

Accessible Schizophrenic and Schizoaffective Patients Successfully Treated with Psychoanalytic Psychotherapy

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ABSTRACT

Purpose: The purpose of this early, small scale research paper is to demonstrate that schizophrenia and schizoaffective disorder, as defined in the DSM and illustrated geometrically in the PPCC model described herein, may be successfully treated with psychoanalytic psychotherapy in patients who respond well, and are accessible to therapy.

Results: In this small-scale observational Study a psychoanalytic concept, a patient's Representational World as described herein, is used to elucidate the cause of her dysphoria which then, if she is also exposed to cognitive confusion, makes her more susceptible to schizophrenia or schizoaffective disorder. Rare psychoanalytic data obtained from a schizoaffective patient was obtained and gave rise to a model, the PPCC model, which perfectly supports the excellent therapeutic work with schizophrenic patients of a Psychiatry-trained Psychoanalyst. Validation of the model confirms the rationale and success of this clinician's psychoanalytic psychotherapeutic treatment of his responsive and therapeutically accessible schizophrenic patients.

Conclusion: Successful and validated treatment of accessible schizophrenic and schizoaffective patients by psychoanalytic psychotherapy has been thereby demonstrated on a small scale.

Keywords

Schizophrenia, Schizoaffective disorder, Psychoanalytic psychotherapy, PPCC model, Remedial, Evidence, validation.

Introduction

Schizophrenia research aims to understand how mechanisms affecting the brain and mind lead to this neurodevelopmental disorder, particularly so that it may be countered and its patients alleviated. Great progress is being made in understanding schizophrenic patients' psychological responses to their environments, and approaching these therapeutically, especially since the 1990s [1]. This paper presents a useful psychoanalytic concept, the Representational World [2], which describes a child's awareness of environments it progressively moves within as it grows. The representational world forms a psychological means of guiding the child through their lived experience. It may also be preserved in adults, and if sufficiently dysphoric may, together

with cognitive, conscious confusion lead to schizophrenia.

Schizophrenic patients are commonly found to be leading very miserable lives. The representational world of a schizoaffective patient was also found to be very miserable when she commenced treatment. Her illness was based upon emotional and cognitive effects of the dysphoria and confusion that she experienced earlier in her life. When her representational world was examined at the start of her psychoanalytic psychotherapy and subsequently after some time in treatment, clinical progress with her illness between these assessments was indicated by the PPCC model.

Uncommonly, this research Study does not address or reduce its rare qualitative data to numerical terminology. As an original observational Study it interprets its data, which comprises her representational world and was derived directly from her mind, as the PPCC model [3]. This model is compared with findings

from a different perspective, a Psychiatry-trained Psychoanalyst's therapeutic findings in his schizophrenic patients (see Table 1). His therapeutic findings were found to coincide precisely with the sequence of psychological changes outlined by the PPCC model. The PPCC model's data are included within the variables described in the Shorter Oxford Textbook of Psychiatry [4]; the variables are defined here as relating to data obtained from psychoanalytic treatments and from which psychoanalytic theories are mainly derived. This model's veracity is thereby illustrated, and consequently an early connection between the psychological symptoms of schizophrenic illness and clinical success is thereby illuminated.

A psychotherapeutic approach to schizophrenia has been taken by a group of psychoanalysts since the early 20th Century when Freud stated that they had "never relaxed their efforts to come to an understanding of the psychoses" [5]. Melanie Klein was one of the first to disagree with Freud in his view that schizophrenic patients could not develop a transference (relate closely to the psychoanalyst) and so could not be psychoanalysed [6]. Hanna Segal [7] and Herbert Rosenfeld [8], both students of Klein, each developed psychoanalytic therapy of schizophrenic patients. One of Segal's patients, Edward, remained well for at least 20 years, and Rosenfeld achieved effective resolution of her illness in his patient Mildred without the use of medication, which had not been thought possible at the time. Frieda Fromm-Reichmann [9] and Harry Stack Sullivan [10] both worked through an interpersonal-relational approach to their patients. Richard Lucas advocated work 'on a psychotic wavelength', relating to patients while psychotic in order to understand them better [11]. Brian Martindale [12] and Alison Summers [13] demonstrated the benefits of a psychodynamic approach, especially with newly psychotic patients.

