Findings that shed new light on the possible pathogenesis of a disease
or an adverse effect

The process of recovery of a schizoaffectively disordered mind: a psychoanalytic theory of the functional psychoses, the psychodynamic pentapointed cognitive construct theory

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Summary

A schizoaffectively disordered young woman made a small study of her mind while she was in psychoanalytic psychotherapy so that she might understand herself better. She worked closely with her psychoanalyst, and with the researcher who wrote up her case. She had a very difficult time for 30 years, but by the end of that time emerged completely recovered and with a great zest for life. This paper provides rare positive/constructive data about the processes involved in a case of schizoaffective disorder that involved manic as well as depressive and schizophrenic symptoms, and also the patient's stages of recovery. It demonstrates how psychiatric and psychoanalytic principles are inextricably linked together both in understanding this patient's ordeals and in her successful treatment, and suggests the clinical potential for theoretical and practical engagement between psychiatry and psychoanalysis.

BACKGROUND

Schizoaffective disorder is a treatable condition involving survival of the personality between psychotic episodes which with treatment cease after early adult life, leaving the personality intact. Schizoaffective disorder may manifest symptoms of the three functional psychoses, schizophrenia, depression and mania; sometimes mania is absent. The relationships between the three functional psychoses were unknown in any patient before this study, as were the precise psychodynamics of any schizoaffectively disordered patient's recovery. Following treatment, this patient still had vulnerabilities, but because she now understood that she was able to self-regulate her emotional life and interact successfully with the outside world. She knew she had an enormous debt to her psychoanalyst, and was pleased to work with the researcher in writing up her perceptions about herself as these progressed. The researcher was cognizant with the principles of psychiatry and with psychoanalytic ideas, and drew up a theory which accommodated the details of the patient's psychodynamic progress. This paper is presented as an academic outline of the process of recovery from a form of schizophrenia when not very much is known about this illness or what can be expected from treatment. Not all therapies have as successful an outcome as this one, but it may serve as encouragement towards what is possible, and to promote discussion between psychiatry and psychoanalysis in working together towards ever-better experiences for the psychotic patient when they are afflicted with such a serious condition.

CASE PRESENTATION

Case 2 was exemplified after Case 1, a patient with morbid jealousy, in the Companion to Psychiatric Studies¹

published in 1973, as being one of 'two people [who] are mentioned not to illustrate any particular pathology but to highlight the powerful reality of the forces that threatened them with grave consequences, and in face of which they were helpless, and which they were reluctant to reveal'. The Companion also states:

'As a specialist source of help, the psychiatrist has got to understand, for example, how the following difficulties can arise and be ameliorated:

'Case 1: A patient with morbid jealousy ...

'Case 2: An attractive, intelligent and sociable student after a successful first year at university found herself unable to carry out the tasks set by her tutors. She failed her second year and in the further period granted to her, she was about to fail again. Despite the fact that she faced the termination of the career on which she had embarked with high hopes, she could not get herself to work. She became convinced that her teachers thought 'she was no good'. At the same time, she began to make demands on various people, general practitioners and others, for 'something' to get her out of her difficulties'. (p. 265)

The Companion continues: 'The psycho-analytic method, the most widely used and best described instrument for investigating the nature and origins of the conflicting forces in the person, has been applied during three quarters of a century to an increasingly diverse range of personalities, from 'non-patients' in the form of professional workers of various kinds, through the full range of the neuroses and character disorders to severely ill hospitalised psychoses'.

The patient, Case 2, suffered from a schizoaffective disorder that involved symptoms of depression, mania and schizophrenia. This is a treatable affective psychosis in

which episodes recur during several years of early adult life and then cease with treatment, leaving the personality intact because this is fully restored between successive episodes. A schedule of combined biological, psychological and social treatments restored the patient to full mental health. It was her Kleinian psychoanalysis which ensured that she learnt to use her mind in order to proceed beyond merely surviving her disorder into experiencing life actively and energetically.

The patient's small study

The researcher investigated the schizoaffective disorder of the patient psychoanalytically. She had not encountered any clear psychoanalytic explanation of the three main functional psychoses or their interrelationships as a connected group of conditions, thus depression, mania and schizophrenia. This patient's schizoaffective disorder juxtaposed these three conditions, together with the intervening periods of normality, and the researcher saw that it could be investigated from a small study the researcher knew that the patient had made. The patient regarded her disorder as an auxiliary curriculum, a challenging syllabus additional to her current studies which was to be addressed and mastered. She therefore made a small study of her mind (see below), and the researcher examined the patient's account of her method and her results, and developed the psychodynamic pentapointed cognitive construct (PPCC) theory based on the patient's data.

