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From Adaptation to Disintegration: Affective Inversion as a Relational Mechanism in Severe Psychotic Disorders

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Abstract: Affective inversion, defined as a paradoxical reversal of emotional attachment into hostility or fear, represents a core yet understudied dynamic within severe psychotic disorders. This case se-ries examines five patients diagnosed across schizophrenia subtypes, exploring how disintegra-tion of adaptive mechanisms shapes affective and relational pathology. Using the CARE (CAse REport) framework, each case was analyzed through clinical observation, psychodynamic inter-pretation, and contextual family assessment. The results reveal that affective inversion frequent-ly emerges as a maladaptive form of psychotic adaptation, transforming dependency into perse-cution and love into aggression. These reversals were consistently directed toward primary caregivers, reflecting unresolved trauma, disrupted attachment, and transgenerational repetition of affective conflict. Pharmacological treatment alone proved insufficient, as improvement in positive symptoms did not restore relational coherence or emotional regulation. Integrating psychotherapy, family involvement, and structured containment was essential to achieve partial stabilization and re-establish minimal affective reciprocity. The findings suggest that affective inversion constitutes both a clinical marker and a defense mechanism against unbearable de-pendency and identity fragmentation. Understanding this process through a psychodynamic and systemic lens enhances diagnostic precision and informs comprehensive therapeutic strategies that address not only symptom remission but also the reconstruction of relational meaning and adaptive resilience.

Keywords: affective inversion, psychotic adaptation, schizophrenia, severe mental illness, psychodynamic psychiatry, transgenerational trauma, family dynamics, resilience

1. Introduction

Adaptation in the context of psychosis must be redefined as more than a reactive or compensatory process; it represents a dynamic interplay of cognitive, affective, relational, and structural mechanisms that sustain or destabilize mental organization. Contemporary research has progressively moved away from purely symptom-based conceptualizations of schizophrenia and first-episode psychosis, toward integrative frameworks that acknowledge vulnerability, trauma, attachment, and resilience. For instance, empirical data indicate that insecure attachment configurations are closely associated with impaired social functioning and diminished recovery trajectories in psychotic disorders [1].

Meta-analytic findings further demonstrate that heightened affective lability spans the psychosis spectrum, supporting the view that emotional dysregulation constitutes a transdiagnostic vulnerability rather than a mere epiphenomenon of psychotic states

[2]. Simultaneously, studies on early adversity and trauma highlight distinct developmental pathways through which early interpersonal disruptions shape symptom patterns and functional outcomes via cognitive and affective disorganization [3]. These insights collectively suggest that adaptation in psychosis should be conceptualized not as the restoration of equilibrium, but as the remodeling of emotional and relational architecture under the strain of threat [4].

Within this framework, we use the term affective inversion to refer to a clinically observable pattern in which emotions of attachment and dependency (such as love, trust, or the need for protection) are persistently reversed into fear, hostility, or guilt toward the same significant others or toward the self. Operationally, affective inversion is considered present when a previously relied-upon attachment figure becomes the main object of persecutory or self-punitive meanings, and when this reversal consistently organizes the patient's behavior, symptom content, and relational choices over time. It resonates with recent research documenting robust links between negative self- and other-beliefs, early trauma, and psychotic symptomatology [5]. This reversal of affective orientation can thus be viewed as a maladaptive adaptation, wherein the individual under stress reorganizes relational templates by converting closeness into danger and dependency into threat. Empirical findings on emotion regulation support this process, showing that individuals vulnerable to psychosis frequently rely on avoidance and suppression, thereby reinforcing affective inversion [6].

From a neurocognitive perspective, deficits in the integration of multisensory and affective cues have been identified as key markers of vulnerability, reflecting a breakdown in relational attunement with others and the environment [7]. Theoretical advances have further conceptualized psychosis as a failure of adaptation within complex self-organizing systems, in which the balance between prediction, uncertainty, and free-energy minimization collapses under stress [8]. Complementary evolutionary models propose that psychotic phenomena may represent once-adaptive mechanisms that have become maladaptive in modern contexts [9].

