

Psychoanalytic Psychotherapy for Schizophrenia and Schizoaffective Disorder

Gillian Steggle

Department of Centre for Psychoanalytic Studies, University of Essex, UK

***Corresponding author:** Gillian Steggle, Department of Centre for Psychoanalytic Studies, University of Essex, UK, Email: gill.steggles@btopenworld.com

Published Date: December 27, 2015

The contents of this paper are reproduced with kind permission by BMJ Publishing Group Ltd from “The process of recovery of a schizoaffectively disordered mind: a psychoanalytic theory of the functional psychoses, the psychodynamic pentapointed cognitive construct theory” in BMJ Case Reports 2015, doi: 10.1136/bcr-2012-006683, Copyright BMJ 2015.

Kind permission has been granted by Dr Michael Robbins for reference to his work herein.

Schizophrenia affects approximately 1-2% of the human population, commonly becoming apparent during early adult life, around 18-25 years of age, either with an acute onset or steadily causing the individual increasing difficulty in managing independent living. Most onsets occur between the ages of 15-54 years of age. Men tend to have earlier ages of onset, while women’s incidence tends to have a second peak in later years¹. Schizoaffective disorder is slightly less common, generally affecting less than 1% of the population. This disorder when in its bipolar form causes symptoms of the three functional psychoses i.e. Depression, mania and schizophrenia; sometimes mania is absent, but symptoms of both schizophrenia and depression occur intermittently in all cases of schizoaffective disorder.

Schizophrenia may occur in acute or chronic form. The symptoms of schizophrenia have been classified as “positive” or “negative” for many years, generally indicating active or passive adverse effects on the patient. The active, positive symptoms include thought disorder such as thought broadcasting, thought insertion or thought removal, delusions and hallucinations, and physical features such as over activity, odd behavior or odd postures. Negative features, especially in chronic schizophrenia, may include social withdrawal, under activity, neglect of appearance, and odd postures and movements. Several different symptoms can occur in an individual patient, and the symptoms of acute schizophrenia are generally different from those of chronic schizophrenia.

Psychoanalytic psychotherapy is most effective in young adults, and if it begins shortly after the onset of symptoms, once the patient has been stabilized on medication, the quality of communication that can subsequently develop between the psychoanalyst and the patient is improved. Hospital ward staff is invaluable in recovering the patient from the distress of an acute onset of illness and in preparing them for psychotherapy. There may be a different aetiology between young, acute onset patients and older, chronic sufferers from schizophrenia. What part physical factors play in the illness is not known, but there are indications that brain changes such as enlarged ventricles and notable EEG spikes at P300 may affect or specifically define the symptoms in some way. Young adults tend to be more resilient than older people or teenagers, but whatever the age of the patient there are some characteristics that are absolutely necessary for psychoanalytic psychotherapy to succeed. Most important of all is an ability to commit to the treatment and see it through, come what may. Motivation, determination and a facility to recover from setbacks are what the treatment depends upon for its conclusion to be reached. High intelligence with a capacity for insight, tolerance of unpleasantness and difficulty, patience and forbearance, and a certain generosity of spirit to take the rough with the smooth is all needed for the patient to be able to survive the length of their treatment. The average length of treatment is around 7 years, but this varies from patient to patient for many different reasons. Few successful ones last less than 4 years, and up to 11 years can be required.

By no means is every schizophrenic or schizoaffective patient suited to psychoanalytic psychotherapy. Psychoanalytic psychotherapy is a lonely, isolating and often miserable experience, even if it can be transformative and remedial. It is the depths to which it reaches that empower the patient so effectively. It can be very stressful and there are risks to the patient of becoming lost on public transport, falling victim to ruthless others in many different ways, or of self-harm when pain exposed in therapy becomes too great to bear. The analyst does their best to support their patient through all such difficult episodes, but patients such as these are very fragile and also unpredictable from the very nature of their illness. It has been said that a mental state examination should be done every 5 minutes on such patients to make sure psychosis is not developing unnoticed. For this reason, Psychiatrically-trained Psychoanalysts are the clinicians best-equipped to deliver this treatment. For those patients who are not strong enough to withstand the rigours of psychoanalytic psychotherapy, social skills and anticipatory skills therapy, family

therapy and supportive psychotherapy, together with support from a Community Psychiatric Nurse or a Psychiatric Social Worker may be a much more helpful way of enabling the patient to persevere with his or her life. Medication is the mainstay of the treatment of schizophrenia in its early stages, to alleviate the patient of their distressing psychotic symptoms that prevent ordinary verbal communication. ECT is rarely used, and generally only for very severe secondary depression. Once the patient has stabilized on medication and has adjusted as well as can be hoped to the knowledge of their mental illness, many patients feel ready to commit to a treatment that could alleviate the illness. Many more Psychiatrically-trained Psychoanalysts are needed for the number of patients who could use psychoanalytic psychotherapy, even if not all of these will emerge with their illness resolved: this treatment can help to palliate the schizophrenic patient even if it is not curative. But the full psychoanalytic psychotherapy treatment should be given to patients who fulfil the criteria mentioned above and have the potential to resolve their illness.