Formulation

The patient had suffered mistreatment and repeated misunderstandings by members of her immediate family. In addition, her exposure to close contact with her father's schizotypal personality disorder quite apart from his molestation of her had seriously adversely influenced her emotional and personal development. Her role of familial responsibility for her younger siblings further denied her scope for considering her own needs as an individual growing up.

Her father's schizotypal personality disorder and her mother being prescribed lithium carbonate suggest a genetic basis for the patient's illness, but her traumatic molestation aged 8 years and the effect of this, and subsequent incidents, on her family relationships led to her being completely misunderstood during her development. She had no sense of herself at all, even though she performed well academically.

Contact with medical authorities was infrequent until her first mental breakdown, despite mild eating and social difficulties at her boarding school, 400 miles from her home, where she felt isolated and stressed. Her supportive psychotherapy following her first episode of illness allowed her to continue her University studies, and careful management of three further breakdowns before her psychoanalysis enabled her to work successfully.

Her medication was her mainstay of treatment both before and following her Kleinian analysis. During her analysis her medication prevented extremes of mood and confusional states so that she could concentrate on learning about herself from her analyst's interpretations of her free associations and behaviour. In this way, her physical and psychological treatments reinforced each other in enabling her to develop self-awareness, self-understanding

and self-control. Once she had learnt to control her mind's reactions to her own memories and adverse past experiences, she increasingly successfully mastered her mind's responses to her external environment.

Her prognosis was good from the beginning of her illness because of the nature of her diagnosis, the emotional nature of her predominant symptoms, the level of contact she maintained with her treatment staff, and the effort she put into her psychoanalysis and into taking all her medication. When she became happily married she felt fully understood at last, her situation was more secure and she was able to adopt other new roles such as teaching piano, exercising at a local sports club, helping with neighbourhood Jubilee celebrations, learning to use a computer competently, studying music composition, writing and illustrating a book of poems and working as a secretary. She no longer contacted her original family because of the danger to her health that their misunderstandings posed for her, and vigorously pursued her interests with her husband. She remained on maintenance medication, which was gradually reduced, concentrated on learning to understand herself fully, and eventually ceased to be concerned about her own reactions, predilections and interpersonal responses, aspects of her life which had previously been causes for considerable concern to herself and others. She found inner strength from her relationship with her husband, even steeling herself to face survival without him after he had had an early mild heart attack. The passage of time, improved quality of her relationships and pleasanter life situation all helped to smooth her progress into an excellent quality of life and good mental health.

TREATMENT

The patient was treated initially, and for a period of 20 years, with chlorpromazine, trifluoperazine, imipramine and orphenadrine. Subsequently, she was given a trial of fluphenazine for a year without significant effect. After a bout of major depression she received one electroconvulsive treatment, and her medication was changed to paroxetine, risperidone, lithium carbonate and procyclidine for a further period of 15 years, following which the paroxetine was discontinued. She received 4.5 years of Kleinian psychoanalytic psychotherapy, a supervised hostel placement for 2 years, and outpatient supervision for 21 years. She was admitted to psychiatric wards on 11 occasions, and received supportive and interpretive therapy from 276 staff.

OUTCOME AND FOLLOW-UP

The PPCC theory

Structure of the PPCC model

Four months into her psychoanalytic psychotherapy, on 12 September 1982, the patient realised that she understood so much more than previously, from listening to her analyst, that she wanted to examine her mind in this state. She wished to write a book about her understanding, having realised that she was on the cusp of the illness of her schizoaffective disorder and the clear, normal thinking stimulated by her analyst.

In order to study her mind, she adopted the Buddhist meditation technique of emptying her mind towards

stillness and then quietly seeing what entered it. Ideas steadily emerged at approximately 1-s intervals. These were simple concepts which were to be chapter headings for her book (see appendix).

And then saw that these could be structured diagrammatically into an attractive and symbolic representation of her analyst in her analytic sessions. This structure was her personal construct² that helped her relate to her new and complex situation as an analysand with her analyst. When her psychoanalysis was prematurely terminated due to external factors her personal construct filled the role for her of an abstract transitional object³ which she could hold on to and derive strength from while she continued to emerge from her disorder without her analyst's help.