Relationally, attachment and trauma research emphasize that adaptation in psychosis is embedded within interpersonal networks rather than isolated intrapsychic processes. Evidence from psychometric validation studies underscores how disorganized attachment consistently predicts histories of abuse, relational fragmentation, and increased psychotic vulnerability [10]. At the same time, integrative reviews of the emotion–psychosis interface show that affective regulation strategies mediate both the onset and maintenance of psychotic experiences [11].

Together, these findings affirm that adaptation in psychosis must be understood as a multilayered and context-dependent process, spanning cognitive–affective mechanisms, relational templates, structural vulnerabilities, and systemic dynamics. The concept of affective inversion offers a coherent framework to integrate these dimensions, illuminating how adaptive capacities can collapse into disorganization and how relational repair can restore coherence. The present study therefore examines a series of clinical cases characterized by affective inversion to elucidate how adaptation deteriorates and how integrative psychotherapeutic frameworks may foster reintegration at both individual and systemic levels.

2. Materials and Methods

This article is based on a retrospective multiple-case series. We conducted a secondary analysis of clinical files and psychotherapy notes from patients treated in the same adult psychiatric service, focusing on episodes of psychosis in which affective inversion was repeatedly described. The aim was not to obtain a statistically representative sample, but to illustrate in depth how this pattern may organize symptom content, relational choices, and treatment trajectories.

This case series was conducted at the Prof. Dr. Alexandru Obregia Clinical Psychiatry Hospital in Bucharest, Romania, between January and December 2024. Each case

was selected for its clinical complexity, chronic course, and the presence of significant relational pathology involving primary family figures.

Cases were purposefully selected according to the following inclusion criteria: (a) a primary diagnosis of schizophrenia, schizoaffective disorder, or other non-organic psychotic disorder according to DSM-5 or ICD-10; (b) at least two psychiatric admissions or documented episodes of psychosis; (c) repeated notes in the file describing a stable pattern of affective inversion toward one or more significant attachment figures; and (d) sufficient longitudinal information to reconstruct both symptom evolution and family relationships. We excluded patients with known neurological disease, intellectual disability, or other major organic conditions that could account for the psychotic picture.

Data were collected retrospectively from hospital records, clinical observations, and psychotherapeutic notes. The CARE (CAse REport) guidelines were used to ensure standardized case documentation, emphasizing clinical presentation, family history, symptom progression, and treatment outcomes. Each case was further analyzed from a psychodynamic perspective, focusing on defense mechanisms, object relations, and transgenerational dynamics, as well as from a systemic family standpoint, assessing the interplay between psychotic processes and family role structures.

All diagnoses and treatment decisions followed national psychiatric guidelines and were consistent with international standards for clinical assessment and intervention. Pharmacological management included combinations of atypical antipsychotics (Clozapine, Amisulpride, Risperidone, Quetiapine), mood stabilizers, and electroconvulsive therapy (ECT) in refractory cases. Psychotherapeutic approaches varied depending on the patient's level of insight and cognitive capacity, integrating supportive, cognitive-behavioral, and psychodynamic techniques. Family sessions were conducted when feasible, aiming to restore communication and reduce relational hostility.

The case series adhered to ethical principles in accordance with the Declaration of Helsinki. All patients and/or their legal guardians provided informed consent prior to inclusion in the study. The consent process ensured full understanding of the study's aims, the voluntary nature of participation, the confidentiality of personal information, and the right to withdraw consent at any stage without prejudice to ongoing medical care. All cases were anonymized using a multi-layer confidentiality protocol before inclusion in the manuscript. Potentially identifying information such as names, occupations, specific locations, family structures, and chronological markers was removed, aggregated, or modified without altering the clinical meaning of the cases. Sensitive relational or developmental details were retained only when essential for understanding the psychopathology and were reformulated to prevent identification by relatives or acquaintances. No audio, video, or raw clinical notes were used. The authors ensured that no combination of reported details can reasonably lead to patient identification in compliance with institutional, national, and European data protection standards (GDPR).

All patient data were anonymized during transcription and analysis. Direct identifiers were removed, and sensitive information was replaced with coded descriptors to ensure full compliance with EU General Data Protection Regulation (GDPR 2016/679).