One of the most successful of all practitioners of psychoanalytic psychotherapy for schizophrenia is Dr Michael Robbins of Massachusetts, USA. His personal portfolio of 18 schizophrenic patients treated by him following a DSM-III-R - consistent diagnosis of schizophrenia, this being paranoid schizophrenia in many cases, shows that 9 achieved “a positive outcome”, with 6 of these being “very successful”². He treated many more, including one case that he wrote up as “The successful psychoanalytic therapy of a schizophrenic woman”³. He found that male schizophrenic patients tend to be more refractory to intensive interpersonal psychological intervention than females and, as outlined above, that the patients he found most treatable ranged in age from adolescence to early adulthood (approximately age 16 to the late twenties)². He has written up much of his lifetime’s experience in his book

“Experiences of Schizophrenia”², which richly describes his work with schizophrenic patients, his successes and what he has learned about why some patients did not succeed in evolving through their therapy with him. This book is a mine of information about this little-known treatment area in psychological medicine, and is written in an engaging, clear and very honest style which elucidates fresh truths about the treatment of schizophrenic patients who are determined to become well and face reality rather than remaining in their – bravely acknowledged – states of delusion. Dr Robbins practices psychoanalytic psychotherapy based on psychoanalytic principles, using his psychiatric skills in managing psychotic states when these occur in his patients, and psychological understanding combined with commonsense in the day-to-day management of his patients. Sometimes his patients become extremely unwell, thrashing about on the floor and needing to be pinned down in their hospital ward at times. Such occurrences are, of course, very distressing to all concerned and clearly especially so for the patient, but part of psychoanalyzing schizophrenic patients consists in recognizing the intense pain that they undergo and have to live through in order to experience the truths about themselves which provide meaning for them. Dr Robbins describes his patients’ rage when they have to face the harsh realities that they have been avoiding by developing their illness. This rage can cause the analyst to collude with the patient’s schizophrenia, and result in premature termination of therapy.

Schizophrenic patients are debilitated by symptoms, initially, but at the same time the patients who are candidates for psychoanalytic psychotherapy do have a sense of self that is not content to continue with the confusions, pains and despairs caused by their distorted and ill mental structure. Each of Dr Robbins' successfully treated patients has recognized in him an agency that understands this part of themselves, and they want to give themselves to his scrutiny so that they can change whatever it is in themselves – which they don't know – that needs changing before they can experience wellness. This is not uncommon in psychoanalytic treatment, but Dr Robbins has succeeded very well indeed in understanding how to apply this treatment to schizophrenic patients.

Dr Robbins has established a series of 7 Stages² through which all of his schizophrenic patients move in their progress from schizophrenia through their psychoanalytic psychotherapy to good mental health. Those of his patients who did not succeed in completing their treatment still manifested the earlier Stages, as far as they were able to progress; there are two Stages, Stage 1 and Stage 3, where more difficulty than usual is likely for the patient, and it is at these Stages where the patient is most likely to drop out of treatment. (Figure 1) illustrates the 7 Stages, describing each one, briefly. The first Stage describes Protopatho symbiosis or “parasitism”, where the psychotic patient has invested in their psychosis to the extent that they are unable to relate to the analyst therapeutically, but only as their schizophrenic self who is known to everyone else as idiosyncratic and irrational. They are wholly dependent upon the analyst for the nature of the relationship and cannot help themselves within it.

<u>Stages of Psychological Therapy of Schizophrenia: Dr Michael Robbins</u>	<u>PPCC Model of patient's mind: Dr Gillian Steggle</u>	<u>Stages in the patient's experience</u>
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 insightful 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 intolerable 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 1: Stages in the Psychological Resolution of Schizophrenia

The second Stage of Dr Robbins' therapeutic progress occurs when the patient engages therapeutically with the analyst despite their psychotic mindset. Their sense of individuality is threatened because the analyst does not concur with their strange ideas, nor will he accept unrealistic statements or beliefs without drawing their oddness to the patient's notice for their

attention in rectifying them. This challenges the patient fundamentally. The experience is not pleasant for the patient; in fact, it is hard for them to bear, since it may be the first time anyone has effectively addressed their idiosyncrasy with them. Family members may have tolerated and accepted the patient's unusual ways of managing and personal characteristics for the sake of peace at home. The patient usually has a strong desire to maintain their status quo with the analyst as it was at home, and continue as themselves just as they have always been within their family.

Stage 3 describes the patient in engagement with the analyst initially as their psychotic self, in a tenuous Pathosymbiotic state. They have a relationship with the analyst, but it consists of them being still very ill and unable to endorse reality. They may be expressing rage vociferously. They are still very dependent upon the analyst, in a pathological symbiotic manner. In Stage 3, the patient is challenged by the analyst to emerge out of their state of unreality. So far, they have continued to retain their distorted view of reality that they developed within their family. Now, they are expected to adhere to what the analyst says to them about the world around them and about themselves which is at odds with their existing awareness. Maybe they are not yet strong enough to cope with actual interpretations, but they are well enough to know when the analyst is informing them differently about themselves than what they tend to think when on their own, during the other 23 hours of the day away from their sessions. This new knowledge is very difficult for them to accept. But accepting it is necessary for therapy to continue. If the analyst rather weakly is unable to continue asserting realistic truths to the patient, but colludes with the patient, who may be full of rage, and allows time to pass without work being properly done, therapeutic stalemate prevails. This may occur for various reasons such as simple weakness in the analyst, an ulterior motive in relating to a dependent, admiring patient, financial considerations of assured income, or another secondary gain. Its occurrence is unusual, but it bodes ill for the patient because they can no longer work towards better understanding of themselves or of reality. They begin to flounder in the environment of the analyst agreeing with them all the time, and eventually impasse occurs. Neither party can address the other constructively, so continuation of treatment is pointless, and therapy ends.

