

Evidence for The Effective Resolution of Schizophrenia and Schizoaffective Disorder Using Psychoanalytic Psychotherapy, Derived Through Visualization of The Process

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ABSTRACT

Background: The Psychodynamic Pentapointed Cognitive Construct (PPCC) model [1] illustrates visually that schizophrenia and schizoaffective disorder may be resolved in patients through the psychological treatment technique of psychoanalytic psychotherapy, utilizing also psychotropic medication as required.

Objectives: The aim of this paper is to demonstrate the veracity of how this may be achieved; and then to present the evidence base for this therapeutic process described by visualization so that it may be replicated.

Methods: The author studied the illness schizoaffective disorder closely, and then investigated how schizophrenic illness could be treated. She made a careful Case Study of a schizoaffective patient who was recovering through Kleinian psychoanalytic psychotherapy, and benefiting also from psychotropic medication. The findings from this Case Study were then compared with the clinical results of the work of a psychiatrically-trained psychoanalyst in Massachusetts, USA, Dr Michael Robbins MD [2], who has conducted psychoanalytic psychotherapy on his portfolio of 18 paranoid schizophrenic patients.

Findings: The PPCC model's formulation of the specific recovery process when using psychoanalytic psychotherapy, from the patient's perspective, coincided precisely with the therapist's perspective of the Stages of recovery observed by Dr Robbins. This indicates a process where the two experiences of the therapy corroborate each other. The factors underpinning this corroboration were then enumerated to present the evidence base for the process.

Conclusion: This paper provides evidence on a very small scale that demonstrates that this treatment is clinically effective.

Clinical Implications: It can be delivered safely and cost-effectively.

Keywords

Schizophrenia, Schizoaffective, Psychotherapy.

Introduction

There is an imperative to alleviate the suffering of those patients diagnosed with schizophrenia and schizoaffective disorder, as for all patients, as far as ever possible. Knowledge of the NMDA receptors on GABAergic interneurons interfering with dopamine neurotransmission in the brains of schizophrenic patients may lead to more effective and thus widely welcomed medications; but it

will not resolve the confusing experiences these patients have accumulated over their lifetime and which occlude clear thinking in their minds. To achieve this, a patient needs time to learn how to experience their own mind in a state unaffected by anything (- given that medication is ideally used only to suppress symptoms that interfere with the ability to think cogently at all, and no further) except the medically prescribed administration of an intelligent and wise, kind and compassionate psychoanalyst, who can help them address, in a safe environment, their very painful and confusing lifetime's experiences; and this in a manner that enlightens them

about themselves, individually and in relation to other people; and then to gain confidence in themselves about their own self's nature, identity and capacities for engaging in their future life, without the difficulties caused to them by their past illness. In this way, the "psycho" element of the biopsychosocial approach of Psychiatry to psychological disturbance may be enhanced.

Aims and Objective

Modern Psychiatry investigates the evidence substantiating the range of factors and measures that promote mental health and its understanding. The aim of this paper is to illustrate scientifically that psychoanalytic psychotherapy may be observed, through a visualized Case Study, to lead to psychological alleviation of the distress caused in a patient by schizoaffective disorder; and then to show that the process of this observed alleviation is confirmed by a psychiatrically-trained psychoanalyst's independently conducted clinical work with paranoid schizophrenic patients. This paper's objective is to demonstrate thereby the evidence for the potential of psychoanalytic psychotherapy to alleviate schizophrenia and schizoaffective disorder in patients, so that this may be replicated.

Methods

The author (GS) made a Case Study of a schizoaffective patient who, from her own interest, had already made a small study of her mind while 4.5 months into her Kleinian psychoanalytic psychotherapy; the patient had wanted to write a book about her experiences and to derive chapter headings for her book from her experiment. The patient had therefore examined the ideas that entered her mind, during her small experiment, after she had prepared her mind by stilling it completely. She wrote out the 29 ideas that popped into her mind at approximately 1-second intervals, resulting in five naturally-occurring groups (with pauses between them), and then assembled these on to a pentapointed diagram because she had eidetic imagery and wanted to display her results in the most positive way possible for her.