Methods

Scientific methodology for qualitative research: Institute of Psychiatry, Psychology and Neuroscience, 2004/5 (IoPPN, 2004/5)

- a) This paper does not address or reduce its qualitative data to numerical terminology; it relates its data forming a model of schizoaffective disorder, the PPCC model, to qualitative clinical findings from a different perspective.
- b) Understanding is not assumed simply from the patients' superficial behaviour and beliefs. This paper shows how schizophrenic and schizoaffective patients' minds may be analysed psychologically, by understanding them consciously and unconsciously. This addresses particularly their dysphoria and confusion experienced in their early environments. Psychoanalysis has been described as depth psychology.
- c) The PPCC model originally captured the sample contents of a patient's mind at one instant, consisting of the patient's accumulated experiences, before further thought occurs: a specific psychological observation. This was then extended to represent the psychodynamics of the therapeutic session between a psychoanalyst and an analysand (patient). It may be adapted clinically to illustrate the representational world of

a schizophrenic or schizoaffective patient.

- d) The psychological observation of the original schizoaffective patient, a small dataset, can be examined and used as a research basis for understanding schizophrenic patients better, via their dysphoric and confused internal world. This approach, using patients' intense experiences of their successive unhappy early environments from childhood onwards, may be used in this way more widely by working analytic practices. Currently, experienced Paediatric Psychiatrists diagnose which children are likely to be at risk from schizophrenia, after dysphoric and confusing family experiences.
 - e) This paper's analytic model, the PPCC model [3], can be used to analyse dynamically patients' observed qualitative data when applied to it, and will be straightforward to set up on computer software.
 - f) This methodology has been quite widely published [3,14-18].
 - g) Limitations: This original observational qualitative research is on a very small scale, ie. it studies only 19 patients; but it has a low and therefore good NNT (only 2). Also, large sums of money are required to complete treatment even though the financial and humanitarian costs of not treating a patient's schizophrenia are greater.
- A Case Study was carried out to discover as much as possible about the internal workings of a schizoaffective patient's mind [3]. The PPCC theory and model resulted [3,16].
 - The data-driven results of this Case Study were then compared with the clinical findings of a Psychiatry-trained Psychoanalyst, Dr Michael Robbins, who treated paranoid schizophrenic patients in pioneering work [1,14]. Dr Robbins observed 7 Stages of successful psychoanalytic psychotherapy which were confirmed by the PPCC theory and model (see Table 1).
 - The combined findings were integrated to produce evidence for the process of healing of patients' schizophrenic and schizoaffective minds as they undergo psychoanalytic psychotherapy, so that improved treatment and management practices can be developed.

The Case Study [3]

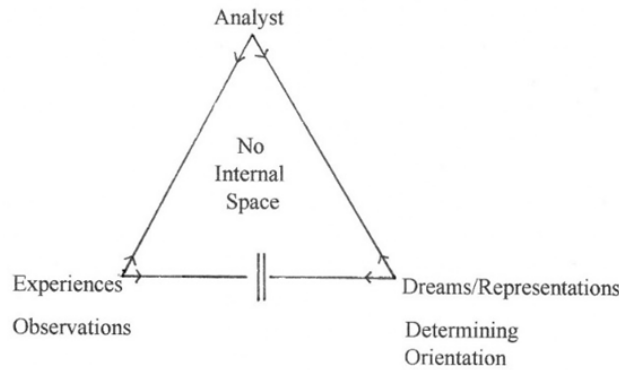
A 28 year old single schizoaffective woman in a simple study of her mind produced a series of 29 sequential ideas, emerging steadily in a flow from her preconscious mind when she relaxed it into complete stillness. She wrote the ideas down and studied their flow as a single thought. This produced objectively in practical terms, and confirmed, the abstract view of the former Freud Memorial Professor Psychoanalysis at University College London, Professor Joseph Sandler, of a developmental feature of childhood useful to the child. This aspect of childhood was the Representational World. It formed one of the important parts of a child's mind [2], and may also represent aspects of an adult's mind. The patient-produced written realities of the data-based PPCC model, the representational world outlined herein, consists of variables acknowledged by the Shorter Oxford Textbook of Psychiatry published in 2006 [4]. The representational world was conceived of by Professor Joseph Sandler and Bernard Rosenblatt as a mental structure (a form of

