

Visually Conceptualizing Psychoanalytic Resolution of Schizophrenia and Schizoaffective Disorder

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ABSTRACT

A 28 year old schizoaffective woman receiving Kleinian psychoanalytic psychotherapy made a small study of her mind which resulted in producing her representational world (an unconscious concept of some of her life's environmental features that were important to her) in a pentapointed shape. This shape in itself manifested some of the features of her mind. A researcher made a Case Study of this woman, and adapted her geometric shape to illustrate her progressive mental states in therapy. These shapes, forming the Psychodynamic Pentapointed Cognitive Construct (PPCC) model were compared with Dr Michael Robbins's successful results in treating a series of paranoid schizophrenic patients with psychoanalytic psychotherapy. The researcher derived shapes that illustrated: the young woman's psychotic and non-psychotic parts of her mind; the internalization (inclusion) of her Analyst in her mind; Melanie Klein's paranoid-schizoid and depressive positions; her adjustment to her life's experiences in a non-threatening and non-alarming way; and her evolution into an integrated, autonomous and independent individual. These shapes of her experience as a patient also perfectly complemented Dr Robbins' therapeutic view of his schizophrenic patients' progress as occurring in 7 main therapeutic Stages. The progress of the young schizoaffective woman's evolution into a healthy, independent individual through her psychoanalytic psychotherapy was also experienced by half of Dr Robbins' schizophrenic patients, who reached "a positive outcome" of their therapy, ie. of marriage, achieving a university degree or coming off medication. Their recovery may be conceptualized visually by the progressive geometric shapes of the PPCC model.

Keywords

Schizophrenia, Schizoaffective disorder, PPCC Theory, Resolution, Psychoanalytic psychotherapy.

Background

A newly-appointed Research Senior House Officer sought material for a research project. A 28 year old woman with a schizoaffective disorder had done a small study of her mind [1] which resulted in a pentapointed diagram of her representational world. Joseph Sandler and Bernard Rosenblatt [2] in 1962 conceived of the Representational World as a collection of representations of its successive environments that a young child accumulates unconsciously as he or she develops during its life. The child is not aware of its existence, but it acts as a guide to future new encounters, and is adjusted and develops accordingly as the young child itself develops. The Research SHO decided to make a Case Study of this interesting patient.

Methods

The Research SHO followed up the patient for 30 years, and during this time the researcher drew geometric shapes that illustrated the patient's states of mind as she moved progressively through her illness as it resolved from psychosis (Freud's "primary process") to stable thinking (Freud's "secondary process") [3] and integration, autonomy and independence [1]. The geometric shapes' properties and characteristics themselves represented properties and characteristics of the patient's changing stages of mind. To see these properties is to understand those characteristics of the patient's mind at that time.

The young woman's representational world contained elements of her previous environments that had contributed to her difficulties, and she arranged these components, which had become apparent to her mind in five groups, on the five points of a pentapointed geometric structure (Figure 1).

