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Double (i) Non-consciously Registered and (ii) Unconscious Guilt as an Aetiological Psychological Bind with Contributory Aetiological Scientific Paradigms in the Wholly Effective Psychotherapeutic Psychoanalysis of a Schizoaffective Woman

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ABSTRACT

This paper presents double unconscious guilt as an aetiological psychological factor in the development of schizophrenia and schizoaffective disorder. Two instances of guilt are caused unconsciously by experiences with an external source, eg. a schizophrenic individual. If these experiences of unconscious guilt are accessed by another external factor they may become conscious, and lead to the experience of schizophrenia or schizoaffective disorder. Other factors in the aetiology of schizophrenia and schizoaffective disorder include a genetic basis, which may affect physiological processes eg. in the prefrontal cortex, relating to dysfunction of pyramidal cells involving NMDA receptors. Sensory misattribution may lead to false inference. This in turn may lead to delusions, a common symptom of schizophrenia. Schizoid illness may run in families: bipolar disorder and schizoaffective disorder occur more commonly in families which have a schizophrenic member. Psychoanalytic psychotherapy in skilled hands may lead to resolution of the psychological symptoms and difficulties experienced by a schizophrenic or schizoaffective patient. Careful prescription of medication and secure inpatient care involving treatments such as group psychotherapy as further treatments may, when carefully supervised, led to resolution of the conditions.

Keywords

Double guilt; Schizophrenia; Schizoaffective disorder; Aetiology; Psychoanalytic psychotherapy; Scientific paradigms; Medication..

Thesis

Double (i) non-consciously registered and (ii) unconscious guilt that forms a bind in schizophrenia comprises 2 factors:

- 2 forms of (i) non-consciously registered and (ii) unconscious guilt are experienced.
- 1 source: one person or a specific group of individuals in a social setting.

Symptoms

Irremediable confusion

Double (i) non-consciously registered and (ii) unconscious guilt occur together in the aetiology of schizophrenia, operating in both directions, ie. both for doing something, and for not doing it or incurring further guilt, in relation to the same person or specific individuals.

Ignorance of the conscious experience of guilt itself, as shamelessness and remorselessness, with attenuation of feelings of self-guilt, is held to underlie sociopathy [1]. It is, further, proposed herein that when a person is involved with two or more situations causing guilt in relation to one individual, or to a specific group of individuals in a social setting, this may lead to schizophrenia. In the case of schizophrenia the individual continues in a state of guiltlessness because the origin of (active) guilt (i) is so horrific, for example a sexual invasion, that its memory is repressed into the person's unconscious mind; and because a second (passive) guilt (ii) is unconscious at its initiation. In schizophrenia, when the individual is initially ignorant of conscious, or of unconscious

guilt, ie. of any guilt being inflicted, there is no opportunity due to ignorance of resolving the guilt. It is proposed that the second experience of unconscious guilt (see below, proposed double guilt) confuses the first experience of unconscious guilt and leads to intense unconscious confusion and disturbance. This ultimately may lead, after the confusion becomes conscious, to schizophrenia itself.

1. Ignorance of the conscious experience of simple guilt is sociopathy.
2. Ignorance of two non-conscious experiences of guilt in relation to one person, or to a specific group of individuals in a social setting, ie. when non-consciously registered guilt, and a further confusing, unconscious guilt, are accessed by an environmental factor and become double, confused conscious guilt, schizophrenia, results.

Proposed understanding of the symptoms

Schizophrenia is the result of double (i) non-consciously registered and (ii) unconscious, inflicted, guilt, eg. from inflicted experience of close acquaintance with a confusing or, especially, a schizophrenic individual or a group of confusing others, such as a schizophrenic father or a poorly functioning family.

Double (i) inflicted non-consciously registered and (ii) inflicted unconscious guilt, or double unconscious guilt, is one consequence of, for example, sexual invasion by and subsequent disturbing contact with one source, eg. a schizophrenic, known individual or a specific group of unsympathetic contacts as in a painfully functioning family. Schizophrenia may ensue from at least one or more secondary guilts after an intrusive primary insult when these, as double, unconscious confused guilts, become conscious.

Proposed double guilt

1. The first instance of guilt is experienced for this invasion itself: it inflicts guilt that is not consciously registered even though it is a very unpleasant physical experience; but, rather, it becomes repressed into the unconscious because of its horror. Unconsciously, this first instance of guilt is for actively taking part in the offensive intrusion, and for not defending the individual's self in self-defence. The guilt becomes unconsciously repressed because of its unpleasantness.
2. The second instance of guilt is for passively not consciously recognizing, also in self-defence, the sexual invader for what he is: commonly bad and confusing, such as a schizophrenic invader. This second instance of guilt is for passively accepting him and not actively defending the self from him despite unconsciously recognizing him. This offensive guilt (ii) also is held in the unconscious. It becomes confused there with guilt (i). The confusion with unconscious guilt (i) is very unpleasant. The unconscious confusion and disturbance is eventually likely to become accessed by one or more environmental factors. The unconscious confusion then surfaces as conscious confusion: schizophrenia.

These are two forms of non-consciously registered guilt, for doing and not doing something consciously, relating to the one confusing person or group of people and mooted as unconscious guilt. The two confused forms become conscious due to being accessed by an environmental factor. They become consciously confusing to the individual as schizophrenia.

Proposition

These two experiences, (i) and (ii), both being inflicted guilt that is not consciously registered but mooted as unconscious guilt, lead through access by a connected environmental factor to conscious awareness of confusion: schizophrenia.

This double (i) non-consciously registered and (ii) unconscious guilt creates a bind that is found in schizophrenia.

Discussion of the proposition

1. The individual suffering double (i) non-consciously registered and (ii) unconscious guilt, at the same time, is not consciously aware of either, or of her unconscious predicament. The consequence of this is that she cannot identify the unconscious guilt feeling's two unconscious directions nor its unconscious presence in herself, or therefore deal with either. She cannot recognize either non-conscious form or their unconscious presence in this bind; but when it becomes conscious, triggered by an environmental factor, it becomes conscious, and schizophrenia is the result. If only one form of non-consciously registered but unconscious guilt existed the consequence would be sociopathy [1].
2. A schizophrenic individual who may project double guilt into another person may behave completely normally, or only slightly oddly. This disguises his schizophrenia. Sometimes he may let slip his true mind. The sufferer of guilt who is experiencing him chronically feels unconsciously that she "cannot do anything right" in her miserable prodrome to her illness, because of both directions of her bind, ie. her unconscious experience of him. Her unhappy experience of him is unconscious and feels very unpleasant. It is a very painful representational world [2] for her to tolerate when this includes her invader. And commonly it eventually becomes conscious, as schizophrenia. And he always makes out he is right, reinforcing the experience of double guilt.
3. When, after analysis, the individual is released from her cognitive blunting perhaps by medication change, and cognitive functioning is restored, abreaction as blinding potentially catastrophic guilt may be experienced.

