neither the mother nor the child is usually aware of this. Our discussion of such a possibility in his family led him first to get angry at me. He took a cup of black coffee on our second restaurant session, coffee and toast on the third, and then began to have breakfast and eat regular meals. Years later, when he visited Paris, he recounted with tears in his eyes, “I can’t tell you what French cooking is like. There is nothing like it in America.” I knew I had helped him.

Six months after beginning intensive psychoanalytic therapy without medication, this “incurable schizophrenic” was back at work on a full-time basis as an academic. The patient stayed in treatment for years, working on new issues including his difficulty about writing his first book, his experience of psychosomatic problems, his marital problems, and his need for help in undoing the harm he felt he had done to his now adolescent son, who had a psychotic father when he was young. The patient stated, “that was a hell of a thing to do to a kid and I need help in undoing the harm I did him.”

The patient ended up becoming a good father and husband, an excellent teacher, and a first rate scholar with an international reputation. He sent me a note about a prestigious award he received stating that he had never really expressed his thanks to me for returning a life to him. (I felt that he had appropriately thanked me, but he apparently did not.) Remembering the trauma of never having his excellence appreciated by his parents, I wrote him a note saying, “From time to time I have heard from students about your teaching and from colleagues in your field about the importance of your contributions, and it has always been a source of satisfaction that I was available when you needed me.”
One year, I taught a seminar about Psychotherapy of Psychosis for residents in psychiatry at a state hospital. I clearly made them anxious because I sustained that lobotomy (which was still being done) was destructive, that Electro-Convulsive Therapy (ECT) was destructive, that medication was of limited benefit, and that residents should be talking to and listening to their patients. That was not what their other supervisors had said even though the Director of resident training had asked me to teach the seminar to the residents. Indeed, at first, members of the psychiatric staff attended the seminar. However, the residents asked that the psychiatric staff be excluded. They told the director of resident training that the staff made so many objections that the residents felt they were not being allowed to learn. The residents said they already knew what the staff thought and wanted to hear, at least, what I had to say. Nonetheless, I made them anxious. They asked me to interview a patient. Most schizophrenics are not dangerous. However, the residents showed their hostility by choosing a patient who was very muscular, moved very fast, and had a history of assaulting strange men. Knowing that they had never been that close to anyone that dangerous, who moved that fast, I got even by insisting that they sit in the same room with us during the interview. At least I knew some things about violent people that I could rely on while they did not, and that if I found him scary, they would be ten times more scared. The patient was not only dangerous, but also grossly incoherent. Whenever he was not incoherent, he stuttered very badly. The only way the residents could have found a patient seemingly less suited to verbal psychotherapy would have been finding a patient who either could not talk at all or only talked a foreign language.

There were over ten years of hospital records on him, the length of time he had been a patient on the locked chronic ward. In those records, which included a family history, there were apparently no traumas that would account for the severity of his problems. He grew up in a lower socioeconomic family in Detroit. His father was an alcoholic. He had developed a speech disorder (stutter), which did not respond to speech therapy. Eventually he went into the army. He showed up on sick call with a venereal disease, the site of infection being his mouth. Shortly thereafter, he assaulted a stranger supposedly for no reason, but never received a general discharge. His history then became to be hospitalized as severely disorganized, pull slowly together, be discharged and soon assault another stranger, and be rehospitalized as a disorganized schizophrenic.
The traumas came to light in therapy. He had a symptom that worried the attendants: From time to time, he would grab a patient and choke him until the victim, feet in the air, would become unconscious. The patient had not killed anyone yet, but the attendants were concerned that he might. In my value system, which most patients share, the first issue to deal with is possible homicidal danger, followed by possible suicidal danger, followed by anything else. Consequently, I continually brought up this symptom in the first session. Despite the patient’s apparently incoherent remarks, he was able, bit by bit, to tell me how his mother would put a cloth around his neck and would choke him for minor offenses such as not eating. Since all of us biologically go into panic when our ability to breathe is suddenly cut off, the repeated early childhood trauma must have been unbearable for him. After he and I had reconstructed and discussed this trauma, his choking other patients ceased permanently.