Beyond the CARE reporting structure, each case was examined through an integrative psychodynamic and systemic model that aimed to clarify the clinical and relational logic of affective inversion. The psychodynamic analysis drew on contemporary object relations theory, attachment-based formulations of psychopathology, and the classical conflict–anxiety–defense matrix. For each patient, we reconstructed the longitudinal development of defensive patterns including splitting, projection, projective identification, cycles of idealization and devaluation, denial, and forms of early omnipotent control. We explored how unmet dependency needs were reorganized into persecutory meanings under the pressure of psychotic disintegration. Particular attention was

given to failures of mentalization, disturbances in symbolic functioning, and the emergence of hostile internal object representations. From a systemic perspective, we assessed transgenerational relational themes, caregiver–patient role configurations, unresolved family conflicts, and the circular interactions between psychotic symptoms and interpersonal responses.

Case selection was intentionally purposive and focused on individuals exhibiting pronounced affective inversion and high relational complexity, a strategy that inherently introduces selection bias. These cases were not intended to represent the full spectrum of psychotic presentations but to illuminate, in depth, the mechanisms through which attachment, dependency, and aggression undergo psychotic transformation. As such, the cases serve a heuristic and conceptual function rather than an epidemiological one. The insights derived here should therefore be interpreted as illustrative rather than generalizable, highlighting clinically salient patterns that warrant systematic investigation in future controlled studies.

The primary analytical focus of this case series was to identify recurrent psychodynamic and transgenerational mechanisms underlying affective inversion in psychotic disorders. Secondary objectives included evaluating the effectiveness of multimodal treatment (pharmacological, psychotherapeutic, and family-based) in improving emotional regulation, social functioning, and relapse prevention.

For each case, a comprehensive clinical narrative was constructed, incorporating diagnostic evolution, symptomatology, family relationships, and therapeutic responses. Longitudinal follow-up assessments were conducted at three and six months post-discharge to evaluate symptom remission, medication adherence, and relational adjustment.

3. Results

The presentation of findings begins with an important methodological clarification regarding the nature and structure of the available clinical material. Although data were gathered according to the CARE framework, differences in documentation quality, illness chronicity, and the depth of collateral information produced a heterogeneous evidentiary base across cases. Standardized psychometric, neurocognitive, or relational instruments were not uniformly applied, which precludes strict quantitative comparison. Consequently, the Results section emphasizes the phenomenological patterns, psychodynamic consistencies, and relational mechanisms that recur across cases rather than attempting parallel metric analysis. This approach allows for a more coherent examination of affective inversion as it manifests within diverse clinical trajectories in severe psychotic disorders.

3.1. Case 1: Affective Schizophrenia with Chronic Cannabis Use and Psychotic Decompensation.

Table 1. Overview of Diagnostic Profile, Relational Context, and Key Symptoms in Case 1

Category	Details
Age/Gender	26/M
Diagnosis	Affective Schizophrenia
Onset	Adolescence (15–16 years old)
Substance Use	Cannabis (~1.5-2g/day), Nicotine
Family Dynamics	Absent father, conflict with mother
Key Symptoms	Delusions, hallucinations, aggression, affective inversion
Treatment History	Multiple hospitalizations, non-compliance, ECT
Prognosis	Guarded

3.1.1. Clinical Background and Developmental History

This case concerns a 26-year-old male diagnosed with affective schizophrenia, characterized by a chronic illness course marked by disorganization, recurrent psychotic relapses, and longstanding heavy cannabis use. His developmental environment included significant early adversity. His biological father, a chronic drug user, abandoned the family at the age of three and subsequently died from substance-related complications. The patient spent much of his childhood under the care of maternal grandparents in a setting described as chaotic and emotionally inconsistent. Reports indicate emotional deprivation, low stimulation, and unstable caregiving arrangements.

During adolescence, he exhibited social withdrawal, oppositional behavior, and marked affective instability. Cannabis use began around age 15–16 and escalated progressively to daily consumption of 1.5–2 grams. Academic and occupational functioning deteriorated, and repeated failures were interpreted by the patient as signs of familial opposition or betrayal. Early adulthood was marked by unsuccessful attempts to maintain employment or studies, as well as recurrent interpersonal conflict.