The researcher recognised that the patient's pentapointed diagram was a psychodynamic representation of her therapeutic dyad. The researcher called this the patient's PPCC and saw that it consisted of scientifically derived and observed data. She saw that, on the cusp of disorder and normality, it comprised the patient's representational world⁴ by incorporating both her illness's influence and her analyst's influence on how she regarded this sample of personally significant features of her life's history (see appendix and figure 1).

The researcher then saw that the PPCC described psychoanalytic features of the functional psychoses manifested by the patient, and set about elucidating the nature of such psychoanalytic and psychosis-related processes as the PPCC construct describes.

Twenty-nine chapter headings emerged in total in the patient's study, with four natural breaks. The five homologous groups, each consisting of between two and nine chapter headings, were each given a group name. Twenty-four years later, these group names were found to be identical to the four variables described in 2006 in the Shorter Oxford Textbook of Psychiatry⁵ (p. 89) as providing data, in the course of psychoanalytic treatment, from which psychoanalytic theories are mainly derived: 'These data relate to the patient's thoughts [spoken thoughts, Observations], fantasies [Fantasies/Facts], and dreams [Dreams/Representations], together with their memories of childhood experiences [Experiences].' The PPCC's fifth variable represents Problems, duly apportioned to the Analyst's domain in order to help the patient.

The PPCC in its original and fundamental form (see figure 1) illustrates the therapeutic dyad in the form of an analyst relating to an analysand. Its outlines demonstrate lines of communication between parts of the analysand's mind and the analyst, and the initial directions of flow.

The Experiences variable represents the analysand's experiences in their lifetime up to and including the present moment. Dreams/Representations is the variable that represents mental representations that the analysand may accommodate in relation to features of their external world, or figures within it, and also the analysand's past dreams. Experiences and Dreams/Representations are the analysand's Established Variables, since they relate predominantly to the analysand's past life.

The Observations variable and the Determining Orientation variable form the Agentive Variables of the

Figure 1 The psychodynamic pentapointed cognitive construct in schizoaffective disorder.

analysand's mind that predominantly engage in communication with the analyst. The Dreams/Representations and Experiences variables are also agentive in depression and mania, respectively, but Observations and the Determining Orientation are agentive in all three functional psychoses.

The Internal Space contains all parts of the analysand's mind that are not represented by the four analysand variables. The analyst is the analysand's predominant internal object,⁶ in his position in the PPCC construct, and other internal objects may be found in the Internal Space. External reality surrounds the PPCC, outside the therapeutic dyad.

The functioning of the PPCC variables

The fundamental form of the PPCC is that of schizoaffective disorder itself. In this condition there is considerable 'splitting' of objects (people) and realities into 'good' and 'bad'. The juncture between the two agentive parts of the analysand's mind, Observations and the Determining Orientation, describes the paranoid-schizoid position.⁷ This juncture keeps apart (split) the Observations and Determining Orientation variables of the analysand's mind, and in this position the analysand is only able to demonstrate tight construing (see figure 1).

If the analysand's state of mind radically improves in treatment, the Observations and Determining Orientation variables conflate, and the PPCC structure adopts its depressive position⁸ form (figure 2), where the analysand is able to demonstrate looser construing with greater freedom of mind.

Wilfred Bion⁹ held that the psychotic patient has a non-psychotic part of his mind in addition to the psychotic part, and this view has been subsequently endorsed by Richard Lucas,¹⁰ Murray Jackson¹¹ and Leslie Sohn¹² in

their clinical work. This egosyntonic, non-psychotic part of the analysand's mind is represented in the PPCC model by the Observations variable, and the psychotic part by the Determining Orientation variable. The Determining Orientation variable describes which form of psychosis prevails at a given time, thus depression, mania or schizophrenia, by representing Facts (depression), Fantasies (mania) or Concrete thinking (schizophrenia).