thought) just as the PPCC, a structure, does indeed describe the representational world. The PPCC also comprises, within the representational world, the data as content within the PPCC's structural variables [4], making the PPCC as psychological data a dynamic entire individual thought consisting of both form and content. Thus the patient's representational world, modelled as the PPCC, was originally written out physically as ideas forming data, from her mind by a schizoaffective patient.

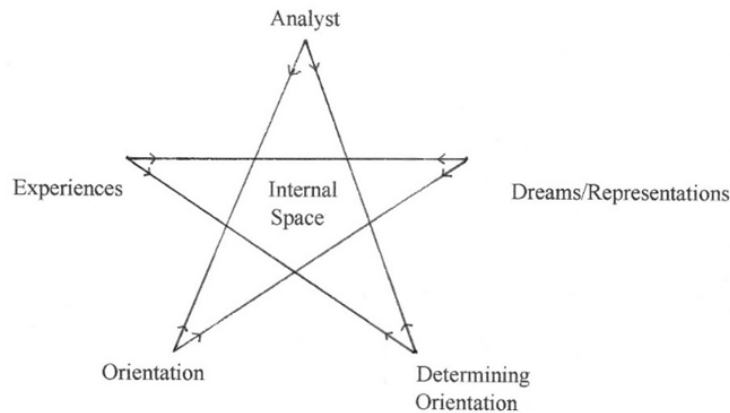
These ideas were arranged as they had emerged, in 5 homologous groups, on a star-shaped model, the PPCC model. The groups of data were given headings as 5 variables, 4 of which were identified 24 years later in the Shorter Oxford Textbook of Psychiatry [4]; here they were specified as data that emerge from psychoanalytic treatments and from which psychoanalytic theories are mainly derived.

The theory that emerged from these data, the Psychodynamic Pentapointed Cognitive Construct (PPCC) theory [3], illustrates the relationships between the functioning parts of the schizophrenic or schizoaffective patient's mind as her representational world

(see Figure 1). This contains the significant elements of her past life [2] in the context of the disabling dysphoria and confusion of her earlier existence. The 4 variables together surround an active central area, the Internal Space, which contains, for example, the affective aspects of schizoaffective disorder, and are connected to the Psychoanalyst, the 5th variable. They describe and represent the mind of a schizoaffective patient in therapy. The mind of a schizophrenic patient illustrates the blockage between the conscious, non-psychotic (Observations) and unconscious, psychotic (Determining Orientation) parts of her mind. The Observations variable relates spoken Thoughts, and the Determining Orientation specifies either Fantasies, Facts or Concrete thinking (or neutral, when the patient is well), depending upon whether the patient is tending towards mania, psychotic depression or schizophrenic symptoms. The patient's Experiences and Dreams or Representations up to and including the present time are as described in the Oxford Textbook of Psychiatry [4]. An example of the applied PPCC model is illustrated (see Figure 2) of the sad representational world of one of Dr Robins' patients, Sara.