If, however, the analyst is strong and continues to address the patient responsibly, repeatedly referring to reality and helping the patient to understand themselves better, and the patient disengages from the pathological symbiotic collusion and, instead, develops personal insight into their motivation, their mental tendencies and detrimental habits that contribute to their unhappiness, then they make a major move forward in their therapy on to Stage 4. Here they become able to address with their analyst what it is about themselves that is causing them to be unhappy with their own functioning. It is never easy to begin this process of self-scrutiny, and for a patient who has had to struggle with schizophrenic illness this is particularly difficult, because their sense of themselves to begin with is so frail and unfamiliar to them. They have to trust the analyst, and to see themselves anew within the consulting room environment as the person they

wish to become. Much depends upon the analyst to convey good emotions at all times towards the patient, so that when the patient reaches cusps of awareness or watersheds of learning - either they progress in this direction or in that direction, eg. In to confidence or into greater anxiety - they have access when they need it to adopting good mental responses that can fortify them during future challenging new experiences. So the patient relinquishes her pathological relationships with the analyst and also with others, and learns to contemplate reality, and begins to develop fresh, more meaningful relationships instead.

Stage 5 is the continuation of more normal, growth-promoting symbiosis between the analyst and his patient. The patient, in addressing reality with her analyst, may suffer very difficult experience of herself because of so much painful distress that she has endured over past years, and because of having to relive this in the course of rectifying her attitudes. She has to learn to understand her past conflicts. But she can draw strength from the good feelings that her analyst offers her. She can learn, from her daily attendance in his company, that life is “not all bad”, as Melanie Klein once wrote. She has her own motivation to become well, and together with her analyst she can fulfil the promise that her clinicians evaluated in her before the start of her treatment. Dr Robbins’ written-up case histories justify this attitude, for example in his paper “The successful psychoanalytic therapy of a schizophrenic woman”³.

Eventually, the patient demonstrates differentiation into the person she has been trying, all along the duration of her treatment, to become. This is Stage 6. She has been making choices throughout this time, each one attempting to keep her on track towards understanding how to live her life as herself. The analyst’s guidance and comments have provided a backdrop of reassurance to her every time she has faltered. She becomes able to integrate into her individuality, and to show autonomy and self-sufficiency as she goes about her daily ventures. Stage 7 is the successful therapeutic termination of her therapy. Dr Robbins saw this happen with at least 6 of his series of 18 patients, and it is a good result which all concerned in the therapeutic team can celebrate.

The successive Stages of psychoanalytic psychotherapy can also be described and represented by the phases through which the patient’s mind passes as they progress from schizophrenia or schizoaffective disorder through to healthy integration and functioning after recovery. The Psychodynamic Pentapointed Cognitive Construct theory⁴ describes this psychological progress in diagrammatic form. In Figures 2 to 7 and 9 to 11, the patient’s psychological progress is indicated by the diagrams’ shapes, and the therapeutic dialogue by the lines drawn between the Analyst and the Analysand, or patient, with arrows showing the initial directions of communication between them. The PPCC model’s phases, parallel to Dr Robbins’ 7 Stages of recovery, are shown in Figures 1 and 11. The PPCC Theory commences with the representation in the patient’s mind of their difficult and unhappy world where they begin their life’s journey. The idea of the Representational World was developed by Joseph Sandler and Bernard Rosenblatt⁵ in 1962 to describe this internalization of a child’s external environments, a concept which is modified and changes as the child grows up. The PPCC considers this internal, representational world.

When the PPCC construct was originally formed, five groups of ideas emerged from a particular schizoaffective patient's representational world. Four of these five groups were identical to the variables described by the Shorter Oxford Textbook of Psychiatry as arising during the course of psychoanalytic treatment and providing the data from which psychoanalytic theories are mainly derived⁶. The analyst becomes included in this representational world at what was originally the "Problems" variable, at the top of the structure (Figure 2). Inclusion of the analyst as the 5th variable confirms his influential position in the patient's mind.