The author observed her results and recognised four group variables that summarized her patient's ideas, together with a fifth variable of the patient's choosing. Gradually, over a period of many years, the author developed a model, forming the Psychodynamic Pentapointed Cognitive Construct (PPCC) Theory [1], which illustrates visually, through subsidiary geometric diagrams, the process of recovery of her schizoaffective patient treated with psychoanalytic psychotherapy.

The author then investigated the work of a clinician working in Massachusetts, USA, Dr Michael Robbins MD, who had applied psychoanalytic psychotherapy to his portfolio of 18 paranoid schizophrenic patients. The author, GS, examined his findings, which included a paper entitled "The successful psychoanalytic therapy of a schizophrenic woman" [3], and then compared these with the results of her own Case Study.

Following the observation that these results coincided precisely with her own findings, the author set about identifying the validating aspects of the two independently arrived-at sets of results so that

these might permit future treatments on a firm evidence base.

Findings

The author was very interested to observe her chosen Case Study patient's small experiment, and identified 4 variables, in addition to the variable "Problems" which soon was superseded by the variable "Analyst" because the patient felt her Analyst could resolve her problems in the treatment. These 4 patient variables, thus Experiences (including childhood Experiences), Representations (and Dreams), Observations (articulated Thoughts), and Determining Orientation (including Fantasies), were discovered 24 years later by the author to comprise, verbatim, the variables identified by the Shorter Oxford Textbook of Psychiatry [4] as providing the data during psychoanalytic treatment upon which psychoanalytic theories mainly depend. The original diagram produced by the patient, annotated according to the author's group headings, formed the basis for the core model of the author's PPCC Theory of the functional psychoses (Figure 1).

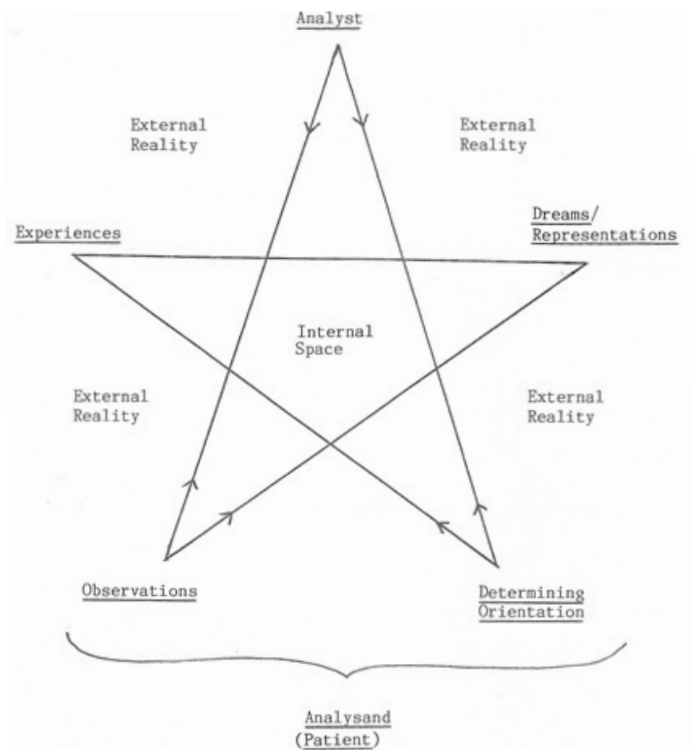


Figure 1: The Psychodynamic Pentapointed Cognitive Construct (PPCC) in schizoaffective disorder (c) BMJ 2019.

Altogether, 14 factors similar to this finding form the evidence base for the PPCC Theory's validity as a sturdy illustrative foundation for understanding this application of psychoanalytic psychotherapy, the remedial technique for schizophrenia and schizoaffective disorder practised by Dr Michael Robbins:

- (i) Evidence for the psychoanalytic and psychological validity of the PPCC model's conceptualization of the process of psychoanalytic psychotherapy for schizophrenia:
 - The PPCC model is consistent with psychoanalytic concepts and utilizes several of these, viz. the representational world

[5], transitional objects [6], and distinguishing a psychotic part of the mind from the non-psychotic part [7-10].