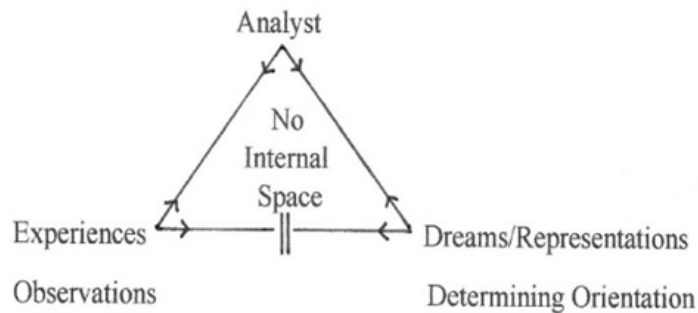


The PPCC model for schizophrenia



The PPCC model for schizoaffective disorder

Figure 1: The PPCC models for schizophrenia and schizoaffective disorder.



Representational World:

Analyst

directs therapeutic activities towards resolving patient's problems.

Experiences

childhood trauma
 neglect by mother
 inadequate nourishment
 exposure to danger
 insensitivity and emotional unavailability of father
 exposure to severe isolation abroad when only a child
 family pride in equating maturity with masculinity and suppression of emotion

Dreams/Representations

mentally unstable mother
 emotionally absent father
 'macho' brothers, one of whom queried her need for hospitalization
 believed she was a castrated male
 dream: of a large family dining-room with dangerous chairs; a clown caused her sister's death

Observations (non-psychotic thoughts and comments)

patient was getting "a few crumbs"
 "I really think I'm alive, and if I think about it I get so sad and I get really angry"

Determining Orientation (psychosis and disturbed behaviour)

tried to be inconspicuous and hide herself from her mother
 concealed badly cut finger from her mother
 tried to run away from home to skid row areas of cities
 her low self-esteem allowed men to abuse her sexually in exchange for food and a place to sleep

Internal Space

none

Figure 2: Sara's schizophrenic representational world.

The patient's long term progress towards mental health is illustrated by the PPCC model (see Figure 3), including 3-dimensionally enclosing all the sad memories, experiences, beliefs and thoughts of the patient's lifetime, in a 5-sided pyramid that is added to, as time passes. Here the patient becomes orientated in time, place and person, and so well adjusted to her life through contact with her Psychiatry-trained Psychoanalyst that the sadness and horrors of her illness' development no longer stimulate psychosis. Training in both Psychiatry and Psychoanalysis is necessary in Britain for the therapist to be able to treat schizophrenic patients with psychoanalytic psychotherapy; in the United States, Psychoanalysts often work with Psychiatrists when delivering psychotherapy. Psychotic symptoms require careful management using medical skills

In time, through active social life, residual psychological flaws eg. excessive shyness, anxiety, or impatience and irritability gradually resolve and the patient's mental health emerges.

Evidence for the Psychoanalytic and Psychiatry-confirmed veracity of the PPCC model of schizophrenic and schizoaffective minds: [3,15].

1. The PPCC model is consistent with psychoanalytic concepts.
2. The PPCC model confirms several psychoanalytic theories.
3. The PPCC model aligns the psychoanalytic theories of Sigmund Freud and Wilfred Bion with the psychological theories of Jerry Fodor [3].
4. The PPCC model, which describes the theories of Freud, Bion and Fodor, elucidates that the conflation of a factor inside the mind and a factor outside the mind results in a mental outcome [3].
5. Many techniques of psychotherapy including that supported by the PPCC theory, psychoanalytic psychotherapy, indicate that dialogue is often very effective in helping to resolve psychological difficulties in patients.
6. The PPCC model reflects the reality of the therapeutic dyad in the consulting room.
7. The PPCC model incorporates the psychological movement of the patient's Psychoanalyst into the workings of her mind.
8. The variables of the PPCC model are those defined in the

Shorter Oxford Textbook of Psychiatry as being those incorporating the data derived from psychoanalytic treatments and which are those mainly used in psychoanalytic theories [4].

9. The PPCC model for schizophrenia demonstrates the Psychiatrically-observed complete blockage in the mind of a schizophrenic patient between his or her non-psychotic spoken thoughts and their psychotic thinking [16].
10. The PPCC model includes the therapeutic stage of the patient containing, as it becomes 3-dimensional, a new Psychiatry-affirmed capacity for orientation in time, place and person (Figure 3).
11. The PPCC model utilizes and observes objectively the practical manifestation of the representational world, a concept advanced by the former Freud Memorial Professor of Psychoanalysis at University College London, Professor Joseph Sandler [2].