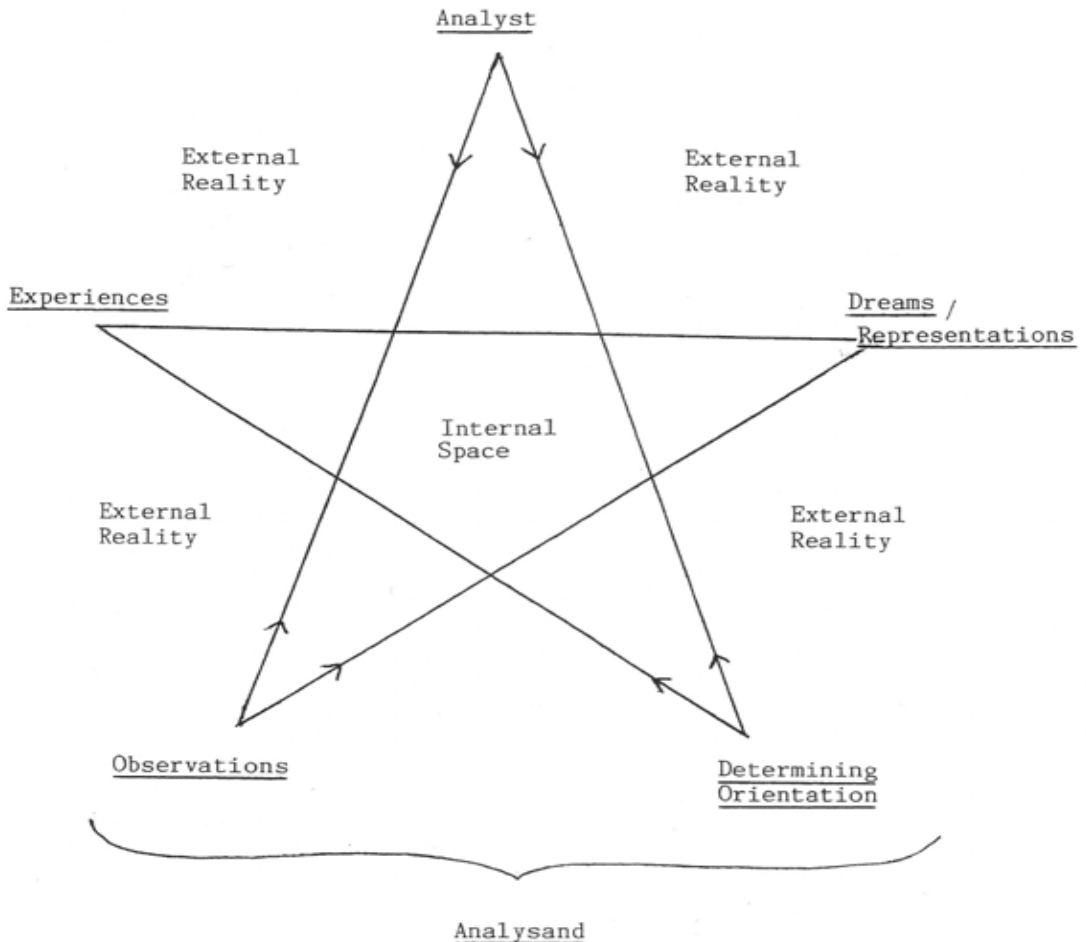


Figure 2: The PPCC model in the paranoid-schizoid position

© BMJ 2015

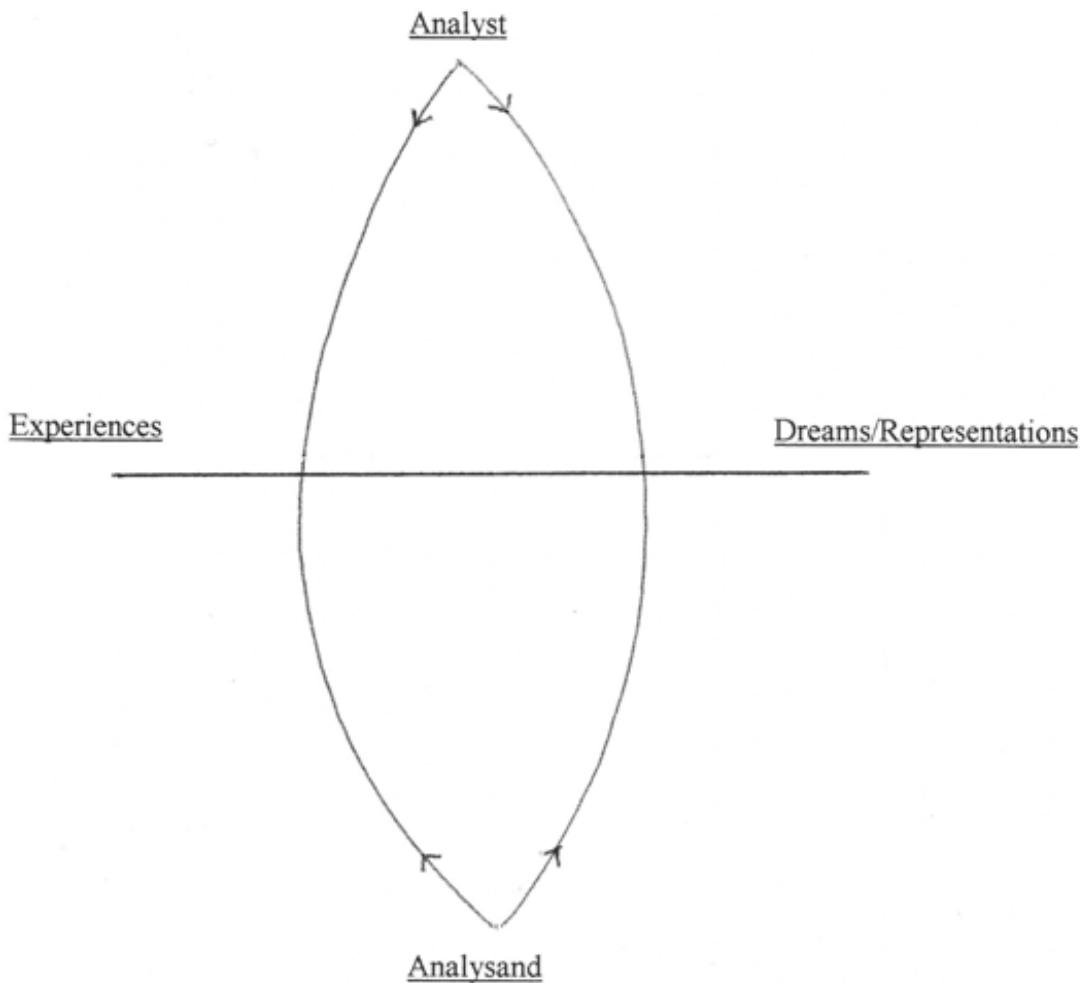
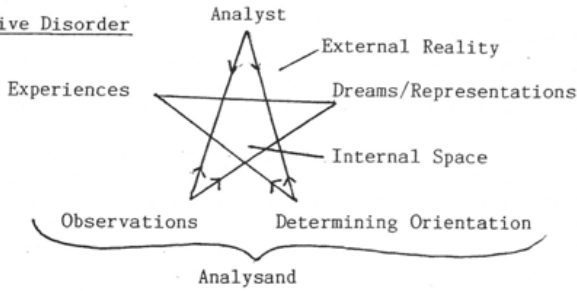