Distortion of the PPCC in each functional psychosis

In depression the analysand is commonly affected by facts such as the very sad loss of a loved person or other valued part of their life. In mania fantasies commonly provide a defence from the pain of depression; and in schizophrenia a form of concrete symbolisation prevents the analysand from being able to use metaphor, and concrete thinking may prevail. Some immature thinking styles sometimes seen in childhood identified by Peter Fonagy¹³ bear some resemblance to the kinds of thinking that are active in the functional psychoses. Psychic equivalence, where the child perceives eternal reality to correspond with his own internal world, is similar to the bleak nature of the external world registered by the patient suffering from depression in his internal world. Pretend mode, where fantasy leads to a mental state of self-deception and a rejection of alternative realities that threaten the pretend mode, is in some ways similar to the subjective distortion of self in context seen in mania. Teleological thinking, where a child understands agency purely through physical actions and constraints, is similar in some ways to schizophrenic concrete thinking, where in symbolic equation,¹⁴ as shown by Segal, symbols are used as if they were the actual 'things-in-themselves'¹⁵ (after Bion). The Determining Orientation variable represents Facts as they affect

Figure 2 The psychodynamic pentapointed cognitive construct in the depressive position.

depression, Fantasies as these are found in mania (mania is thought to be a defence against depression, and is not primarily a reaction to external facts) and Concrete symbolisation as this is found in schizophrenia. The fundamental PPCC construct for schizoaffective disorder subsequently changes to describe the dynamics of each functional psychosis (figure 3).

Distortion of the PPCC in depression

A composite psychoanalytic model for depression is provided in figure 4, illustrating Freud's theory of depression combined together with two theories of Jerry Fodor and Wilfred Bion. Brown and Harris's study¹⁶ of 1984 demonstrated that the most common aetiological factor evident among their studied depressed subjects was the previous loss of a loved person, thus confirming Freud's theory. Fodor's and Bion's theories suggest more generally how, in mental functioning, one mental factor can combine with a second mental factor to produce an outcome, thus a content-laden mental state or a conceptualisation, respectively.

This composite psychoanalytic model in figure 4 upholds accurately Freud's theory of melancholia and can

be applied to the process of the mechanism of inception of Major Depressive Disorder in terms of a very sad Mental Representation (Freud's 'shadow') and sad Observations made by a patient (Fodor's Person O regarding very bleakly the external world which has borne the sad Fact of the loss of a loved person). Conflating Freud's with Fodor's and Bion's theories of mental functioning illustrates how Freud's theory of depression demonstrates a similar, parallel mental process to those studied in cognitive thinking (Bion) and philosophy of mind (Fodor).

The philosopher Jerry Fodor's Representational Theory of Mind¹⁷ holds that a Person O develops a content-laden mental state or Propositional Attitude A as a result of standing in a 'functional or computational' Relation R to a Mental Representation MP. The Propositional Attitude is a belief, desire, hope or concern about a particular content such as 'My friend's illness is serious'. The Mental Representation has a causal relation to the worldly facts which it is about, encodes the content of the Propositional Attitude, and is its internal vehicle, that is, conveys or bears it. For a Person O to believe that 'My friend's illness is serious' is for Person O to stand in Relation R, constitutive of believing, to an internal

Figure 3 The psychodynamic pentapointed cognitive construct in schizoaffective disorder and its adaptations for major depressive disorder, mania and schizophrenia.

Figure 4 Comparison of the mental processes of Bion's and Fodor's theories of thinking with Freud's theory of depression.

functional state of the person, a mental representation which means that 'My friend's illness is serious'. So if the Mental Representation (Freud's 'shadow') has a very sad content (the lost loved one), and Person O makes consistently sad Observations of the external environment that now lacks their loved one, the content-laden mental state resulting from Fodor's Relation R might well be, consistent with Freud, so melancholy that this overwhelms the patient as depressive illness. Major Depressive Disorder may result from this psychogenesis if brain physiological processes are also conducive towards illness.

The psychoanalyst Wilfred Bion hypothesized¹⁸ that identifying an object consists of a cognitive process whereby a preconception 'mates' or 'coheres' with a sensory experience or realisation to produce a conception. In his theory, if a preconception mates or coheres with a negative realisation, frustration results. This frustration, if it can be adequately tolerated, leads to an alleviating thought and to the development of a non-psychotic part of the mind. If the personality cannot tolerate frustration nor produce a thought it founders in psychosis.¹⁹ Thus Bion's cognitive process and Fodor's philosophical process have similarities to Freud's affective process, whereby two mental entities psychologically combine within a process of interrelationship, leading to a mental outcome. This is the kind of process described by the PPCC model as elucidating the psychological mechanisms underlying the functional psychoses and the mechanisms of their alleviation in the case of this patient. The sequential steps for the developmental process of depression are outlined in figure 5a, and these points are summarised in an operationally identical diagram of the PPCC in action (see figure 5B).