- The PPCC model confirms several psychoanalytic theories, and provides independent theoretical support for Sigmund Freud's conception of the origin of depression (in summary, that the shadow of a lost loved person falls upon the patient's ego), being a disturbance of the patient's Representations, and of the origin of mania (in summary, that the ego conflates with the superego), being a change of Experience for the patient, leading in both cases to illness.
- The theories of Sigmund Freud about the origins of depression [11], as described above, of Wilfred Bion about the origin of conceptualizations [12], and of Jerry Fodor, who in his representational theory of mind describes the acquisition of attitudes of mind [13], may all be aligned according to the PPCC model when their processes are seen to start from considering Representations in the mind [1].
- The PPCC model that describes the theories of Freud, Bion and Fodor, (as above) shows, when simplified, that they have in common the feature that the conflation of a factor outside the mind with a factor inside the mind results in a mental outcome (Figure 2). This extension of the PPCC model in relating to other, diverse psychological theories helps to validate its coherence.
- Very many techniques of psychotherapy, including psychoanalytic psychotherapy, indicate that dialogue is usually extremely effective in helping to resolve psychological difficulties in patients. Broad and general improvement in patients' mental health occurs when all the different beneficial effects of articulating difficulties enable the patient to move through psychological obstructions and to function more freely and independently. This argument includes and underpins almost the entire professional objective of psychoanalysis.

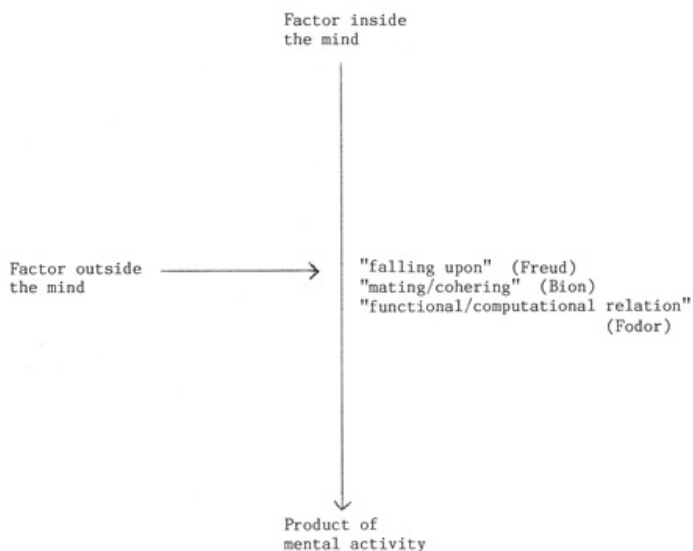


Figure 2: The process of producing mental outcome according to the adapted PPCC model.

(ii) Evidence for the objective scientific and Psychiatric nature of

the PPCC model and its derivations:

- This study shows how the PPCC model reflects reality. The author's Case Study describes an example of schizoaffective illness that was treated in reality with psychoanalytic psychotherapy and adjunctive medication, and was resolved [1].
- Reflecting the objective truth of the analyst entering the patient's world as she experienced it, the PPCC model incorporates the psychological movement of the patient's psychoanalyst into the workings of her mind.
- The variables of Experiences (including childhood Experiences), Representations (including Dreams), Observations (spoken Thoughts), and Determining Orientation (eg. Fantasies) were found in the Shorter Oxford Textbook of Psychiatry to be specified as those variables providing data obtained during psychoanalytic treatment upon which psychoanalytic theories mainly depend, as described above [4]. Thus, Psychiatrists recognise the sources of data that hold value for thinking about mental health in the manner advocated by Eric Kandel [14] in 1999 when he describes his "new intellectual framework for Psychiatry revisited": "Psychoanalysis still represents the most coherent and intellectually satisfying view of the mind".
- The PPCC's model for schizophrenia demonstrates the complete blockage in the mind of a schizophrenic patient [1] between their psychotic thinking (Determining Orientation) and the non-psychotic thinking that they are able to pursue (Observations). This view of complete blockage in schizophrenic patients' thinking is also recognised by Psychiatrists.
- The PPCC model includes the stage of the patient gaining a new capacity for orientation in time, place and person when they are progressing well in their psychoanalytic psychotherapy and learning to endorse all of their previous life's experiences with acceptance, understanding, and an absence of psychosis-inducing anxiety. Psychiatrists recognise this orientation as a basic requirement for mental health, and especially in psychotic illnesses.