In addition:

12. The psychoanalytic psychotherapeutic technique, supported by the PPCC model, provided GS's colleague Dr. Michael Robbins' portfolio of 18 paranoid schizophrenic patients with 'a positive outcome' for half of his patients [1].
13. Dr Robbins' 7 Stages of psychoanalytic psychotherapy have been confirmed both from his clinical, therapeutic perspective and from the PPCC model's theoretical perspective of patients, which coincide with each other as Stages and at the same time complement each other's perspective (see Table 1).

Comparison of the Case Study's results with Dr. Michael Robbins' clinical results

Dr. Michael Robbins' clinical results revealed a series of 7 therapeutic Stages through which all of his portfolio of 18 patients passed, as far as they were able [1,19].

The changes produced in the schizoaffective Case Study patient's dysphoric and psychotic symptoms by her psychoanalytic psychotherapy, described by the PPCC theory, were aligned with the changes Dr. Robbins observed in the successful of his 18 paranoid schizophrenic patients as they moved through his 7

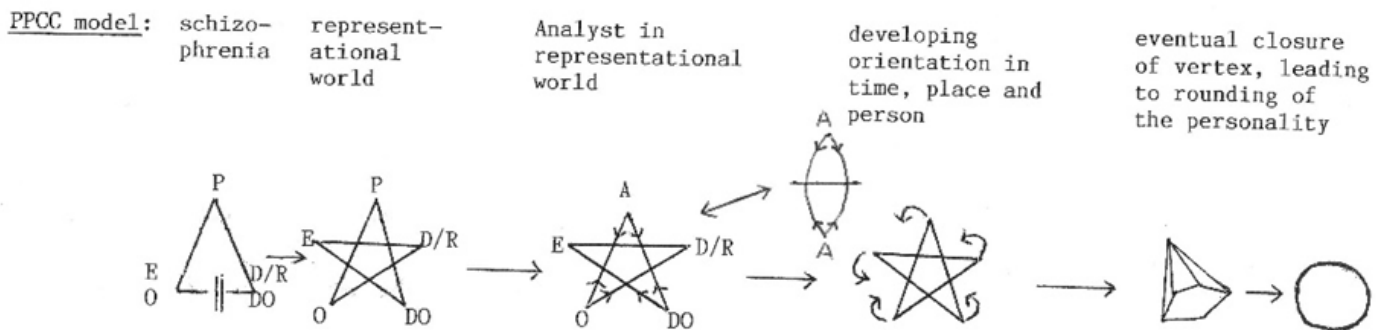


Figure 3: The overall sequence of changes in the mind of a schizophrenic or schizoaffective patient during psychoanalytic psychotherapeutic resolution of the illness according to the PPCC model.

Stages [14] (see Table 1).

Evidence for the efficacy of the process of healing during psychoanalytic psychotherapy

There was a perfect match, confirming the identities of the concurrent steps in the therapeutic process and patients' experience of psychological healing (see Table 1). This support of Dr. Robbins' clinical work by the theoretical strength of the PPCC theory [3,15] provides evidence for the efficacy of

psychoanalytic psychotherapy in the treatment of those cases of paranoid schizophrenia and schizoaffective disorder which are not only accessible to intervention but have sufficient intelligence, determination, goodwill, curiosity, perseverance and patience to complete a psychoanalytic treatment. The closely related psychodynamic psychotherapy has, itself as a treatment method, been demonstrated to be more effective than other forms of therapy for a wide range of conditions [20,21].

<u>Stages of Psychological Therapy of Schizophrenia: Dr Michael Robbins</u>	<u>PPCC Model of patient's mind: Dr Gillian Steggles</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 assays including 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.