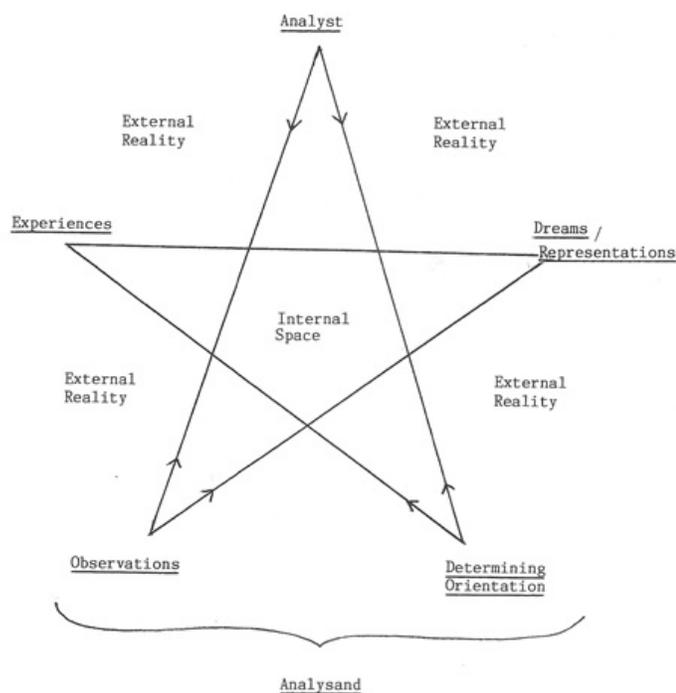


Figure 1: The Psychodynamic Pentapointed Cognitive Construct (PPCC) in Schizoaffective Disorder, in the paranoid-schizoid position © BMJ 2017

Soon after the schizoaffective patient had drawn out her five groups of ideas on the pentapointed construct, she replaced the “Problems” variable at the top with “Analyst”. This was because she assigned her analyst to help her deal with her problems, and because she was internalizing (accepting) the analyst into her personal, or representational, world, ie. into her mind, to be a presence there, as an internal object [4].

When the patient had agreed to be a Case Study subject for the Research SHO, this Researcher gave headings to the other four groups of ideas. 24 years later, the researcher found precisely the same variables in a textbook which described them as “providing data derived from psychoanalytic treatments upon which psychoanalytic theories mainly depend” [5].

Results

The Researcher named this pentapointed geometric diagram the “Psychodynamic Pentapointed Cognitive Construct” (PPCC). This construct may be thought of as an unconscious personal construct [6] which, as the patient’s representational world, helps them to adjust to new encounters. The PPCC Theory states that resolution of schizophrenia and schizoaffective disorder by psychoanalytic psychotherapy may be visualized through geometric shapes representing the states of mind involved in this process. The PPCC model defines this way of conceptualizing the psychological resolution of schizophrenia and schizoaffective disorder. The PPCC construct is the pentapointed diagram itself.

The Internal Space in the PPCC construct contains all elements of the patient’s mind other than her representational world. The

arrows on the lines of the PPCC indicate the directions of flow of communication between the analyst and the two variables of the patient’s mind that are mainly involved during psychoanalytic communications during sessions; these two variables are the non-psychotic Observations variable and the psychotic Determining Orientation variable. The other two variables, Experiences and Dreams/Representations, are not so active and provide more of a background to the activity of the patient’s mind.

The PPCC construct illustrates several points about the mind of a potentially psychotic schizoaffective mind during the early days of a Kleinian psychoanalytic psychotherapy treatment. The representational world, as originally defined by Sandler and Rosenblatt, exists psychologically between the patient’s internal mental workings, in their Internal Space, and the external world. External Reality, in the PPCC construct, exists outside the therapeutic dyad, ie. outside the relationship between the analyst and the patient. The patient’s mind is represented by four variables: Experiences (up to and including the present moment), Dreams/Representations (up to the present time), Observations (non-psychotic spoken or unspoken thoughts), and the Determining Orientation. The Determining Orientation is the psychosis variable, and describes whether the patient is temporarily well or is manifesting symptoms of mania (such as Fantasies), of depression (becoming preoccupied with cold, hard, immutable Facts), or manifesting a confused and psychotic paralysis through suffering Schizophrenic Global Perspectives, where all possible psychological stances are intolerable for the patient. A Schizophrenic Global Perspective (SGP) is one of a number of alternative equally intolerable stances towards their environments that a schizophrenic patient experiences.

Wilfred Bion, Richard Lucas, Murray Jackson and Leslie Sohn were all both Psychiatrists and Psychoanalysts, and they were all of the view that psychotic patients have a non-psychotic element in their minds with which therapists try to communicate realistically during therapy sessions [7-10]. In the PPCC this is illustrated by the non-psychotic Observations variable being separate from the psychotic Determining Orientation variable. Melanie Klein and others held that sometimes a patient can only relate to a particular person when finding them either all good and pleasing in every way, or alternatively as seeing them as a hateful, bad person; this is the paranoid-schizoid position [11]. When the patient can hold both these perspectives in mind at once, and feels sad for having possibly hurt them, with a wish to make reparations to them, this is the depressive position [4]. Psychosis renders the whole world frightening, terrible and bad, and good elements in it are completely split away. The PPCC construct illustrates this split between good, non-psychotic Observations and bad, psychotic elements, and broadly represents the paranoid-schizoid position.