Distortion of the PPCC in mania

In mania, a similar but reciprocal process takes place. Manic defence is the central relation in place of Fodor's Relation R in depression, between sad Observations provoking reactive fantasies and a mood of euphoria resulting from an unconscious experience of the superego fusing with the ego (Freud's theory of mania). More fantasies

feed the manic or hypomanic state and the patient develops prevailing manic representations, especially of the self, which sustain their condition. These stages in the development of mania are outlined in figure 6A, and are summarised operationally in identical steps in the functioning adapted PPCC model (figure 6B).

Integration with Freud's theories of depression and mania

Sigmund Freud considered that in depression 'the shadow of the object [loved person] fell upon the ego' of the future patient.²⁰ The shadow may be considered to be a representation of the object. Therefore in this PPCC model the variable Dreams/Representations translocates as indicated (see figure 5B). Similarly, Freud's view of mania was that 'the ego and the ego ideal have fused together'.²¹ This would be a process occurring within a single mind, that is, an experience, so in this model the variable Experiences translocates as indicated (see figure 6B) to produce the form of the PPCC specific for mania.

Distortion of the PPCC in schizophrenia

Schizophrenia, in the PPCC Theory, is a condition resulting from a patient suffering unliveable unconscious, and usually also conscious, internal conflict between at least two intolerable perspectives, Schizophrenic Global Perspectives (SGPs) 1 and 2. SGP1 and SGP2 are incompatible and highly unpleasant perspectives of the same environments. Normally if a person experiences an environment intolerably they would remove themselves from it. In schizophrenia, the nature of the mind is such that the only alternative way of looking at the patient's life's environments is barely tolerable rather than quite intolerable. For example, in a case of molestation which has resulted in a schizophrenic experience, a molesting parent may be experienced as intolerable, stimulating a prevalence of nameless dread²² and bizarre objects.²³ The only alternative way of looking at this environment for the patient at that time may be, in their despair, as the other, unacknowledging parent or as oblivious siblings who think the confident molester is an ideal parent. It is not

Figure 5 The psychodynamic pentapointed cognitive construct illustrating the development of depression.

until therapy opens up avenues of a third, egosyntonic alternative to these two Schizophrenic Global Perspectives that the patient may eventually be able to tolerate some of these entirely unpleasant components of their life. Learning to use their mind, in creative and constructive endeavours, opens a non-psychotic mental haven for their mind in which the patient can work and rest, and, very much later, attempt to integrate the psychotic parts of their mind in the depressive position (figure 7).

After a truly immense amount of therapeutic work, the schizophrenic global perspectives may become liveable with for the patient. The completely intolerable SGP1 may eventually become compatible with the paranoid-schizoid position; and the barely tolerable SGP2 may ultimately become compatible with the depressive position. The patient may develop capacities of empathy, forgiveness, personal insight and tolerance on a broad scale in therapy with their analyst. While SGP1 and the paranoid-schizoid position may remain very unsatisfactory and the split original, fundamental schizoaffective form of the PPCC may persist, the patient may alternatively learn to tolerate SGP2. If an egosyntonic perspective, the non-psychotic Observations variable, is

facilitated significantly by the analyst, and SGP2 matures to become compatible with the depressive position, then the egosyntonic Observations variable conflates with SGP2 and the psychotic part of the patient's mind becomes absorbed into the non-psychotic part. This takes the form of a deep understanding and empathy of the psychotic features of the patient by their sane mind which the analyst has encouraged to develop. Feelings of reparation,²⁴ as described by Melanie Klein, at last are then able to be felt, since the unpleasant perpetrator of the molestation problem and their oblivious supporters can be forgiven, the SGPs may become tolerable, and the patient may adopt their egosyntonic, constructive attitude towards the whole of their life. The schizophrenic experience can then be tolerated until it recedes away from fresh, life-affirming experiences.