Discussion of thesis

In schizophrenia and schizoaffective disorder the individual suffers unconscious guilt from two adverse but non-consciously registered experiences. These two adverse experiences due to exposure to the same unpleasant person or group of people become confused, and eventually are likely to lead to conscious confusion and sometimes to schizophrenia itself.

This schizophrenic experience of confusion when it becomes conscious clearly can affect entirely the individual's established

personal relationships developed already in her life. All contexts of her life when revealed by psychoanalytic psychotherapy are now seen clearly to be opposite to those previously established: catastrophic guilt may be felt (as contrasting with the more common catastrophic grief reaction), and requires personal awareness, skill and determination not to become evident to those around her.

All the accumulated guilt of the individual's lifetime of carrying her father's guilt is released and suffered during treatment to make it accessible to the individual. For this psychoanalytic psychotherapeutic treatment of schizophrenia to become wholly effective it involves release, during abreaction as a catastrophic guilt reaction, of the analysed accumulated and completely undeserved guilt feelings which she may be carrying as her father's guilt. The abreaction may be experienced as a catastrophic guilt reaction; the individual is filled with very intense feelings of guilt while iterating, extremely forcibly and registering with grief, indignation, anger and rage such expressions as "I'm innocent! I'm innocent! I'm innocent!". This adversity may temporarily affect the individual; but only if she allows existing social relationships to be affected by her change in awareness of her undeserved guilt feelings; she now may incur guilt feelings of her own through her own misbehaviour; whereas, during her earlier life, she did not register her father's guilt, because this was unconscious; and any guilt of her own was obscured by this. She continued in a state of guiltlessness.

Double guilt occurs within the misery of a dysphoric representational world [2] for schizophrenic and schizoaffective patients. Conscious cognitive and affective symptoms ensue. The circumstances of a schizophrenic patient's life are miserable, but they have also become seriously consciously confused through double guilt in relation to one person or to a specific group of individuals in a social setting; a miserable representational world exacerbates conscious cognitive confusion and renders a schizophrenic illness more likely. Sometimes mainly severely dysphoric emotions with mild cognitive confusion become manifest, leading to other forms of psychosis. When both are experienced, dysphoric emotions, and conscious cognitive confusion from double guilt, adversely affect the nucleus accumbens as the brain's wellbeing centre; decreased glutamatergic negative feedback from the nucleus accumbens activates the homeostatic A10 nucleus in the midbrain, leading by the mesolimbic mesocortical pathway to excess dopamine secretion in the nucleus accumbens, and in the prefrontal cortex which has, in many cases, been damaged due to perinatal hypoxia. Pyramidal cells in the prefrontal cortex are adversely affected by the excess dopamine, and manifest prediction errors that accompany NMDA receptor-mediated changes in synaptic efficacy [3]. This leads to sensory misattribution and false inference, and through maladjusted neuronal circuits to confused speech and psychomotor poverty. Psychotic speech and behaviour are the outcome, the symptoms of schizophrenia.

Clinical History

The wholly effective therapeutic psychoanalysis of a 65-year-old schizoaffective woman is described (after Robbins, [4]) here, in the context of a father who was schizophrenic. This history is presented here to demonstrate an application of the proposal in this paper that double (i) non-consciously registered and (ii) unconscious guilt forms a bind in schizophrenia and schizoaffective disorder especially if it takes place within a miserable representational world.

Purpose of this clinical history

The purpose of this paper's clinical history is to show that, in one instance at least of a schizoaffective woman, double (i) non-consciously registered and (ii) unconscious guilt become confused conscious guilt forming a bind that produces the symptoms of schizoaffective disorder. In this paper schizophrenia is described as also representing the schizoid element of the woman's diagnosed schizoaffective disorder. The affective component of schizoaffective disorder may result specifically from a miserable representational world. This clinical history is written to understand and communicate to readers this woman's illness in psychological terms, to be helpful to Psychiatrists and other clinicans in their practice. The woman when aged 28 received an earlier partially successful psychoanalytic psychotherapy, 5 days a week for 4.5 years; and, as described, when 65 years old a second, wholly effective therapeutic psychoanalysis once a week for 7 years.

History

A schizoaffective woman aged 28 years was treated with a partially successful 4.5 year long, 5 days a week psychoanalytic psychotherapy before she underwent her second, wholly effective therapeutic psychoanalysis once a week for 7 years. Her first course of psychoanalytic psychotherapy had enabled her acute fear of men, consequent upon her fear and hatred of her intrusive father, to be somewhat assuaged by her Psychoanalyst's kindness, his presentation of his sexuality under contained conditions, and his gentle though obscure verbal interpretations. Her mother had already sometimes visibly been ashen-faced in relation to her husband. Towards the end of her second analysis, eventually the woman realised she herself became ashen-faced when contemplating the acute horror they both experienced in relation to him. The woman's three siblings were completely unaware of their father's abnormality, having been from early years deluded by him into trusting him completely because of his invasive manipulation of their minds. One particularly cruel incident was making his four teenage children squirm and wriggle in anguish within clouds of horseflies among the heather on a grouse moor on a particularly hot day so that he could "take a photograph of [them] all, quite still, together"; he used this opportunity to order them all to accept without comment his instruction about Medicine: "It's the only career".

This partially successful first analysis enabled the woman to become very happily married for at least 35 years. During the woman's lifetime after commencing her first psychoanalysis and before her marriage she had seriously attempted suicide and four more times was parasuicidal; she made a second serious suicide attempt soon after becoming married. A dream interpreted by her second Psychoanalyst showed a cold, hard, granite tenement building surrounded by deep flowing rivers and cowpats (representing her

father) with a woman in its brightly lit basement surrounded by lots of children (representing her mother).

The woman pursued a career in Medicine, having been ordered by her father to do so. She had her first breakdown, aged 20 years, in her second year at University. This was despite being genuinely interested in an intellectual aspect of Medicine, a physiological discovery, that she had gone to University to understand, even after her first breakdown following 4 terms as a student. She gradually developed, with help from her University and many other agencies, a real academic interest in psychoanalytic research within a Medical capacity. She was intensely grateful to every one of these agencies for trusting and encouraging her to fulfill commitments she had made many years earlier to carry out research she had promised to do.

The woman suffered unconscious guilt doubly. Her first unconscious guilt, incurred when she was 8 years old, was sexual guilt consequent upon her first adverse experience of her father, a sexually based molestation by him when she thought he was going to murder her. Terrified, she experienced him lying on her, running his tongue along her upper lip, preventing her from getting her head away from him, being unable to call out and feeling paralysed under him.