Psychotic symptoms emerged in late adolescence and early adulthood. Prior hospitalizations documented persecutory delusions, auditory hallucinations, mystical elaboration, disorganization, and fluctuating insight. A severe episode in 2021 culminated in a suicide attempt by jumping from a building while experiencing commanding hallucinations. Despite evident injury, he denied suicidality and attributed the event to spiritual testing.

3.1.2. Presenting Symptoms and Observed Behavior

At admission in early 2024, the patient presented with pronounced psychomotor agitation, soliloquy, disorganized thought processes, and persistent persecutory ideation. His speech was circumstantial and tangential, often drifting into mystical or idiosyncratic explanations. Observable behaviors included shouting at unseen interlocutors, banging on doors at night, refusing open food containers, and engaging in ritualistic acts such as burning clothing or sleeping on the floor.

Collateral information from his mother described episodes of unprovoked aggression, alternating with periods in which the patient sought her support. She reported episodes of food refusal associated with delusions of poisoning, progressive social withdrawal, inconsistent adherence to medication, and escalating hostility. These accounts were consistent with prior hospital records documenting similar behavioral cycles.

His mental status examination revealed poor hygiene, blunted affect with intermittent irritability, impaired insight, and marked disorganization. Thought content centered on contamination, spiritual threats, and complex persecutory beliefs. Despite partial pharmacological stabilization, delusional convictions remained firm.

3.1.3. Treatment Course and Clinical Evolution

The treatment plan included Clozapine (100 mg 2-0-2), Amisulpride (200 mg 2-0-2), Depakine Chrono (500 mg 2-0-2), Fluanxol depot (20 mg biweekly), and Romparkin (2 mg 1-0-1). Electroconvulsive therapy was considered but postponed due to partial symptomatic improvement under pharmacotherapy. During hospitalization, the patient's agitation and sleep normalized, but persecutory delusions and poor insight persisted.

Supportive and reality-oriented psychotherapy focused on stabilizing the therapeutic alliance, decreasing hostility toward caregivers, and encouraging minimal engagement. Insight into the role of cannabis remained limited, as he perceived consumption as beneficial rather than exacerbating his symptoms.

3.1.4. Distinction between Observed Data and Interpretative Formulations

The clinical picture is characterized by documented oscillations between proximity and aggression toward his mother, recurrent threats, and dependence on her for daily

functioning. These behaviors were consistently observed both in the hospital and at home, according to caregiver reports.

The patient's delusions of poisoning, avoidance of food prepared by family, and purification rituals represent observable manifestations of his psychotic experience. From a psychodynamic perspective, these phenomena may be understood as expressions of affective inversion, a process in which dependency needs toward a primary caregiver become expressed as hostility when closeness is perceived as overwhelming or intrusive. This interpretation serves as a clinical formulation to clarify relational patterns but does not constitute a directly verifiable mechanism.

Similarly, the recurrent purification behaviors, burning of clothing, and insistence on factory-sealed food items may clinically reflect attempts to regulate internal distress through rigid external control. These formulations aim to contextualize the patient's behavior within broader relational and developmental patterns, but they remain interpretative hypotheses rather than factual causative explanations.

The temporal association between heavy cannabis use and repeated psychotic relapses is well documented throughout his clinical history. Although the patient did not attribute deterioration to cannabis use, the pattern of exacerbation following consumption supports the clinical understanding that cannabis contributed to disorganization and symptom intensification.

3.1.5. Prognosis and Clinical Considerations

The prognosis is guarded. Partial response to Clozapine and the persistence of an emotional bond with his mother constitute positive factors. Negative prognostic indicators include chronic heavy cannabis use, repeated medication non-adherence, cognitive disorganization, and enduring persecutory delusions. Long-term stabilization is likely to require strict pharmacological adherence, structured family involvement, and sustained psychotherapeutic support focusing on emotional regulation, boundary setting, and improved relational functioning.

This case illustrates the interplay between early developmental adversity, substance use, and recurrent psychosis, with affective inversion offering a clinically useful framework for understanding the patient's ambivalent and fluctuating relationship with his primary caregiver.