Table 1: Stages in the psychological resolution of Schizophrenia

Dr. Robbins also identified 8 Systems in a ‘psychobiological’ Hierarchy which forms the basis of a comprehensive therapeutic approach applicable to schizophrenia [1]. This is the same stance as the declared ‘biopsychosocial’ approach to mental illness of the Royal College of Psychiatrists. 4 of these Systems are accessible to therapeutic intervention: neurophysiological-pharmacological, with antipsychotic medications; psychological, with psychoanalytic psychotherapy; family therapy; and social care. He did not subscribe to any one specific psychoanalytic theory in his clinical work, but was patient-centred as was Murray Jackson [22], focusing on the patient themselves. His portfolio of 18 paranoid schizophrenic patients revealed 9 who had a ‘positive’ result from their treatment, and of these 6 who had ‘a very successful’ result. Only half, 9 patients, had ‘a negative outcome’.

These findings provide evidence of the efficacy of psychoanalytic psychotherapy for schizophrenia and schizoaffective disorder, and this is confirmed by the PPCC’s own demonstrated veracity.

Clinical Results

Clear outcome measures are thereby established:

Therapeutic interventions found to be efficacious for accessible schizophrenic and schizoaffective patients (4 of Dr. Robbins’ psychobiological Hierarchy Systems):

- 1. Anti-psychotic medication:** addresses dopamine excess produced by the nucleus accumbens and prefrontal cortex, and addresses the challenge of malfunctioning pyramidal cells’ NMDA synaptic receptors in the cortex, which Professor Karl Friston and colleagues have outlined [23]; this enables the patient via the medication to think more clearly despite her psychotic tendency. Mood stabilizers are also required for schizoaffective disorder.
- 2. Psychoanalytic psychotherapy:** addresses psychologically the prodromal dysphoria and confusion of schizophrenia, and also the psychosis resulting from the consequences of both pyramidal cell dysfunction in the prefrontal cortex [23], and dopamine excess produced by the nucleus accumbens. Long term psychoanalytic psychotherapy allows the patient to respond positively with her Psychiatry-trained Psychoanalyst to the difficulties she has experienced while her illness was developing. When the patient is supported by medication and ward staff, she becomes able to address the painful elements of her past experiences with her Psychoanalyst. This includes becoming orientated in time, place and person to the events of her past so that these no longer psychologically stimulate psychosis within her mind. The long term therapeutic process is illustrated in the PPCC model by a geometric sequence (see Figure 3).
- 3. Family therapy:** addresses any concerns the patient might have with family members. These family members will not initially be aware of the progress their ill relative has made in her insight, independence and autonomy. They will need to be updated and helped to welcome their recovered member back into the family. If they cannot respond positively to her she may have to leave them, but on the best terms possible.

- 4. Social care:** when needed, support will be helpful to the newly recovered patient in settling into her chosen community after leaving the hospital ward. She may require help, especially initially, that has long term benefits until her confidence has grown. Then she will look forward to being able to take her part in her community’s activities.

The need for skilled psychoanalytic psychotherapy

Psychoanalytic psychotherapy may be very effective in the treatment of schizophrenia and schizoaffective disorder. Intensive training is required to attain the skills needed to oversee therapeutic management of these patients, who are extremely mentally frail. Most schizophrenic and schizoaffective patients are not suitable for psychoanalytic therapy because of a wide range of factors. Many attributes are necessarily required in a patient before commencing this treatment, such as intelligence, patience, determination, a capacity for insight, and a generosity of spirit, so that together with a strong transference (relationship with the Psychoanalyst) they can work with their therapist. A wide range of alternative treatments are available that address specific symptoms, and may help an individual patient who is not suitable for psychoanalytic psychotherapy.