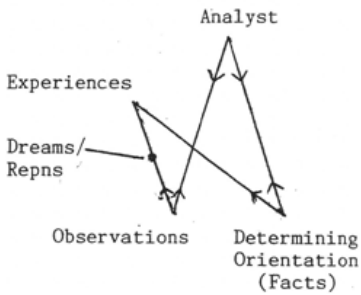
Figure 3: The PPCC in the depressive position

© BMJ 2015

The PPCC:
Schizoaffective Disorder



Adaptations of the PPCC:
Major Depressive Disorder



Mania



Schizophrenia

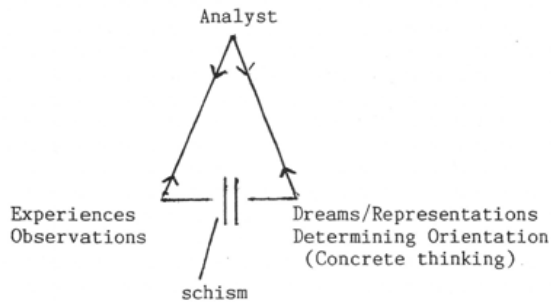


Figure 4: The PPCC model adapted for the 3 functional psychoses

© BMJ 2015

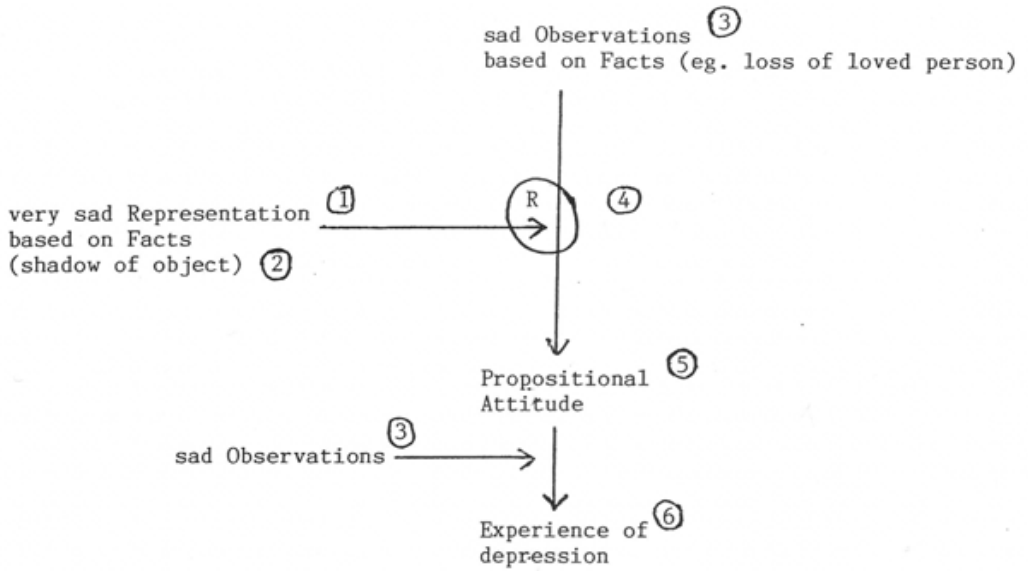


Fig. 5a

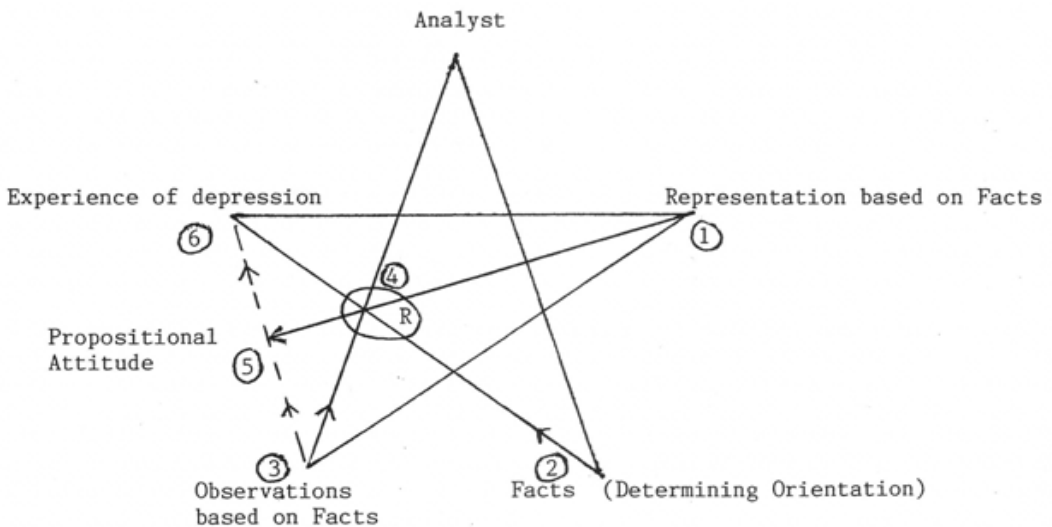


Fig. 5b

Fig 5 The PPCC illustrating the development of depression

© BMJ 2015

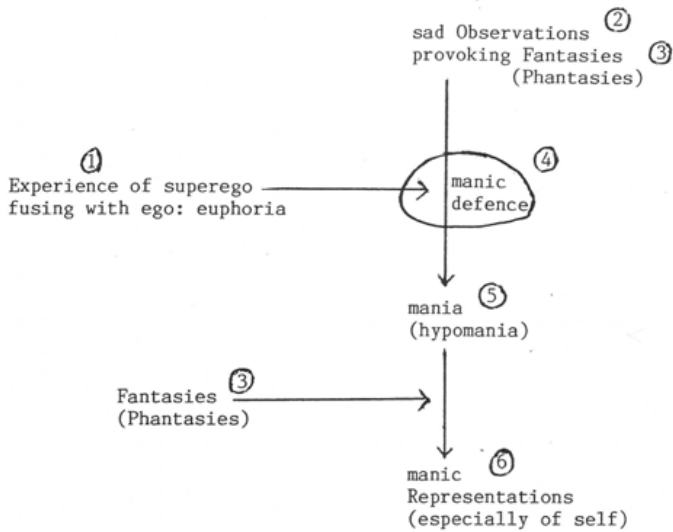


Fig.6a

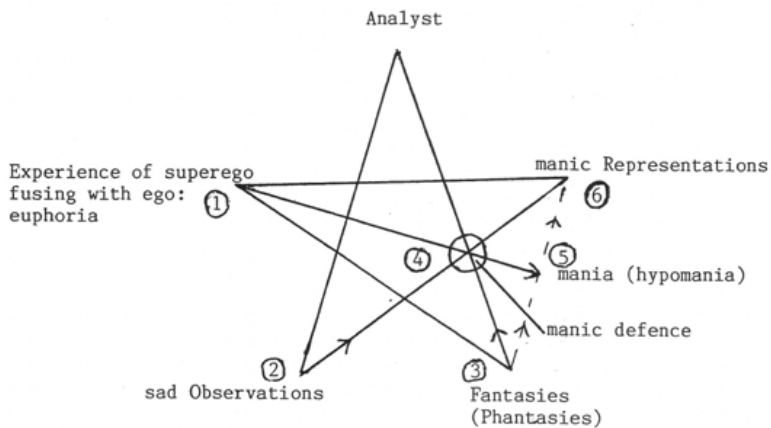