3.2. Case 2: Paranoid Schizophrenia with Conductive Deafness and Religious Delusions.

Table 2. Overview of Diagnostic Profile, Relational Context, and Key Symptoms in Case 2

Category	Detail
Age/Gender	27/M
Diagnosis	Paranoid Schizophrenia
Onset	Late 2019
Substance Use	MDMA (occasional), light alcohol use
Family Dynamics	Divorced parents, distant father, religious grandmother
Key Symptoms	Mystical delusions, hallucinations, auditory pseudo hallucinations
Insight	Partial
Treatment History	Outpatient therapy, dual antipsychotics, ECT
Prognosis	Guarded

3.2.1. Clinical Background and Developmental History

This case concerns a 27-year-old male architecture student diagnosed with paranoid schizophrenia. His psychiatric history developed on the background of early bilateral

conductive hearing impairment and significant family instability. He experienced ototoxic antibiotic exposure in infancy, resulting in chronic hearing difficulties that contributed to communicative frustration and social withdrawal during childhood. His parents divorced early, and the father became emotionally distant and inconsistently involved. For most of his upbringing, the patient was cared for by his maternal grandmother, who was described as rigid, deeply religious, and emotionally reserved.

During adolescence, he developed an intensified attachment to religious practices and rituals, describing them as a source of structure and security. His social interactions remained limited, and academic performance fluctuated due to concentration difficulties. In early adulthood, he reported increasing levels of anxiety, intrusive guilt, and self-critical ideation. His first psychiatric symptoms included a condemning inner voice that he interpreted in religious terms. These symptoms briefly improved with antidepressant treatment but recurred with greater complexity during subsequent stressors and periods of medication non-adherence.

3.2.2. Presenting Symptoms and Observed Behavior

By mid-2021, the patient experienced a full psychotic episode. He reported three distinct types of voices: an aggressive voice issuing commands, an advisory voice with religious tone, and an incoherent voice repeating fragmented phrases. He attributed these voices to supernatural forces, describing them as divine judgment and demonic attack. Observable behavior during this period included prolonged prayer, fasting, and repetitive ritualized gestures such as kneeling in corners and touching walls in a patterned sequence. Self-injurious behavior was also documented, including striking his head against surfaces during states of agitation.

A significant incident involved physical aggression toward his father, whom he attacked while holding a crucifix. When evaluated afterward, he stated that he acted under the belief that the assault represented a form of spiritual correction, combining themes of guilt, purification, and reconciliation. At the time of hospitalization at the Prof. Dr. Alexandru Obregia Clinical Psychiatry Hospital, he presented with persecutory delusions, mystical preoccupations, auditory hallucinations, and limited insight. His affect alternated between agitation and religious elevation, and his speech exhibited latency, tangentiality, and occasional formal derailment.

Mental status examination revealed persistent hallucinations, strong conviction in morally themed delusions, and fluctuating but partial insight into his experiences. His behavior included ritualized movements, avoidance of eye contact, and somatic gestures consistent with internal sensory overload. Audiological review confirmed persistent conductive hearing impairment.

3.2.3. Treatment Course and Clinical Evolution

Treatment during hospitalization consisted of haloperidol and olanzapine, later transitioned to amisulpride 600 mg daily, in combination with gabapentin and lorazepam. Depot flupentixol injections were initiated to enhance adherence. Due to severe agitation and persistent command hallucinations, electroconvulsive therapy (ECT) was administered in short cycles, with clinical improvement observed in the intensity and frequency of hallucinations.

Symptom reduction included diminished self-injurious behavior, reduced religious agitation, and improved sleep. He remained sensitive to auditory overstimulation, and religious preoccupations persisted, although with lower conviction. Partial insight was regained; at one point, he acknowledged that, under stress, “the voices may come from my fears.”

Audiological follow-up was conducted, and care plans integrated the management of sensory impairment alongside psychiatric treatment.

3.2.4. Distinction between Observed Data and Interpretative Formulations

The patient’s observable behavior included structured religious rituals, self-injury during periods of internal distress, and aggression toward his father during a psychotic

episode. His verbal reports consistently referenced spiritual themes, divine punishment, and moral transgression. The combination of sensory impairment, religious symbolism, and interpersonal conflict was evident in both his statements and his actions.