Particularly skilled psychoanalytic psychotherapy is necessary to intercede into schizophrenic illness. Clarity of boundaries is essential. This includes the clinician’s interactions with the patient concerning time keeping. Clear starts and endings of the therapeutic hour must be insisted upon. No extra conversations afterwards should be engaged in. Payment methods for the sessions must be formal, clearly agreed and adhered to. Gifts are not allowed in any circumstances. And physical contact should be completely avoided, except for example for a handshake at the end of the first and very last consultation interviews, to help establish rapport and good wishes. These measures should be adhered to because doing so helps to avoid complications with the treatment.

The patient requires supervision of her psychotic symptoms. The smoothest progress from the patient’s perspective emerges when this function is carried out by her Psychoanalyst, who in this position is required to be psychiatrically trained. In the United States of America the patient’s Psychoanalyst may rely on a Psychiatrist colleague to fulfil this function. In Britain, the Psychiatry-trained Psychoanalyst communicates his understanding of what his patient says to him, and her implied unconscious meanings, back to her. In doing so over many months and years she gradually begins to feel understood. From this improvement, she starts to gain self-understanding. Her dysphoria gradually responds to the cognitive improvements she makes from the influence of her therapist.

The Psychoanalyst may sit with his patient during long passages of silence while she addresses the terrible feelings and experiences that have accumulated during the development of her schizophrenia. One of Dr. Robbins’ patients, Sara, told him that what she remembered most from her therapy was Dr. Robbins sitting with her, hour after hour, session after session, while she adjusted slowly to her terrible pain and mental anguish [19]. This

led to her understanding of herself, the basis for her mental health. After several years, the patient may eventually have described her memories of pain, confusion and despair to her Psychoanalyst from within the depths of her mind sufficiently to adjust to them. Then she becomes able to assimilate these as conscious realities, and to become her own best friend, in self-support of her increasing independence.

The usefulness of ward psychodynamic groups

A good way of facilitating the recall of memories and experiences is to set up ward psychodynamic groups (up to 7 per week) where patients contribute what comes to their minds as discussion ensues [20].

Notable memories and experiences are recalled which, in turn, may be shared and elucidated during sessions with the Psychoanalyst. This is the core of psychoanalytic practice. The PPCC model offers theoretical understanding of this practice when applied to schizophrenic and schizoaffective patients.

Excellent care at discharge

Schizophrenia is such a major affliction on the mind that treatment requires up to 5-9 years to tackle it effectively. Sequential admissions to the treatment centre are the norm, until a level of stability is reached when the patient gradually becomes competent at managing herself and handling daily life without requiring nursing care. Excellent care at discharge is needed to ensure the continued progress of her mental health.

Suicide prevention

Suicide and self-harm become a risk when the schizophrenic patient becomes aware of her mind as a very troubled entity that requires treatment. Morale in hospital psychotherapy units is generally high, in a positive and supportive ambience. When the patient moves away upon discharge, good relations with the staff need to be consolidated. Providing an open door for informal visits back on to the ward is a good way of tending the patient's needs for survival and for reminding her of the kindness of the staff as an aspect of her present new life.

Psychoanalytic psychotherapy will produce in many patients self-regard and self-acceptance if continued for long enough – if she is willing to put in the hours of attendance at her sessions without being aware of the great benefits she is accruing. Self-understanding allows her to identify good qualities in herself so that the idea of self-harm gradually recedes. Her Psychoanalyst's kindness is the lynchpin that she can depend upon for psychological strength right into her future.

Discussion

Aligning two sets of clinical data using a model scientifically derived becomes particularly unusual when the model embodies a psychoanalytic theory whose variables are defined by a Psychiatry textbook.