Progress beyond psychosis

The original, fundamental form of the PPCC describes processes taking place in the psychoanalyst's consulting-room. After a very great amount of work by the therapeutic dyad, the analysand may become able to relate to memories of experiences from her earlier life, more

Fig. 6a

Fig. 6b

Figure 6 The psychodynamic pentapointed cognitive construct illustrating the development of mania.

benignly than she did at the start of treatment when these caused her so much pain, having originally been so traumatic. Gradually, the analysand may become able to build up a picture of themselves, and of their life, which approximates well to normality. This marks tremendous progress, since the traumatic nature of the past experiences may have shocked all reality far beyond her access to it. This psychological position was the only one the patient was aware of prior to treatment, beyond ephemeral consolations that had broken into her life and at these times convinced her of the goodness of life. Her psychological stance at the time of starting analytic treatment was one of complete helplessness and some awareness of possible grave consequences if she did not understand what her solution might be: in this the Companion to Psychiatric Studies was quite correct.

Eventually, and with much work with her analyst, the nullification of her mind which the patient may have experienced may prove to be only temporary. To achieve this, the analysand needs to be able to tolerate all her memories, and all her experiences of remembering, and to have recourse to accommodation, a social network, finance, continued access to her analyst, and some innate strength from inspirations she has imbibed along her life thus far.

By looking backwards, and by introspecting, in the company of her analyst, the patient is enabled to learn about herself. Her analyst may be the first truly benign, intelligent, cheerful person she has ever spent long intervals of time with. Hearing him continuously speaking over, above, beyond and through her mind, and thus in the kindest way both containing and penetrating her mind while she may be quite unable to think during her sessions, may allow her to

Fig.7a The PPCC tending towards illness in schizophrenia

Fig.7b The PPCC tending towards resolution in schizophrenia

Figure 7 The psychodynamic pentapointed cognitive construct illustrating the processes towards illness and towards resolution in schizophrenia.

feel emotionally perfectly normal for the first time since her earliest years. The patient may become enabled to relax and strengthen from her disabled state, and thereby learn to use her mind normally, and also naturally. In doing so, the schizophrenic process is reversed and then left behind.

Integration over time

After sufficient practice at addressing her past, the previously psychotic analysand may eventually find that she has nothing to fear from it. She may become able to reflect upon all her memories, and upon all the people she had encountered since her birth, benignly. At this point, she becomes oriented in time regarding her lifetime, as well as in person (with her analyst) and in place (in his consulting-room). The PPCC's variables integrate, and the PPCC's vertex closes (figure 8).

When the patient has experienced real confidence in her own mind's perspective, this solidity may be perceived conceptually as a solid entity (see figure 8) that can contain the psychoses' aetiological conflicts. Her life in retrospect can appear to be transformed, while currently and actively using her mind, and her human qualities of reparation and commonsense continue to be paramount.

Closing the vertex

Closing the PPCC's vertex is an immensely important stage in the patient's progress, since it endorses the innocuous nature, regarding the provocation of psychotic effects, of the patient's past experiences. New awareness of these experiences' benign nature, as discussed interpretatively and reassuringly with the analyst, overlays their previous fearsome implications and potential for the

Figure 8 Overview: the long-term resolution of a schizoaffective mind illustrating incorporation of the analyst's influence, the closure of the vertex, and the mind's integration into a unified whole.

patient. So the PPCC becomes a solid structure describing the patient's mind now resolved from the damaging effects of her past life-experiences (see figure 8). It incorporates the influence of her analyst, becomes rounded and more responsive and balanced, and finally the patient's mind may itself be experienced as functioning smoothly. Thereafter the analyst's task is to concentrate on focusing on the external world of reality around her, and to become routinely and normally productive and resilient.

DISCUSSION

From the perspective of the medical science of psychiatry, however, it is described it is the human mind that demonstrates psychosis: therefore self-sufficient and parallel descriptions of theoretical processes occurring in the non-psychotic human mind deserve scrutiny in order best to understand its native state. Integrating philosophy of mind, psychology and psychoanalysis is necessary for understanding the psychogenesis of psychosis because these approaches are each able to describe mental function: and psychosis is an outcome for several kinds of mental pathways' dysfunction. It is helpful, therefore, to consider how these academic approaches to the healthy mind can each describe from their own perspective their pathways to health or to pathology, and to compare these with each other (see figure 4).

Drawing analogies between similar theoretical functional patterns (Fodor's, Bion's and Freud's theories of mental functioning) that effect mental events, such as the alternative outcomes of psychosis or a normal propositional attitude, allows consideration of the likelihood of these patterns operating in mental life. In this instance, as shown in figure 4, three different perspectives apparently lead to the alternatives of psychosis, depressive psychosis, a normal propositional attitude or a thought. The three processes are parallel and similar but agree on the essential mechanism: that is 'functional/computational', 'falling upon' or 'mating or cohering'. This would appear to be the mechanism operating not just in psychotic depression or melancholia (Freud) but in normality (Fodor) also, and in the initiating of either thought or psychosis (Bion). At present, not enough information equivalent to that for depression is available to support the PPCC Theory of mania or schizophrenia.