She could not move from terror. Years later she experienced hypnogogic hallucinations of diving backwards, trying to get away from him; this was enactment of a physical memory. Aged 20 she had a sleep paralysis hallucination, experiencing him as a black psychopath outside her bedroom window trying to control her in the middle of the night, after she had contacted her doctor at mid-day to make an appointment and the next day going into hospital.

Her second guilt was from his psychology towards her. Her brother, while with his father in the basement cellar of the parental home, called out towards the hall where the woman was, "Why is [Claire] so horrid to Daddy?". She had done nothing deliberately ever to be horrid to him. Her brother was in collusion with him, as became her other brother and her sister, convinced by him to trust him. As a young schoolgirl when her sister proudly announced to him "[Claire] has won a First Year Scholarship!" he met this with a scathing "My my!".

Aged 12, she had experienced acute inchoate embarrassment from her nascent teenage modesty when her father looked at her in her bath. Prior to her parents' divorce, an employed nanny persuaded the woman aged 14 to tell her of anything amiss. She told her about her acute embarrassment at her father looking at her in her bath; she had blanked out of her mind her molestation; she had repressed the molestation, but her father openly blamed her when her words to the nanny were read out in court. This was her own, open, guilt on behalf of her father, however undeserved. It made her feel for the next 50 years that she had been "the straw that broke the camel's back" of her parents' marriage. All these memories came to light and were discussed during her second, wholly effective second therapeutic psychoanalysis.

Aged 14 he had derided her appearance, with her hair in plaits at that age while struggling with O levels, in comparison with an elegant 14-year-old girl, her age: "How old do you think she is?" in a magazine wearing a diaphanous gown and hair piled attractively on her head. When aged 18 he had described her efforts to make a golden wedding anniversary cake only as "a gesture", when she had really put her heart into baking this cake for her much loved grandparents. This comment proved to be the environmental factor that precipitated her illness. While she was working at her first Medical post as a House Physician she told her father that she was responsible for two wards full of patients. He replied "No wonder the NHS is on its knees!". After her first psychoanalytic psychotherapy she thought about what work she could do. She considered "I could be a teacher!" Her father's response was "A pathetic creature like yourself?!" He taught his grandson, when only about 3 years old, to recognize pregnancy by an enlarged abdomen. On seeing his pregnant aunt, and to her shock, the little boy said "Have you organized another baby?"

Any means justified his ends. He organized her sister's marriage. Her sister stayed with him for her last 3 years at her new day school. Her very guilty expression in a portrait of her husband and 9-year-old son, and herself, demonstrated the damage her father had done to her in suggesting to her that she could marry the brother of a schoolfriend: "a very lucky girl" according to her sister-in-law. His plan for her detracted from her independence for herself and autonomous thinking. Completely under his control, her love was a planned one, arguably deceiving her future husband by the plot suggested by her father and carried out by herself. This reason for finding herself married to her husband with their son could not be denied even by herself, horribly, in her moment of happiness. Like her father, she had used any means, in this instance deception, to attain his, and her, ends: her marriage to her husband. And so her unconscious guilt was clearly visible in her family portrait.

These symptoms experienced by the woman and other family members including her sister, who also developed a schizoaffective disorder, may be understood psychoanalytically, psychologically, and from a Psychiatric perspective. Irremediable confusion arose from the symptoms experienced by the woman, and was only rendered harmless to her mind during her second, therapeutic psychoanalysis when she was 65 years old.

Conscious confusion commonly occurs from 2 apparently contradictory statements. Non-consciously registered (i) and (ii) unconscious guilt also can occur in both directions, eg. for doing something or not doing it. Continuing with her hair in plaits would apparently be wrong. But the woman could not improve her appearance while struggling with her schoolwork. She felt confused but was not consciously aware of why. Ignorance of the conscious experience of simple guilt with or without unconscious guilt is generally accepted as an aspect of sociopathy [1]. Ignorance of the presence of unconscious guilt may or may not lead to illness. But conscious experience of double guilt is, however, very unpleasant and confusing and is proposed as producing a bind in schizophrenia. The woman had been accused of being horrid

to Daddy, while what she had been trying to do was to avoid his communications with her. She felt powerful feelings of hatred and disgust, and she was at a loss to understand what her brother had accused her of: he was himself in close engagement with and colluding with his father. She had worked hard for her scholarship at school, as required by her two parents, but her hard work was met by scathing. She could not understand why. The same was experienced with her grandparents' golden wedding cake, why he should belittle her efforts.

Her sister had also suffered, starting with a tearful collapse after 2 years at the senior boarding school the two sisters attended. She continued her life through the next 3 years by attending her new day school while living at her father's house; and she went through the process of her becoming married which she never registered as his manipulation of her. The sister continued in a state of non-consciously registered guilt after the start of her marriage, and bearing double unconscious guilt – for deceiving her husband, and for enduringly living with this deception; which was why she appeared so guilty in her family portrait. She was unaware consciously that she was being manipulated; and she was unaware that her father was bad and that she should then have asserted her independence. She had no opportunity in practice of resolving her situation consciously by the opposite, ie. not marrying her friend's brother, partly because this would not be possible, but also because she was not conscious of doing any wrong.

Here was double unconscious guilt inflicted on another daughter, the woman's sister: non-consciously registered guilt for actively deceiving her husband with her father's plan, and unconscious passive guilt for her own happiness while living with this situation, a horrible unconscious reality. This is a parallel to the woman's non-consciously registered guilt for actively participating in her initial sexual invasion; and her subsequent passive guilt for thinking that he was bad. Invasiveness by the father was followed by wrongful deception by him in each case. In both cases it was double unconscious guilt that was inflicted, with no opportunity for either daughter of resolving their father's intrusions consciously by the opposite. The sister firstly did not actively assert herself for her own free decision to become married, and secondly she did not understand her passive tolerance of her deception, because she was not conscious of not making her own decision. The woman likewise was firstly bound, aged 8 years, by her active, shockingly traumatic molestation by her father, and secondly in passively accepting her intense dislike of her father when the family outwardly at least held him to be good. This is the proposed unconscious double guilt bind in both sisters leading to schizoaffective disorder: which became manifest when the double guilt passed from being unconscious to becoming conscious, triggered by an unconscious factor which was, in the woman's case, her father's dismissive remark about her golden wedding anniversary cake.

A new theoretical construct that may be seen from the schizoaffective woman's history is that of double unconscious guilt as an aetiological precursor to schizophrenia or schizoaffective disorder.

The first unconscious guilt (i) is experienced for actively undergoing the initial invasion itself. This consists in the case of this woman of the severely traumatizing experience of her father invasively molesting her aged 8 years when she thought he was going to murder her, that she would die at his hands.