Researchers in schizophrenia all contribute to knowledge

potentially useful in understanding the illness well enough to assist delivery of alleviating therapy. The illness causes terrible suffering. How to access the patient's mind is the question on which the whole of her therapy depends. Remedial treatment aids her thinking using antipsychotic medications to nullify psychotic intrusions, and then aims, through her Psychoanalyst's diligent interpersonal dialogue as psychoanalytic psychotherapy, to enable the patient to externalize her memories of her dysphoric early life. The patient's premonitory personality holds keys as to why their dysphoria became so intense that excessive amounts of dopamine were secreted and made her psychotically ill. The Psychoanalyst's skill is to connect disparate memories sufficiently well to enable the patient to make sense where previously only confusion lay. In this qualitative rather than quantitative observational Study, the simultaneous identification of the 7 Stages of therapy from the coinciding therapeutic and experiential perspectives fills the role some studies display of mathematical integrity. Schizophrenia, as a psychological state, is amenable to careful and detailed study of its different component parameters. In this qualitative Study the illness as a whole and its overall psychological therapeutic movements in the 7 Stages are examined and compared. Its elements are held up to scrutiny qualitatively from the two perspectives, and clarity seen.

Theory and progress

The dependence of clinical success on the correct resolution of disordered brain functioning by antipsychotic medication has been made clear in the structured treatment advocated in this Study; this paper elucidates the process of overall clinical treatment and optimal psychological recovery most effective for schizophrenic patients. All 4 levels of intervention with the patient are necessary for her best psychological functioning; in particular, skilled clinical psychoanalytic psychotherapy in addition to knowledgeable prescription of the correct antipsychotic medication is required, and effective supportive social care with or without that of the family of birth. The Psychiatrically-affirmed structural basis of the model with its endorsing textbook definition lends ratification to this early scientific Study. All these points when considered in a proof of concept study would ascertain or refute the very encouraging results of the present original Study. Focus on careful patient selection and excellent ward and supervisory care, being the two most important indicators of clinical success in addition to the therapist's skill applied as psychoanalytic psychotherapy, will achieve best results for such a confirmatory study.

Implementation

Expanding Dr. Robbins' practice with a proof of concept study would be the best approach to confirming the excellent efficacy of his psychoanalytic psychotherapeutic practice. This practice, in short, hands life itself to recovered patients, and their gratitude is surely what drives this initiative. The joy of recovering from schizophrenia is not widely appreciated because of its rarity, but should be, and its accessibility made available to those who need it.

Patient safety

Patient safety is the overriding principle to consider when these

very ill patients' minds are engaged in therapy. Loyalty to ward staff, who engage in their own safety measures, for example their own psychoanalysis, is perhaps the strongest factor in ensuring smooth continuity for the patients during the length of their psychoanalytic treatment. Particular care is required when patients negotiate transport on buses or trains to reach their Psychoanalyst's consulting-room from hospital. The organization of the hospital unit where patients are accommodated while they adjust to their therapy, and staff training, require detailed attention to ensure that all the patients' therapies proceed smoothly.

Conclusions

Schizophrenic and schizoaffective patients identified by their resilience through their past lives, intelligence, and the transference with their future therapist, may through closely supervised psychoanalytic psychotherapy recover mental health. This has been demonstrated by a pioneer in the field, Dr. Michael Robbins. This author's psychoanalytic model of their minds, the PPCC, confirms through its veracity and through close comparison with Dr. Robbins' clinical therapeutic findings, the successful process of healing as it unfolds throughout the patients' treatment. A recognizable though small proportion of schizophrenic and schizoaffective patients are thoroughly well versed in life's requirements of them as they have lived thus far; they may have lived exemplary lives. Despite disadvantageous psychological influences of physiological changes in their brains and, invariably, extremely unpleasant experiences, these brave patients hold on to life, supported by their Psychoanalysts until they can begin to thrive and live fulfillingly.

Limitations

A proof of concept study would refute or confirm the number of patients needed to treat (NNT) with psychoanalytic psychotherapy in order for one patient to become well; this very small study has an NNT of 2. Ethical values must be strictly adhered to. A proof of concept study would be an ideal opportunity to confirm questions of technique for schizophrenic illness among Psychiatry-trained Psychoanalysts. Such a study would be worthwhile because, quite apart from the humanitarian ethic, the cost to society of an untreated schizophrenic lifetime (Schizophrenia Commission 2012 figures) is £1.8 million. The cost at present of delivering a psychoanalytic psychotherapy treatment to a schizophrenic patient is £5-900,000.

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