(iii) Evidence for validation of the potential efficacy of psychoanalytic psychotherapy for schizophrenia and schizoaffective disorder:

- The author (GS)'s colleague in Massachusetts, USA, Dr Michael Robbins, provided "a positive outcome" for 9 of his portfolio of 18 paranoid schizophrenic patients whom he treated with psychoanalytic psychotherapy [2].
- Dr Robbins' 7 Stages of Therapy [2] coincided precisely with the author (GS)'s PPCC model (Figure 3), thus confirming inter se the efficacy of the two independently arrived at sets of observed clinical progress, ie. from the patient's and from the therapeutic perspectives.

(iv) Circumstantial evidence for a philosophical relation conveying existential biological plausibility between human psychology and ubiquitous features of physical life forms on Earth:

- The PPCC pentagram incorporates the Golden Ratio [15], a

unique mathematical aspect of many phenomena on Earth, including the genealogy of bees, many aspects of proportions of the human body, and the numbers of petals on daisies. In this way, the PPCC pentagram relates the human mind philosophically to many different life forms and phenomena on Earth.

- The 4 patient variables in relation to the analyst variable in the PPCC model are of some interest in comparison with the commonly observed vertebrate limb, where 4 digits function in relation to an opposable thumb. This pattern of (4 + 1), so evidently apparent in the bodies of nearly all vertebrates is, arguably, reflected in the PPCC model of the patient's compromised human mind comprising 4 variables that is in stable communication with a stronger other, ie. the analyst. The relation to the analyst in the mind of the patient, with their 4 variables, is thus similar in human life, as a biological and developmental analogy, to the relation of the hand's less powerful 4 digits to the stronger, independent thumb.

1. Protopathosymbiosis
(patient helpless in representational world).
2. Engagement with analyst pathologically
(patient includes analyst in rep. world).
3. Pathosymbiosis
(patient tries to communicate with analyst); then
- 3b. Potential therapeutic stalemate
(patient cannot accept analyst's truths); or
4. Disengagement from pathosymbiosis
(patient rejects her previous stances).
5. More normal symbiosis with analyst
(patient orientates in time, place and person).
6. Psychic differentiation and integration
(patient becomes integrated and autonomous).
7. Therapeutic termination from therapy
(patient becomes self-sufficient).

Figure 3: Summary of Dr Robbin's 7 stage of the resolution of schizophrenia by psychoanalytic psychotherapy, paralleled by changes in the PPC model: Robbin's (and PPCC).

These 14 points of evidence are assembled so that the validity of the indications provided by the PPCC Theory regarding resolution of schizophrenia and schizoaffective disorder by psychoanalytic psychotherapy may be evaluated.

Discussion and Clinical Implications

The very small scale of this observational study necessarily, therefore, uses John Stuart Mill's empirical method of inductive reasoning to reach its conclusions. It is sometimes said that epidemiology is the most important science for Psychiatry. Generalizing understanding and knowledge from experiencing a single observation, on a small scale, compared with reaching conclusions from the much larger scale of an epidemiological study, is equivalent to the difference of looking through a microscope compared with looking through a telescope. Each has its merits as a method of learning. This study was meticulously performed,

and does itself invite analysis, discussion and evaluation so that its substantive aspects may be built upon in the endeavour of alleviating the dreadful distress, especially confusion and fear, caused by schizophrenic illness. Epidemiological findings are most meaningful when the individual units they enumerate are thoroughly understood.