The second unconscious guilt (ii) is from passively not recognizing the reality of her father's badness nor her inflicted confusion: which was what made her unconsciously believe she was bad. She did not recognize, though she felt, her father's badness in causing his son to take his part in colluding with him to accuse her of "being horrid to Daddy". The two unconscious guilts are commonly experienced from close contact with schizophrenic individuals, making schizoid illness sometimes appear twice or more in a family. The woman was, in this second, passive unconscious guilt, "guilty" of thinking and feeling he was bad when she should think him good, according to the family dynamics. His illness was never acknowledged within the family except by the mother and a neighbour. Eventually, the woman was not guilty when recognizing he was bad.

The two experiences of this woman mooted in the proposition: ie. being described as inflicted in stages (i) and (ii) with guilt that was not consciously registered but unconscious, ie. doubly unconscious, are proposed as leading to her schizoaffective illness. When her inflicted double unconscious guilt bind became a conscious guilt bind, following the trigger of her father's remark about the cake, her schizoaffective disorder became manifest as an inflicted illness.

Discussion of the case history

This woman's second, wholly effective therapeutic psychoanalysis of 7 years was carried out after near-completion of her academic research, commencing 45 years after her first breakdown and 29 years after she first became married.

The 'academic defence', ie. using applied intellect to defend the self from otherwise unendurable emotions, enabled the woman to live her life: together with, upon reflection, learning about Jose Saramago's self-ascribed technique for pursuing his life by remembering good, sound memories eg. of a beloved grandfather, which were contemporaneous with some indescribable cruelty inflicted upon him as a very young child [5]. Remembering his grandfather and writing about him with compassionate creativity, love and courage in his inimitable literary style enabled Saramago, as described thus in detail by Dr Murray Jackson [6], to pursue his journey through life. The woman in later years adopted this philosophy in continuing her own extremely troubled early life. In the same way as Saramago she became enabled after her second psychoanalysis to devote her memories of her own much-beloved Grandad to overcoming her sense of disgust at her family home despite her mother's very loving efforts to preserve her life. The disgust they both felt about the schizophrenic husband and father united her mother and herself; but her mother never understood that whereas she had had the supportive resource of her life prior to becoming married, the woman had no experience of life before being assaulted by her father. Her mother never understood her

daughter's, the woman's predicament.

The woman's younger and much-loved "lovely, gentle, sweet", but lost, sister also became schizoaffective. She told the woman that "she was the only one who really understood" what they as companions had lived through: their parents' extremely acrimonious divorce; 8 years at boarding school for the woman; and 10 years at the boarding school 400 miles from home which were intended for her poor sister, who collapsed after 2 years at the senior boarding school. The other comment from her sister that made the woman – who self-deprecatingly described herself as "a very bossy big sister", an identity first attributed to her by her elder young brother - deeply moved, was: "I was glad you were there", in the family.

As her big sister, the woman had had to endure being made a scapegoat in the family; and being referred to as a "black sheep" by her very correct mother; and ostracized by her father. One of her brothers, the elder, colluded fully with their father; and the other, though affectionate towards her, was completely engulfed by his father's delusions and accepted his perspective entirely, even naming his son with the same name as his father, and of he himself. His father's delusional system consisted of money, his own personal social standing, and big houses; he believed himself to be an aristocrat, and that successive generations should occupy the same houses as their predecessors. Both his sons enacted this idea in practice.

Conclusions

In this second treatment by a wholly effective therapeutic psychoanalysis of a schizoaffective disorder, all the accumulated unconscious guilt of the individual's lifetime is released and suffered during treatment to make it accessible to the individual. This treatment of schizophrenia or schizoaffective disorder when completely effective involves release during abreaction of the analysed unconscious, and accumulated, and completely undeserved guilt feelings. This adversely affects the individual only if she allows existing social relationships to be affected by her change in awareness of her guilt feelings; she now has guilt feelings whereas during her earlier life she could not have her own feelings of guilt, because these feelings were previously obscured by the very great extent of unconscious guilt she was carrying that was her father's guilt. This guilt was not registered consciously, nor unconsciously accessible, and therefore was for a long time unable to penetrate consciousness; however, when accessed by an environmental factor that precipitated her first admission to hospital, her father's description of her cake-baking as 'a gesture', her confused feelings and thoughts, caught up in her double bind with her father, entered her consciousness. The patient began to be relieved of them during her first admission to hospital aged 20 years following a terrifying sleep paralysis experience symbolizing her hatred and fear of her father. Ordinary guilt feelings of her own ensued, after her abreaction had alleviated her of her father's guilt, carried by her. These were now registered consciously, for example, eating a tangerine in a bright, warm kitchen while her husband was out on a cold day purchasing the daily paper.

It is important in this treatment for schizophrenia that gradual, smooth, unobservable progress is maintained with ongoing long term relationships, and that no disruption is caused by the sudden awareness after treatment of what guilt feels like; and is so, even if the nature of what guilt is has previously been fully known, comprehended, understood, and especially everything that could possibly be done has been done, and is done, to prevent it: and so to live a righteous life.

Psychoanalytic psychotherapy

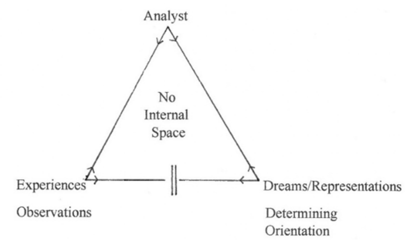
Psychoanalytic psychotherapy is the Medically-, Psychoanalytically- and Psychiatry-orientated treatment which, in conjunction with medication, saved this woman's life. This treatment is practised by psychoanalysts and, in the case of psychotic disorders such as schizophrenia and schizoaffective disorder, must be practised only by Medically trained practitioners. This is required so that recognition and containment of the psychotic features of the patient's illness, and recognition of a need for medication, may not be missed. In skilled hands it has been shown to resolve schizophrenia [4], and schizoaffective disorder, as shown in this paper. Its psychoanalytic component addresses conflicts and unconscious processes, which is required to reach the foundation of serious distortions of the human mind. Its psychotherapeutic element kindly supports the patient as she addresses with her Psychoanalyst these distortions as they affect her.

The woman had written a letter setting out her very troubled family situation for her doctors to understand, immediately prior to her first hospital admission. If her family's relationships related in the letter had been studied systemically and psychodynamically, even at a distance clinically, and restored or adjusted, perhaps much of her future suffering might have been pre-empted. As it was, two lengthy psychoanalyses were undertaken to establish the psychological facts of her case when these had already been clearly set out right at the start of her illness.