A patient who suffers a psychotic episode has ceased to remain generally oriented in time, place or person. Their

brain has ceased to permit conscious function, that is, mental function according to its secondary process,²⁵ In its place, uncontrolled unconscious or primary psychological process²⁵ determines the patient's mental functions.

At such a time, the patient's links to external reality are broken. Between such episodes they have a window in which to forge connections with reality, ideally through a psychoanalyst seeking contact with the non-psychotic part of their mind. This patient took her chance to examine in her small study what her links with the world, as she knew it in her mind, actually were. Her representational world, condensed into her personal construct, encapsulated her links to external reality and fortified her for some 30 years, keeping her in touch with reality through each and every potential or actual psychotic episode during this period of time.

In the patient's awareness just before she did her study, the influence of her analyst on her mind balanced the influence on it of her illness, so she reasonably expected her resulting psychodynamic representational world would be substantially representative of the psychologically beneficial effect of psychoanalysis in balance with the psychologically debilitating effect of her illness: this was especially so, given also the mental freedom provided to her by all the support of her medication and social support. This balanced meaningfulness, for her, was why she set such great store by her study's results, and eidetically conceived of its easily recognisable pattern for easy reference and aesthetic comfort: it represented her core psychological conflicts in resolution. It became a permanent fixture in her life, as an abstract transitional object like a child's comfort blanket until she had no further need of it; it reminded her of the realistic probability of her condition's resolution which, although a far distant goal, she anticipated from knowledge of its usual prognosis after such remedial treatment as she had received.

The researcher thus elucidated psychodynamically how the patient had benefited psychologically from the psychoanalytic method of treatment. Her findings from her 29-year longitudinal study of the patient led her to formulate her PPCC Theory of the functional psychoses.

The researcher was aware that her PPCC Theory of the functional psychoses was based only on a single instance, the patient, 'Case 2', of the inclusive functional psychosis diagnosis, schizoaffective disorder that involved mania as

well as depression and schizophrenia. She used John Stuart Mill's principle of scientific inductive reasoning on the basis that this patient was indeed a sample of this condition, and that the rational integrity of what she worked out in the instance of the patient was intellectually intact but remained based on only a single case history. It was a plausible and possible explanation of the patient's disorder, aetiologically, psychodynamically, psychoanalytically and in accordance with the representational theory of philosophy of mind, but was based only on a single tiny study. She reasoned that if her theory was quite accurate for a single case, inductively it could be accurate for other cases. In addition, the researcher did not encounter any factors which proved to be incompatible with the PPCC theory; rather, her theory tended to support psychoanalytic theory such as Bion's, Lucas', Sohn's and Murray Jackson's theoretical and clinical findings that a psychotic patient has a non-psychotic part of their mind which is accessible to, and should be sought by, their therapist. The PPCC theory is also compatible with Freud's views of depression and mania. But far broader scope and wide discussion are required to criticise and repeatedly re-evaluate this very limited study and analysis of psychotic disorder. Therefore the researcher set out her theory to be open to refutation, according to Karl Popper's philosophy of science. If it proves helpful in the meantime, until it is superseded, it will have provided its usefulness.

Learning points

- Psychoanalytic treatment can liberate even a psychotic patient's genuinely authentic inner self into good mental health, and therefore should be offered with full support to patients who could benefit from it.
- This case demonstrates how much benefit becomes accessible to patients when psychiatric care engages with psychoanalytic processes: goodwill between both professions enables the patient to learn optimally about themselves towards self-regulation and thence true mental health, not merely symptom suppression.
- There are now theoretical grounds for understanding as the psychodynamic pentapointed cognitive construct (PPCC) theory the interrelationships of the functional psychoses in schizoaffective disorder, based upon rare data obtained from a schizoaffectively disordered mind in its comparatively healthy paranoid-schizoid state. These inter-relationships may become disrupted by psychosis into the PPCC's distortions by depression, mania and schizophrenia before being returned to the PPCC and its eventual healed, consolidated form by treatment.

► An additional data is published online only. To view this file please visit the journal online (<http://bcr.bmj.com>)

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