Fig.6b

Fig.6 The PPCC illustrating the development of mania

© BMJ 2015

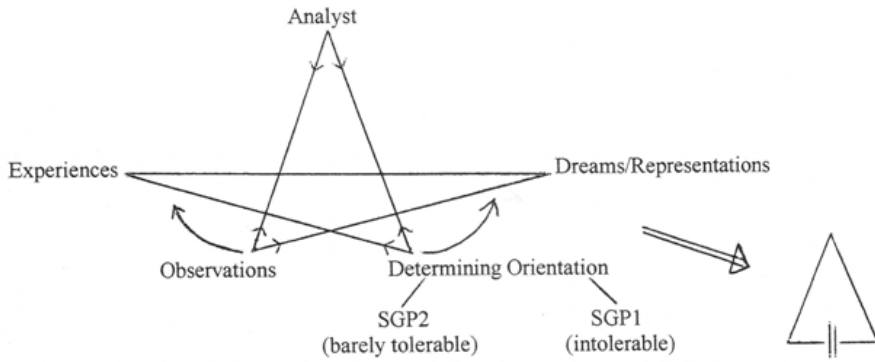


Figure 7a: The PPCC tending towards illness in schizophrenia

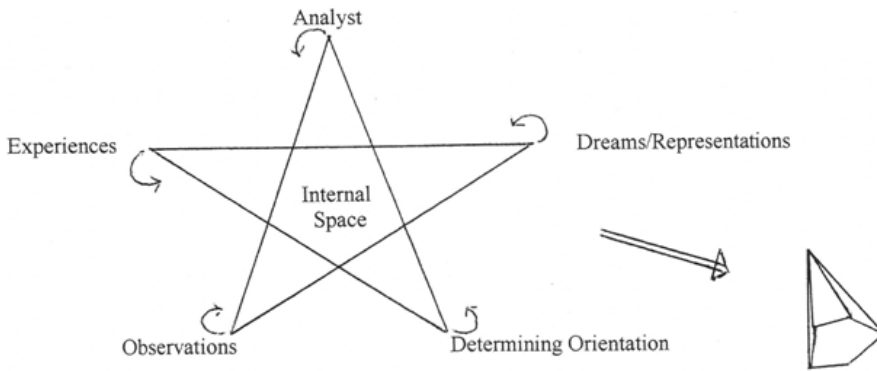


Figure 7b: The PPCC tending towards resolution in schizophrenia

Figure 7: The PPCC illustrating the processes towards illness and towards resolution in schizophrenia

© BMJ 2015

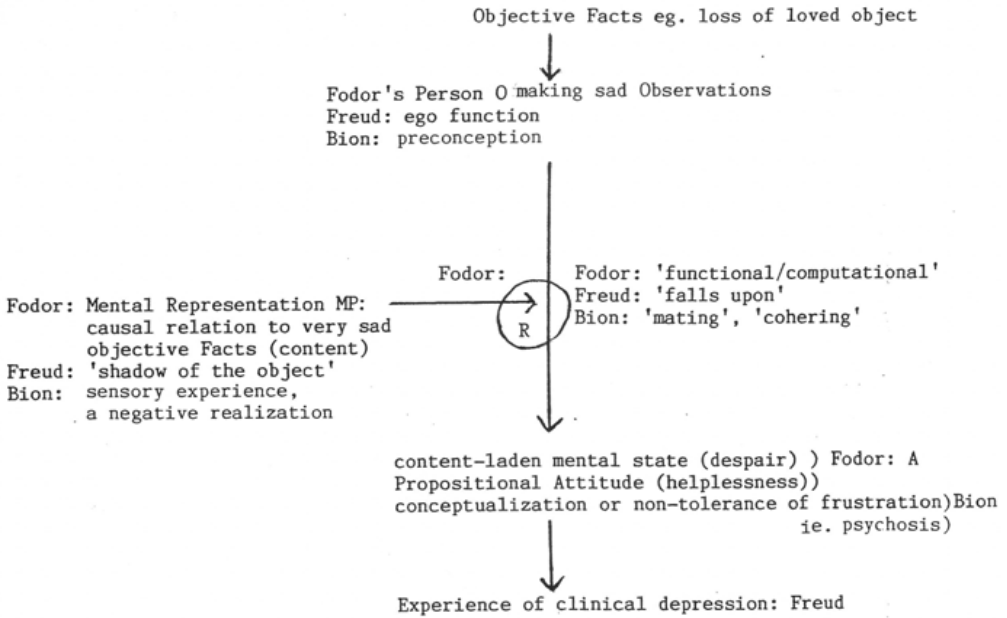


Fig.8 Comparison of the mental processes of Bion's and Fodor's theories of thinking with Freud's theory of depression

© BMJ 2015



Figure 9: Closure of the PPCC vertex

© BMJ 2015

(Robbins, 1993)

Analyst's: pacification
+ soothing
role

unification

disillusionment

interpretation

(patient's: (tension)
mental
state)

(disintegration)

(unreality)

(intrapsychic
conflict and
defences)

PPCC model: schizo- represent-
phrenia ational
world world

Analyst in
representational
world

eventual closure
of vertex, leading
to rounding of
the personality



Figure 10: The PPCC model of the maturing personality's "corners rubbed off"

© BMJ 2015

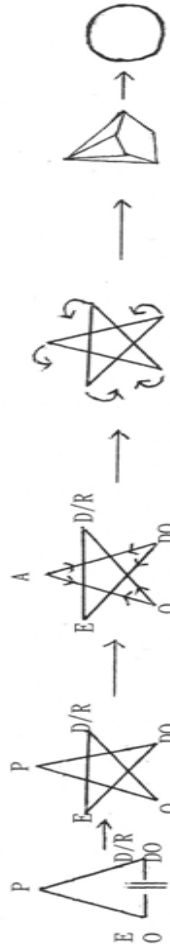


Figure 11: The overall changes in the schizophrenic patient's mind through therapy