This woman's illness, including symptoms commencing during her school and home life from the age of 8 years and before being diagnosed as schizoaffective aged 20 years, affected her life between the ages of 8 and 71, including the 7 years of her second, therapeutic psychoanalysis between the ages of 65 and 71. Before this period of 63 years, she recalled happiness including a happy memory aged 6 years, until her molestation by her schizophrenic father aged 8; and she experienced happiness again following the conclusion of her second wholly effective therapeutic psychoanalysis aged 71. She enjoyed a great deal of happiness during her life, interspersed by her treatments for periods of illness, especially after her marriage. During the period of her second psychoanalysis her experience was of her Psychoanalyst "physically" carrying her over the dividing line between schizoaffective illness and good mental health.

The process of her recovery upon receiving psychoanalytic psychotherapy for the first time has been described [7]. This previous paper documents her registering and addressing at that time the schizoid elements of her illness – her second psychoanalysis

addressed primarily the emotional element of her illness. The psychodynamic pentapointed cognitive construct, PPCC, model [7,8] that describes her progress after her first psychoanalytic psychotherapy includes demonstration of psychodynamics relating together 4 variables outlined in a Psychiatry textbook [9]: "Psychoanalytic theories are mainly derived from data obtained in the course of psychoanalytical treatment. These data relate to the patient's thoughts, fantasies, and dreams, together with their memories of childhood experiences". The variables Experiences, Dreams/Representations, Observations (spoken thoughts), and Fantasies (the Determining Orientation variable for mania is fantasies, as distinct from hard facts for depression and concrete thinking for schizophrenia) are the main elements of the PPCC model, a psychoanalytic theory of the functional psychoses, together with the variables of her Psychoanalyst and the contained Internal Space. These variables were arrived at independently of reading the textbook, which was read 24 years later, and are seen in Figure 1. The PPCC model demonstrates the dynamics of the therapeutic session between a Psychoanalyst and an analysand (patient) in schizophrenia and in schizoaffective disorder. The PPCC model illustrates through its variables the therapeutic relationship in both illnesses as a dynamic, functioning process. The variables contain the contents of the patient's Representational World.



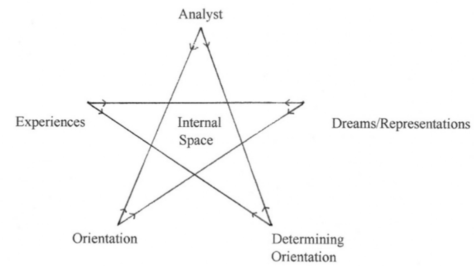
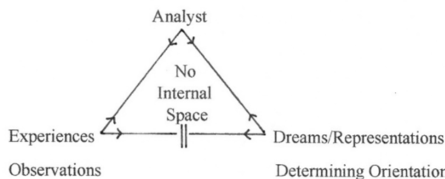


Figure 1: The PPCC models for schizophrenia and schizoaffective disorder



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

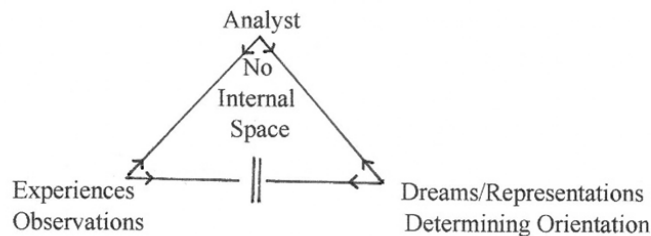
Observations (non-psychotic thoughts and comments)
patient was getting "a few crumbs"
"I really think I'm alive, and if I think about it I get so sad and I get really angry"

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 Representational World of a child was conceived of by Professor Joseph Sandler and Bernard Rosenblatt as a preconscious psychological structure in a child's mind that comprises salient items which are significant to her in the environments she successively encounters as she grows and learns about the world around her [9]. It acts as a guide for her in helping her to adjust to new situations. Two adult schizophrenic patients studied, Sara and Emily, were also considered to suffer representational worlds that were experienced by them to be very miserable. Their case histories were related by Dr. Michael Robbins [4,10], who treated them. The details of their very miserable two schizophrenic case histories are illustrated in the PPCC's blocked form for schizophrenia (Figures 2 and 3). The PPCC model when extended (Figure 6) shows the model for schizophrenia developing, during psychoanalytic psychotherapy, into the model for schizoaffective disorder, which contains an Internal Space. Initially, there is no internal space in a schizophrenic patient nor in the PPCC model for schizophrenia; but once engaged in therapy the patient's mind becomes more accessible, emotions are experienced, and an internal space develops.



Representational World:

Analyst
directs therapeutic activities towards resolving patient's problems

Experiences
she had to tolerate surgical assaults by her father
was a baby girl (when her mother wanted a boy)
separated temporarily from mother in first year
nocturnal phobias, school phobia
temper tantrums
bullied at school

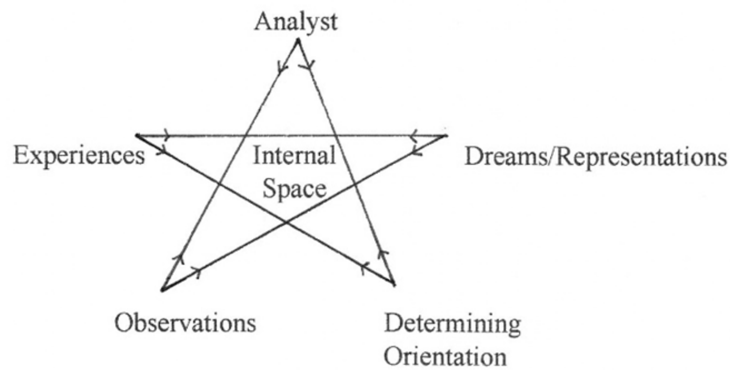
Dreams/Representations
painted well
hallucinated advising and admonishing robed figures
cut and burnt her body in symbolic patterns
a teacher called her 'Virginia Woolf' and she secretly began to think of herself as Van Gogh

Observations
someone was trying to poison her
she knew no-one would take care of her the way she wished

Determining Orientation (psychosis and disturbed behaviour)
having to tolerate surgical assaults by her father
scratched her abdomen till it bled
hallucinated at school and college
dress and hygiene deteriorated
fits in which she smashed things
several overdoses of pills
cut and burnt herself
wrote incoherently and in a bizarre way of despair and suicide
slit her wrists
delusional, grandiose and paranoid

Internal Space
none

Figure 3: Emily's schizophrenic Representational World.