The endpoints of recovery decided upon in the evaluation of the Case Study schizoaffective patient's treatment, and of Dr Robbins' paranoid schizophrenic patients' therapy with him, are considered to be reached when the patients become able to live independently and flourish in their communities through progress of different kinds. Examples of endpoints reached in these patients include achieving a university degree, marrying, adopting a young person to care for, or coming off medication with an ability to think dependably through her experiences and without being restricted by any lack of adjustment to her psychological pain.

Necessary psychoanalytic skills have not been addressed here, but personal qualities of robustness are necessary in the analyst to enable him or her to conduct this therapy as successfully as Dr Robbins. One of Dr Robbins' patients informed him of one aspect of her treatment with him which stood out for her as the most beneficial factor towards her recovery as she experienced it: this was Dr Robbins' practice of sitting with her, hour after hour in her sessions, sometimes in silence, sometimes with a very heavy atmosphere in the consulting room between herself and Dr Robbins, simply tolerating this while the patient learnt to tolerate her own feelings, whatever these might be; and often they were hostile, rejecting, fearful, distressed, perplexed, resentful, and of many other unpleasant forms, either separately or in combination. Dr Robbins' ability to tolerate these situations robustly enabled him to conduct the therapy successfully. So, in any discussion of psychoanalytic psychotherapy for schizophrenia the suitability of the analyst's capacities for resilience must be at the forefront when the working relationship is being contemplated. This paper's validity is contingent upon training Psychiatric psychoanalysts who are confident in their work; and all mental health clinicians require and must be given support to meet their professional needs, including by the hospital ward that accommodates the patient when this is needed. In this way the patient will be enabled to flourish maximally.

The therapy described is both long term, perhaps continuing for 4-8 years, and may seem expensive. However, the lifetime cost of supporting a largely untreated schizophrenic patient, at 2012 levels when The Schizophrenia Commission made its calculations, is £1.8 million, or £60,000 per year. The cost of psychoanalytic consultations at that time was around £60 per day, and in 2019 may be £100 per day; this amounts to a cost of 5 times per week therapy per year (including the analyst's holidays) of £13,800 at 2012 levels and £23,000 at 2019 levels.

But the cost of therapy per year, even with intermittent hospital accommodation for the first few years of treatment, is unlikely to exceed the overall costs of funding the entire life of a fully

dependent schizophrenic patient. So, treating the illness early is an opportunity to obviate the very large costs to society of untreated illness, in addition to its unquestionably humanitarian benefits. And if there is an attitude of substantial investment for the patient who is prepared to work hard to become well, in both the patient and their family, and the hospital consultant and the analyst, then the patient may be accepted for psychoanalytic psychotherapy treatment.

This decision, made in the NHS by the hospital consultant in the case of a schizophrenic or schizoaffective patient, is a clinical one and involves at least all the factors mentioned in this paper. And as time passes for a carefully established treatment, the patient is likely to progress *pari passu* and recover. When this result is anticipated and delivered, the financial saving to the NHS and society and the emotional saving to the patient and their family are immense; in this way, the financial outlay at the outset of treatment may be seen to be proportionately well worthwhile in relation to the cost of not treating schizophrenic illness except by medication.

A factor that supersedes all other considerations of psychoanalytic psychotherapy for schizophrenic illness, as for all other medical treatments, is patient safety. Schizophrenic illness is very difficult to treat and great skill and vigilance is required to manage the risk it poses. Risk may be embraced, managed or avoided. Clinical supervision, reflective practice and staff's own psychoanalyses embrace existing risk for themselves and for their patients. Managing psychological risk is a substantial arm of clinical Psychiatric training. And ways of avoiding risk include regular fire drills and safety checks. All these measures need to be taken to manage schizophrenic illness successfully, as elsewhere.

In conclusion, all these factors described, including an evidence base that may be visually apperceived, contribute to the possibility of establishing successful evidence-based resolution, through psychoanalytic psychotherapy, of schizoaffective disorder and schizophrenia in suitable patients in the NHS.

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Permissions

Significant sections of this paper are based upon Reference

(1) below, as is Figure 1. *BMJ Case Reports* is published by BMJ Publishing Group Ltd, who therefore only requires clear referencing, as provided.

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