The marquise adaptation of the PPCC construct’s geometric shape [1] represents the depressive position (Figure 2). Here the patient, or analysand, has much more freedom to relate as a unity to the analyst during her sessions. External Reality continues to surround the therapeutic dyad. The Observations and Determining

Orientation variables, now integrated with each other, indicate the integrity, as a whole, of the patient. They are the Agentive Variables because they are the most active of the four analysand variables. Experiences, representing the patient's experiences up to and including the present time, and Dreams/Representations, similarly representing dreams and representations occurring up to and including the present time, are the two Established Variables. In the depressive position they form the background for the discourse between the analyst and the analysand. The patient's whole mind is largely unified, with her Internal Space conflating with her Representational World. When psychosis threatens, the marquise-shaped depressive position reverts to the pentapointed PPCC construct. The two positions alternate with each other in healthy minds as well as under specific pathological conditions.

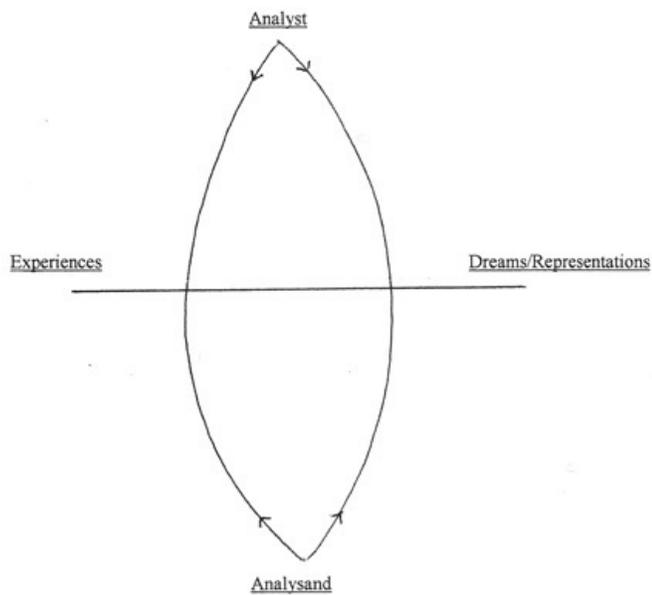


Figure 2: The PPCC in the depressive position
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The PPCC construct becomes 3-dimensional when the patient has done enough analytical work to be able to accommodate all her past experiences without feeling afraid or too hateful or resentful about them (Figure 3). The solid PPCC shape, a penta-sided pyramid, symbolically accommodates the patient's entire past life, and she is orientated harmoniously in time, place and person regarding all aspects of them. By this stage, none of the patient's past experiences has the potential any longer to destabilize the patient as a troubling memory; the patient is adjusted to her life and her past, and can now think of addressing her future.

The patient now interacts increasingly effectively with other people. Any rough corners or difficulties in her personality such as irritability, anxieties, hostilities or a trend towards moroseness may become resolved through social interaction, and the patient feels more comfortable and more confident in their new life. These last two stages, of the patient accommodating all past memories as a three-dimensional, penta-sided pyramid, and of then becoming a rounded, comfortable personality, are illustrated in Figure 3. This Figure illustrates the overall development of mental health in a

schizophrenic or a schizoaffective patient; it presents the PPCC model's depiction of stages of their mind as it resolves into health.