Representational World:

Analyst
none

Experiences
loneliness
misery
despair
hopelessness
fear
molestation aged 8 years (still unconscious)
first breakdown aged 20 years

Dreams/Representations
black psychopath: sleep paralysis

Observations (she had observed from father)
Plaits not beauty, aged 14 years
"My, my!" upon learning of school scholarship
"gesture" upon making cake
"horrid [Claire]" in hall
guilt – had disclosed embarrassment in bath to Nannie
"pathetic creature" as a teacher
"NHS on its knees" as a House Physician

Determining Orientation
schizophrenia
depression

Internal Space
misery

Figure 4: Woman aged 20 years' schizoaffective Representational World.

Analyst

Experiences

Internal Space

Dreams/Representations

Observations

Determining Orientation

Representational World:

Analyst
intelligently and kindly clarifies the patient's mind.

Experiences
happy with husband
beautiful home
music
poetry
Medical studies
friends

Dreams/Representations
wishing she was well: and now is
psychoanalysed dream: of her father as a granite tenement building surrounded by deep rivers and cowpats: her mother as a woman in its brightly lit basement kitchen, surrounded by children.

Observations
pleased that her sister said to her: "You are the only one who understands"
"I was glad you were there"
so happy to be alive
delighted to be living with joy and integrity outside her family of birth

Determining Orientation
neutral

Internal Space
contained her abreaction emotion: "I'm innocent! I'm innocent! I'm innocent!"

Figure 5: Woman aged 71 years' schizoaffective Representational World.

The representational world of the schizoaffective woman is illustrated herein, miserable as it was at the onset of her first illness aged 20 (Figure 4), which was still in its distressing state at the start of her first psychoanalytic psychotherapy treatment aged 28. Her representational world following her wholly successful second therapeutic psychoanalysis, completed at the age of 71 when it was resolved and happy, is also illustrated (Figure 5).

The extended PPCC model (Figure 6) demonstrates the overall therapeutic process for a schizophrenic or schizoaffective patient, according to this model, from the commencement of psychoanalytic psychotherapy to its conclusion. The woman's therapy followed this process: psychoanalytic psychotherapy for 4.5 years starting at the age of 28 years (there had been an 8 year delay after the onset of her illness aged 20 years for educational reasons, during which time her illness was managed with medication and supportive psychotherapy) to her good mental health at the conclusion of her second, 7 year treatment aged 71 years. This extended PPCC model of the woman's psychologically disturbed history, involving her two courses of psychoanalytic psychotherapeutic treatment, concludes as a rolling, functional sphere; the sequence diagrammatically illustrates her eventual mental freedom and health, reached after much therapy. Her recovery is completed once remaining psychological hindrances such as anxiety, irritability or lack of confidence have been "rubbed off" her now functioning, intact psychology, through social interaction with friends and contacts during her convalescence. Her final stage in the PPCC's extended model, as a smoothly rolling, functional sphere, describes her happiness in the mental health she recovered in her later life consequent upon her entirely effective second therapeutic psychoanalysis. This happy state is demonstrated in her representational world at the age of 71 (Figure 5). Her schizoaffective illness, treated with two courses of psychoanalytic psychotherapy, may be seen as a temporary illness in her life, being preceded and concluded by clear mental health, facilitated by medication. Today, there are many maintenance therapies addressing diverse symptoms which can ease these and comfort schizophrenic patients who are not suitable to undergo psychoanalytic psychotherapy.

Aetiological scientific paradigms underlying the clinical findings

Genetic basis

Genes for both schizophrenia and bipolar disorder, which include the genes for schizophrenia and schizoaffective disorder, the illnesses that are discussed in this paper, are widely held to overlap considerably. There appears to be no single gene responsible for schizophrenia, which is unsurprising considering the wide range of symptoms in schizoid illnesses. Clinically it is unclear how these genes interact; but it is known that bipolar disorder and schizoaffective disorder occur more frequently in families with a schizophrenic member than in families where psychotic and schizoid illnesses do not occur.

Interactions with N-methyl-D-aspartate (NMDA) receptors are known to be part of the process of gene expression in schizophrenia. For example, the effect of serine on NMDA receptors may be 'modulated' [adjusted] indirectly by the gene G72 on chromosome 13q, which has been reportedly linked to schizophrenia [11]. Further, it is known that genes in schizophrenia "relate to the NMDA receptors and their interactions with neuromodulatory [neurologically-adjusting] systems that are, in turn, under control of afferent projections from cortex with NMDA receptor plasticity" [12], "eg. prefrontal connections targeting midbrain dopamine neurons" [13]. Bonci and Malenka's paper "Properties and plasticity [adaptability] of excitatory synapses on dopaminergic and GABAergic cells in the ventral tegmental area" describes effects of genes on NMDA receptors that are in the cerebral cortex [12] including the prefrontal cortex [13]. Thus Bonci and Malenka state that genes in schizophrenia relate to NMDA receptors and their interactions with neuromodulatory systems which are projected from the cerebral cortex; while Sesack and Carr indicate that these projections include specifically prefrontal connections targeting midbrain dopamine neurons [13] such as the A10 nucleus, the source of the mesolimbic mesocortical dopamine pathway to the prefrontal cortex and the nucleus accumbens. Professor Peter Williamson's findings support the work of Sesack and Carr: "Glutamatergic neurons in the prefrontal cortex….. regulate A10 dopaminergic neurons via projections to the ventral tegmentum." [14], directly affecting the symptoms of schizophrenic patients due to the effects of dopamine from the A10 nucleus on the prefrontal cortex.

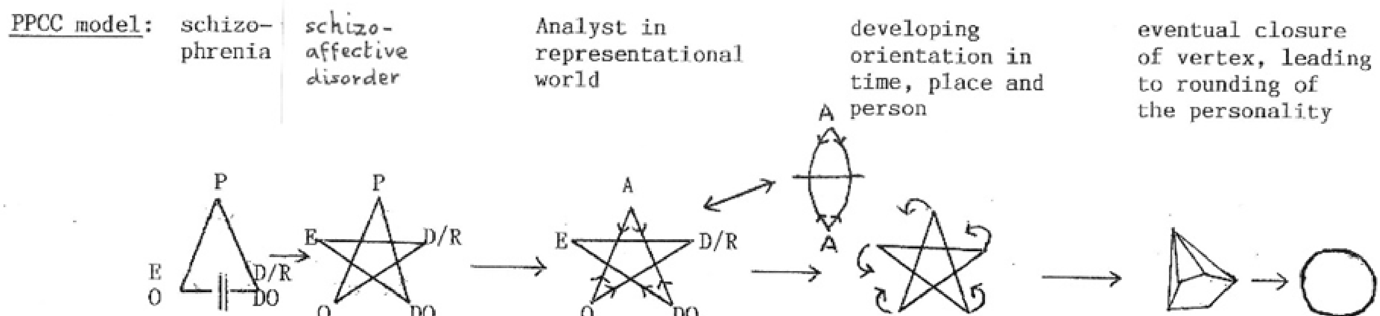


Figure 6: The overall sequence of changes in the mind of a schizophrenic or schizoaffective patient during psychoanalytic psychotherapeutic resolution of the illness according to the PPCC model.