Although we do not always get a dramatic immediate improvement even when we are right, it is a useful rule of thumb to assume that we are doing the right thing when we do get a dramatic improvement in a long-lasting symptom. The meaning of the symptom was his undoing the trauma. He would re-enact the trauma by playing the role of his mother while the victim played the role of the patient. The patient was proving that the mother would have never killed him because he would stop the choking when the victim was unconscious but still alive. The symptomatic act reduced anxiety, but would have to be repeated eventually. It was only when the patient consciously linked the symptom, the trauma as actually experienced, with its meaning, that he understood the symptom and as well as the fact that his mother would never choke him again. The symptom was resolved.

A second trauma came to light in a transference reaction. Once, the patient began a session by shouting at me, “Why did you do it to me, Dad?” Some organically oriented mental health professionals might have simply noted that the patient was obviously confused. But it is not hard to recognize a transference reaction when the patient calls you, “dad,” or “mom.” I asked the patient what I had done, but he would only shout angrily, “You know what you did!” I asked him how old he was; and he said that I knew he was eight years old. Bit by bit, the patient told me that when he was eight years old, I came home drunk and anally raped him. Of course, there were more bad things in his life besides these isolated traumas. One might as well ask what type of mother would choke her young child, what type of father would rape his eight
year old son under any circumstances, and what type of life the client would have led with his family.

Anna Freud, in the Harvard lectures of 1948, compared the reconstructions of psychoanalyses of young adults with the events that had actually happened in their childhood while growing up in the Hampstead Clinic, where the events were recorded (Freud, 1992). If the psychoanalyses were at all careful, the reconstructions were accurate, with one exception. What was remembered or reconstructed as a single event in the psychoanalysis always represented a series of events with a similar meaning. Memory seems to consist of summaries. This is consistent with Sigmund Freud’s statement that all of childhood is contained in the “screen” memories, that is, the apparently isolated and often seemingly meaningless memories of childhood, which when explored and associated to, lead to the important issues and events of childhood, even those repressed (unavailable to conscious recall).

The obvious traumas in this patient’s life involved more than his parents. When he was not grossly incoherent, he stuttered very badly. His stutter had an unusual basis. In the middle of his confusing utterances, I would suddenly hear words in Latin. (In high school they told me that if I wanted to go to college, I should take Latin. I took four years of Latin, and at this one time of my professional career, it became useful). It took me several minutes to wonder how this uneducated man had learned Latin before I thought of altar boys. I asked the patient whether he had been an altar boy. He stated, “You swallow a snake and then you stutter. You mustn’t let anyone know.” The patient seemed very ashamed and guilty. I took the symbolism seriously and guessed that he had probably performed fellatio. He seemed too guilty for it having involved another altar boy. I interpreted it as a sexual experience, an oral one, because with schizophrenic patients much of what seems sexual is really related to morality and survival. In addition, while a snake may represent a penis (because of its shape, extensibility, and dangerousness), a penis may also represent a breast, and a breast may represent love. I told the patient, “I know what you did with the priest, and it’s all right. Anyone as hungry as you were would have done the same thing.” His stuttering, which had lasted many years and which had resisted the efforts of a speech therapist in high school, immediately stopped. When the stuttering resurfaced in subsequent sessions, it became possible to stop it immediately by repeating the same interpretation. For many years, when I mentioned this case at professional presentations, there would always be someone who objected that I had no evidence that the patient had ac-
tually been molested by a priest, and that, after all, a priest would not do a thing like that. In recent years no one makes that objection.

This patient, whose severe schizophrenic symptoms seemed so puzzling in terms of the many years of recorded professional notes documenting treatment by practitioners who medicated without listening, now made good sense. His mother was horrible. When our mother is bad or defective, we turn to our father. But the patient’s father was horrible. Finally, the patient turned to God; and even the priest was horrible. Wouldn’t that drive any of us crazy?

In my view, most psychopathology is the result of trauma. The question is not whether or not there were traumas, but what were the traumas, what was the nature of those traumas, what effects they had, and what we need to do to help. People suffering the most serious of emotional problems, those we call schizophrenic, have simply had the most devastating traumas. We can discover what these traumas were and what needs to be done, if we are willing to hear, listen, and help.

REFERENCES


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