PPCC model: schizo-phenia represent-ational world Analyst in representational world developing orientation in time, place and person eventual closure of vertex, leading to rounding of the personality

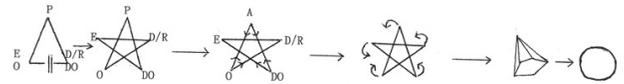


Figure 3: The overall sequence of changes in the mind of a schizophrenic or schizoaffective patient during psychoanalytic psychotherapeutic resolution of the illness

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These psychological stages of healing in the schizoaffective patient's mind are complemented by 7 therapeutic Stages of resolution of schizophrenia identified by Dr Michael Robbins in his paranoid schizophrenic patients whom he treated with psychoanalytic psychotherapy [12,13]. Figure 4 summarizes these Stages identified by him as a therapist, and juxtaposes Dr Robbins' 7 Stages with the equivalent stages of resolution of the patient's mind when the PPCC theory's diagrams are described verbally. Figure 5 succinctly summarizes this joint parallel therapeutic and experienced sequence of 7 Stages, which have been identified by Dr Robbins and are supported by Dr Steggle's PPCC model.

Stages of Psychological Therapy of Schizophrenia: Dr. Michael Robbins	PPCC Model of patient's mind: Dr. Gillian Steggle	Stages in the patient's experience:
1. Protopathosymbiosis (parasitism): patient's identity is invested in her psychotic state.	Patient is unable to function healthily using her impoverished representational world.	Patient feels alienated in her environmental world, suffering from painful schizophrenic confusion.
2. Engagement: patient's sense of individuality is threatened.	Patient unconsciously includes analyst in her representational world.	Patient attempts to engage with analyst; she may be well-defended.
3. Pathosymbiosis: may lead to collusion and Stage 3b: Therapeutic Stalemate.	Patient's 'blocked' schizophrenic mindset may prevent mindful interaction with analyst.	Tendency towards comfortable (but false) assumptions with analyst: reality cannot be contemplated.
4. Disengagement from pathological symbiotic collusion.	Patient succeeds in rejecting her previous maladaptive relationships and unhealthy engagements in her representational world	Patient works at reviewing her relationships and contemplating reality.
5. More Normal Symbiosis: growth-promoting.	Patient is awakened to the reality of her life in all its (painful) aspects of Time, Place and Person in context.	Patient is able to address reality with her analyst; she suffers painful experience of herself; she begins to understand her conflicts; she absorbs good feelings from the analyst; she begins to experience her own self-identity positively.
6. Psychic Differentiation and Integration.	Patient evolves into a discrete, integrated individual.	Patient can contain her own emerging integrated mental life successfully as a discrete individual, relating well to the analyst and individuating from him. Patient evolves into her own independent autonomy.
7. Therapeutic Termination.	Patient's mind is self-sufficient.	Patient leaves therapy with her difficulties resolved.

Figure 4: Stages in the Psychological Resolution of Schizophrenia

Dr Robbins' Stages show that at first the patient is so confused that she is unable to relate to the analyst. Then she forms a highly dependent and pathological unnatural relationship with him while he tries to engage the patient with realism. Here the patient either is able to consider seriously his realistic suggestions and accept

what he says, and become able to progress forward into eventual health, or she is unable to do so, preferring instead the comfortable although injurious and pathological attitudes and mistaken assumptions that she grew up with in her early life and had adopted herself. This leads inevitably to premature termination of therapy, and is a sad result both for the patient and for the analyst. If the patient does adopt the realistic attitudes of the analyst she becomes able to develop her own mind in relation to him. She grows in insight and mental flexibility and health, and eventually gains integration, autonomy and healthy independence. She then is able to leave her analyst and her therapy as a strong and capable individual.

1. Protosymbiosis
(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 5: Summary of the 7 Stages of the Resolution of Schizophrenic Illness using Psychoanalytic Psychotherapy: Robbins (and PPCC)

Conclusion

Thus both schizoaffective disorder and schizophrenia may be understood to be resolvable by psychoanalytic psychotherapy. The PPCC model illustrates visually through sequential geometric shapes how the patient's mind changes during this process, and Dr Michael Robbins' 7 therapeutic Stages describe how the changes in the therapeutic relationship enable this to take place. Visualizing these sequential changes illustrates the nature of the changes, and confirms the clinically therapeutic process of resolution of schizophrenia and schizoaffective disorder by psychoanalytic psychotherapy.

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