Professor Karl Friston explains through his dysconnection hypothesis that it is NMDA receptors' functional response to neuromodulatory systems in the cerebral cortex which, when malfunctioning, is implicated in schizophrenia. He confirms that genetic expression leads to neuromodulation of NMDA receptors and, after many physiological and neurological interconnections, to schizophrenic symptoms. "Crucially, the dysconnection hypothesis explains how the physiological consequences of abnormal modulation of NMDA receptor-mediated plasticity (such as altered pyramidal cell gain) translate into computational impairments at the level of neuronal circuits – and how this leads to false inference and psychomotor poverty" [3].
As an early stage in gene expression Professor Friston writes: "The genetic alterations in schizophrenia have pathogenetic implications for NMDA receptors and their interactions with neuromodulatory transmitters". Genetically-based errors in NMDA receptor functioning are shown to affect prefrontal cortical activity involved in schizophrenic patients' thinking [3]. He writes further that it is plausible to say that "schizophrenia is caused by de novo or inherited mutations of one or more genes that influence the expression of (other genes and) proteins mediating the neuromodulation of synaptic efficacy or postsynaptic gain [excitability], in specific brain systems; particularly prefrontal systems", and that he thinks that "this molecular pathology arises from an abnormal response of the NMDA receptor to specific (eg. dopaminergic) neuromodulatory receptor activation".

More broadly, it is known that genetic mapping "identifies many associations between genetic variants and psychosis" [15] as in the example of gene G27 on chromosome 13q's reported link to schizophrenia. It has not so far proved possible, however, to utilize knowledge of schizophrenia's genome in clinical practice to moderate symptoms of illness in patients suffering from schizophrenia.

The woman discussed in this paper and her schizoaffective sister clearly inherited from their father some genes found in schizophrenia; their two brothers did not show signs of inheritance, but may have inherited some genes that did not become manifest through clinical penetrance. Their father's intrusive schizoid behaviour towards both the sisters provided ample opportunity for them to be presented with a schizophrenic bind by him. They evidently suffered both this genetic schizophrenic complement and the binds illustrated from the woman's case history (above) and from her sister's early life. Under these conditions the appearance of psychotic and indeed schizoid illness in both their lives would appear to have been inevitable. Their mutual diagnoses of schizoaffective disorder are explicable as the outcome of their genetic complement from their father and binds and educational stress they experienced within the family. Their father's invasive behaviour may be seen thus to have affected his wife, the woman, her sister, his grandson, the manipulation of his colluding son, and the attitudes towards life of his second son who, devoted to him, named his son, like himself, after him.

Neurophysiology

Physiological processes in the brain's neocortex have been closely studied in relation to schizophrenia. The consequences of these neurophysiological processes are mooted as underlying the schizoid illnesses seen in both the woman described in this paper and in her sister and father. Professor Karl Friston has elucidated as the dysconnection hypothesis a physiological process occurring in the neocortex that involves errors in the communications between small pyramidal cells in layer 3 of the cerebral cortex and large pyramidal cells in layer 5 [3]. This is a functional error in brain processes which arguably leads to psychological effects of functional dysconnection in NMDA synaptic efficacy and subsequently to disintegration of the psyche. Behavioural processes in schizophrenic and schizoaffective patients such as psychomotor poverty are also affected. Professor Friston shows how interaction between the two layers of pyramidal cells involved in sensory processing normally produces a system of 'predictive coding' between the two layers: the cells make interactive predictions of their respective representations. However, sometimes these predictions involve errors in the pyramidal cells' communications with each other, which occur physiologically through maladjustment of nerve cell receptors such as NMDA receptors. Mismatch between a pyramidal cell's prediction, ie. its expected result from its NMDA receptor-based connections with other cells, and the actual result, is termed a prediction error. Abnormal processes involving NMDA receptors affect the pyramidal cells' predictions and cause some neuronal circuits in the brains of schizophrenic patients to malfunction [3].

The errors proposed in Professor Friston's account of the cortical pyramidal cells' prediction errors become manifest as cortical, conscious symptoms. The patient's thoughts are distorted. This can lead to psychological false inference and physical psychomotor poverty. False inference is involved in delusions, such as the delusional system of the father of the woman described above: delusions about his personal social standing, big houses, money, and imagining that he was some kind of aristocrat eg. purchasing as his family car a 1934 Rolls Royce with a registration number BMA 1. The woman also made a false inference in the hall by thinking guiltily that she must have been "horrid to Daddy"; whereas the true situation was that he was asserting unpleasant and untrue behaviour towards her when the horrible attitude was his own. The consequences of these dysfunctional neurophysiological processes are seen as affecting both the woman described in this paper and her father.

Professor Friston's example of prediction error is the projection from a cat of a shadow that looks like the shadow of a dog. The mistake caused by the prediction error is then to conclude that the shadow is caused by a dog. In this case, the case of observing the cat and "the dog", cognitive function has been disturbed in an individual regarding the shadow, precipitating an error in attribution.

This process may be called sensory misattribution. This fundamental misattribution may become more generalized at a

higher level and lead to false inference, as in the history of the woman described, when she misattributed the unpleasant content of "Why is [Claire] so horrid to Daddy?" to herself and not to her father. She erroneously felt guilty herself, as a false inference, when guilt should have been her father's guilt in not taking care, as a parent, of his daughter. This is an example of the accumulation of guilt by the woman throughout her lifetime that weighed heavily on her experience of being alive; this weight bore heavily on her during her Medical studies, her initial psychoanalytic psychotherapy, her life between this first treatment and her second period of therapeutic psychoanalysis, and during this second period of treatment. Her two guilts, of the sexual intrusion and then by this apparent, misattributed and falsely inferred, responsibility for "being horrid to Daddy", caused unconscious confusion; and when triggered by an environmental factor, in this case her father's dismissal of her loving effort to please her grandparents with a golden wedding anniversary cake, these unconscious confusions became conscious confusion. This precipitated schizoaffective psychosis, which continued during her life as her susceptibility to psychosis. It was not until the abreaction she experienced at the end of her second treatment, aged 71, which released all her lifetime's accumulation of guilt from her father which she had borne instead of him, that she became free of this heavy weight upon her.

The bases for Sara's and Emily's guilt-related double binds are clearly demonstrated. Sara's guilt related to her sexuality, in the context of men as a group. In her family she was disregarded as a girl, since girls were considered inferior to macho boys, and she considered herself to be a castrated male. Allowing men to sexually abuse her will have given her more, active, non-consciously registered guilt, as well as, possibly, conscious guilt; and she felt passive unconscious guilt when on her own about her sexuality, thinking she was a castrated male. Her double bind consisted of guilt when sexually active and guilt when on her own.