© BMJ 2015

The PPCC model of the patient's mind in psychoanalytic psychotherapy can also illustrate the depressive position (Figure 3) which is compared with the paranoid-schizoid position (Figure 2) in its capacity to demonstrate greater flexibility and movement, ie. Looser construing, so the patient's mind can implement a wider range of responses to the analyst than is possible in the more rigid paranoid-schizoid position, which only allows tighter construing. The PPCC can be adapted to illustrate the three functional psychoses, and their development, manifested by schizoaffectively disordered patients, some of whom suffer manic episodes as well as depressive and schizophrenic episodes (Figure 4). The psychiatrically-trained psychoanalyst is equipped to recognise all three conditions if a schizoaffective individual who is his patient starts to become ill with any one of them, or with a mixed episode. These episodes occur within Dr Robbins' Stages, and should be managed within the context of the overall therapeutic progress as events that are to be expected during the course of the treatment that has been embarked upon. Hospitalization is needed when the patient becomes psychotic since it is not safe for them to remain in the community. Sometimes the analyst may visit them for a session in the hospital, which helps the analyst to see them in a different setting, and also helps the patient feel safe and looked after by the analyst. Affective illness generally implies a better prognosis than non-affective illness, and affect such as anger is not uncommon among schizophrenic patients. The PPCC model is one way of describing the aetiological dynamics that lie behind depression and mania, and also schizophrenia (Figure 5, Figure 6 and Figure 7). The PPCC model can also demonstrate how depression, a propositional attitude or emotive statement about an idea, and a thought can all arise from interaction between a function within the mind and a feature of the external world, when the PPCC model compares the theories of Freud, Bion and Fodor (Figure 8).

As psychoanalytic psychotherapy progresses, the PPCC can represent later changes to the recovering schizophrenic or schizoaffective patient's mind. Once most of the therapeutic work has been done which, as mentioned, can take 4-11 years overall, commonly around 7 years, the gradually developing representational world can be encompassed by the patient. Then, closure of the vertex occurs, when the patient can look back and see all of their life in context without being frightened or concerned by it. The PPCC shows how the representational world's 5 variables fold back to enclose the events and people in the patient's life (Figure 9). Events and people who may have been triggers for distress in the patient, contributing to her psychosis, have been adjusted to, and the patient is now orientated in Time, Place and Person with respect to all of their past life. They have nothing to fear, therefore, and nothing to be threatened by, within them. This differentiation and individuation is summarized by their maturing mind appearing as a sphere, with all their uncomfortable and distracting "corners rubbed off" (Figure 10). Overall, the PPCC model illustrates in simple, easily understandable forms the overall changes that a schizophrenic or schizoaffective patient's mind undergoes when it is successfully treated with psychoanalytic psychotherapy (Figure 11). Physical representation can illustrate mental processes; inclusion of the analyst in the patient's representational world, for example, or adjusted containment of past events by a flat object, the pentapointed PPCC construct, becoming 3-dimensional.

Dr Robbins' work in Massachusetts, USA, has established how psychoanalytic psychotherapy may be successfully used to treat schizophrenic patients, and his work has been confirmed by the careful study of a schizoaffective patient's mind as she recovered her health⁴. There is a clear need now for his work to be replicated in the UK. To do this, more psychiatrically trained psychoanalysts are needed; more psychodynamic hospital units run by experienced clinical staff are needed to care for the patients while they are in vulnerable states during treatment, and sheltered accommodation is needed for them when they do not need hospital care but still require distant supervision. The average duration of treatment is around 7 years; so long term planning would be needed, for treatment places and for funding. Sums of £190,000 per patient have been discussed in Health Service circles in the context of 6-month courses of expensive cancer therapy drugs. Now that we know how to treat schizophrenic patients, surely we should make the case for them on a par with all the expensive physical treatments that are currently available. Genetic medicine equipment, electronic limb prostheses, exoskeletons, mobility chairs, 15 hour operations and transplant technologies are all accepted these days as necessary to modern medicine. Surely the particular clinical requirements of specific mental health treatments should be paid for on a level playing field approach. Intelligent, active, motivated and determined schizophrenic patients would make at least as good a run of their future lives after recovery as any other patient in need of physical treatment. The psychology of healthy desires and energetic application is shared by a proportion of schizophrenic patients who need to be identified and adequately treated. Their enthusiasm for life is not different from physical patients' appetites. Prior aptitude for excellence or achievement is a strong marker for future success in therapy. Psychological treatments are slower to practise and to take effect than most physical treatments and, until the process becomes even more familiar, likely to be risky just as the first, innovative implementation of a new surgical procedure is risky. But if clinical enthusiasm and motivation were pooled, alongside the necessary funding arrangements, a feasibility and viability study and a pilot study replicating Dr Robbins' work in the USA could be organized in the UK. And if this was successful it could lead to a National Health Schedule for schizophrenic patients, in which all schizophrenic patients would receive the form of treatment most appropriate to their needs.

References

1. Gelder M, Andreasen N, Lopez-Ibor J, Geddes J. *New Oxford Textbook of Psychiatry*, 2nd Edition. New York: Oxford University Press. 2012; 544.
2. Robbins M. *Experiences of Schizophrenia: An integration of the Personal, Scientific, and Therapeutic*. New York: The Guilford Press. 1993.
3. Robbins M. The successful psychoanalytic therapy of a schizophrenic woman. *Psychodynamic Psychiatry*. 2012; 40: 575-608.
4. Steggle G. The process of recovery of a schizoaffectively disordered mind: a psychoanalytic theory of the functional psychoses, the psychodynamic pentapointed cognitive construct theory. *BMJ Case Reports*. 2012.
5. Sandler J, Rosenblatt B. The concept of the representational world. *Psychoanal St Child*. 1962; 17: 128-145.
6. Gelder M, Harrison P, Cowen P. *Shorter Oxford Textbook of Psychiatry*, 5th Edition. Oxford University Press: New York . 2006; 89.