Emily's double bind related to her body being cut and to her father. She had to take part actively in tolerating surgical assaults by her father, and there is no mention in her history of consciously resenting this; as her response, she will therefore have non-consciously registered it with guilt and fear and other emotions. She felt sufficient unconscious guilt about it, however, to cut and burn herself and scratch her abdomen till it bled, which will have given her further unconscious guilt. Her double bind, relating to her father, consisted of herself actively taking part in her father cutting her, which caused her to feel non-consciously registered guilt; and she incurred further unconscious guilt by cutting and burning herself and scratching herself until her abdomen bled.

The severe misery of these patients, described both through their miserable representational worlds and their double guilt binds, are mooted to influence the brain's wellbeing centre, the nucleus accumbens. When this misery reaches an intolerable level in schizophrenic or schizoaffective patients, the nucleus accumbens as the wellbeing centre of the brain influences, due to decreased glutamatergic feedback inhibition, the A10 nucleus in the midbrain. The A10 nucleus is a homeostatic nucleus in the midbrain ventral tegmental area, surrounded by other homeostatic nuclei which influence the body's blood pressure, pulse rate, blood saturation levels of oxygen and carbon dioxide, and temperature. The A10 nucleus, being exposed to only decreased feedback inhibition from the nucleus accumbens, accordingly stimulates this nucleus by its dopaminergic mesolimbic mesocortical pathway to secrete excessive amounts of dopamine, to ameliorate the miserable state of the patient. The prefrontal cortex is also stimulated by this pathway to produce excess dopamine. In a notable proportion of cases of schizophrenia it has been found that the prefrontal cortex has been damaged by oxygen deprivation, considered to have taken place perinatally. This damaged prefrontal cortex is adversely affected by its own excessive dopamine secretion and that of the nearby, posterior, nucleus accumbens. It is unable to process as part of its general malfunctioning the extremely dysphoric cortical thoughts including confused unconscious or conscious guilt, and the dysphoric limbic system emotions, also including guilt, that the cerebral cortex and limbic system of these patients present it with. These consequences of the patients' double guilt binds and miserable representational worlds produce from the prefrontal cortex distorted or psychotic words and behaviour: the clinical picture of schizophrenia.

Both the schizoaffective woman described herein and her schizoaffective sister required antipsychotic medication to suppress the excessive dopamine secretion in their brains, and mood stabilizers. Electroconvulsive therapy is sometimes used to treat severe depression, as is sometimes found in schizoaffective disorder and as was needed in the case of these two sisters; the woman received one treatment, while her sister required 12 treatments. The sisters both had to endure 8 and 10 years respectively of very disciplined, and very isolated, lonely, and extremely pressured, academic schooling at a boarding school 400 miles from their home. The sister collapsed mentally during her second year at the secondary boarding school; the woman collapsed mentally during her second year at University. Their representational worlds were so lacking in emotional support, and miserable, together with the double binds persisting in their minds even away from their home, that the dysphoric experiences outlined above led to excessive dopamine secretion by the nucleus accumbens and prefrontal cortex, and consequently, it is argued, to their psychotic schizoaffective illnesses.

Pharmacology

Antipsychotic drugs, together with mood stabilisers in the case of schizoaffective disorder, regulate the patient's brain physiology sufficiently for psychoanalytic psychotherapy to be practised effectively. Conversely, psychological therapy may lessen a patient's need for medication. A Psychoanalyst who is also Psychiatrically trained can, from his experience, weigh the relative influences of the therapy he delivers with the patient's need for medication. Commonly, he would discuss the latter with the patient's ward Psychiatrist. The patient's progress is as dependent on careful supervision of her medication as on her psychological therapy. Both contribute fundamentally towards a successful outcome.

Modern "atypical" antipsychotic drugs such as clozapine, risperidone, aripiprazole and quetiapine are used today in place of older, "typical" drugs such as chlorpromazine, haloperidol and trifluoperazine. Mood stabilizers currently used include lithium carbonate which is particularly effective, sodium valproate and lamotrigine. Antagonism of the neuromodulator dopamine, especially relating to D_2 receptors, is the main determinant of antipsychotic action.

Antagonism of D_2 receptors in the nucleus accumbens by antipsychotic drugs which affect the dopaminergic mesolimbic pathway between the A10 nucleus and the nucleus accumbens is held to be these drugs' main antipsychotic action in the alleviation of the positive (active) symptoms of schizophrenia. Antagonism of the related D_1 receptors in the prefrontal cortex by antipsychotic drugs affecting the mesocortical pathway between the A10 nucleus and the prefrontal cortex is held to exacerbate negative (passive) schizophrenic symptoms such as psychomotor poverty. Professor Karl Friston's dysconnection hypothesis links the dysfunction of the prefrontal cortex's pyramidal cells due to the influence of neuromodulators such as dopamine, to psychomotor poverty, a negative symptom sometimes seen in schizophrenic patients.

Different antipsychotic drugs affect the distributions of D_1 and D_2 receptors differently, leading to the necessarily careful prescription of medication for each schizophrenic patient's particular combination of symptoms. When the patient's psychotic symptoms are controlled by medication, psychoanalytic psychotherapy may be conducted effectively. Many symptoms are due to dopamine's effects on the prefrontal cortex. Medications that suppress dopamine production in the nucleus accumbens and prefrontal cortex are the main group of currently used medications in the control of psychotic symptoms. Malfunctioning in the prefrontal cortex, due to local excess dopamine, gives rise to mistaken thoughts including delusions. Psychoanalytic examination can help to resolve these mistaken thoughts effectively when skilfully administered antipsychotic medication controls patients' psychotic symptoms.

Conclusions

Much improvement in the treatment of psychosis has been gained during the past 50 years. When the scientific paradigms of genetics, neurophysiology and pharmacology have been applied to clinical science, psychoanalytic psychotherapy could be progressively used to treat newly ill schizophrenic and schizoaffective patients when they are most accessible to therapy. Improvements in treating these patients could steadily be developed if even some of this new knowledge is used to adapt psychoanalytic psychotherapeutic technique to further psychotic patients. Good health can be the outcome even for schizoaffective disorder and schizophrenia if psychoanalytic psychotherapy is skilfully administered, correct medication for different phases of progress is selected, and sufficient care is taken of a patient who is determined to become well. It is to be hoped that, in this way, more solutions to suffering among the most severely mentally ill could be achieved and most welcomed. Considerable skill is required when treating psychotic patients with therapy, but a good start has been achieved, especially since the 1990s [4]. Collaboration and pooling of clinical resources in a proof of concept study would, if successful, provide the means of establishing such therapy on a generally accepted foundation.

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