From a psychodynamic perspective, the interplay between hearing loss and limited emotional attunement from caregivers may have contributed to the development of rigid internal representations. These representations offered limited capacity for differentiating internal affect from external threat, which may partially explain the religious framing of hallucinations. This interpretation serves as a conceptual formulation rather than a directly verifiable mechanism.

The aggression toward his father can be understood behaviorally as a response to command hallucinations and persecutory beliefs. Psychodynamically, it may also express ambivalent paternal attachment, shaped by longstanding emotional distance and inconsistent involvement. This represents an interpretative model meant to contextualize relational themes and does not imply causation.

His repetitive rituals, fasting, and self-inflicted pain were consistently observed and interpreted clinically as attempts to regulate distress and impose coherence on overwhelming inner experiences. While psychodynamic formulations may understand these behaviors as symbolic attempts at control or purification, such interpretations remain theoretical constructs intended to clarify the patient's subjective experience.

3.2.5. Prognosis and Clinical Considerations

The prognosis is guarded to moderate. Improvement with antipsychotic medication and ECT, alongside partial recovery of insight, represent positive prognostic elements. Persistent religious ideation, fluctuating insight, and the emotional impact of sensory impairment represent ongoing vulnerabilities. Long-term management will require sustained pharmacological treatment, careful monitoring of hearing-related stressors, and psychotherapeutic work focused on differentiating emotional experience from hallucination-generated content.

Given the patient's reliance on spiritual frameworks to interpret distress, therapeutic approaches should acknowledge his religious language while assisting him in distinguishing personal meaning from psychotic elaboration. Family involvement will remain essential, particularly in addressing paternal ambivalence and reducing the emotional intensity surrounding past conflicts.

3.3. Case 3: Severe Hebephrenic Schizophrenia with Behavioral Regression and Affective Inversion: A Case from the Borderline of Symbolic Collapse.

Table 3. Overview of Diagnostic Profile, Relational Context, and Key Symptoms in Case 3

Category	Detail
Age/Gender	42/F
Diagnosis	Hebephrenic Schizophrenia
Onset	Early adulthood
Substance Use	None reported
Family Dynamics	Unknown, lived with family under supervision
Key Symptoms	Disorganization, compulsive eating, aggression
Insight	Absent
Treatment History	Long-term antipsychotics, ECT
Prognosis	Poor

3.3.1. Clinical Background and Developmental History

This case concerns a 42-year-old female patient diagnosed with hebephrenic schizophrenia, presenting with profound behavioral disorganization, cognitive decline, and severe functional deterioration. Her illness appears to have emerged in early adulthood and progressed without substantial periods of remission. Documentation of her devel-

opmental history is incomplete due to the absence of reliable informants. Family reports indicate longstanding behavioral difficulties since childhood, including poor academic performance, limited frustration tolerance, and episodes of staring or talking to herself.

The family environment was described as restrictive, with limited emotional expression and a dominant maternal figure. There was no history of substance use or significant medical comorbidities. Over time, the patient became increasingly dependent on family supervision, eventually losing the ability to maintain basic self-care or engage in coherent communication. Prior psychiatric interventions were limited to antipsychotic treatment and supportive measures, with variable adherence.

3.3.2. Presenting Symptoms and Observed Behavior

At the time of admission, the patient exhibited severe psychomotor agitation, marked disorganization, and unpredictable aggression. Observable behaviors included compulsive eating, hoarding food from inappropriate sources such as the floor or waste bins, and episodes of unprovoked attacks against staff. Her speech was fragmented, repetitive, and largely unintelligible, consisting of brief utterances without semantic continuity. She showed minimal engagement, avoided eye contact, and displayed rapid shifts between flat affect and sudden outbursts of rage.

Her global functioning was severely impaired. She required assistance with hygiene, feeding, and basic daily tasks. Cognitive testing could not be performed due to her level of disorganization. Physical examination revealed obesity, motor stereotypes, and psychomotor slowing. There was no documented substance use, and laboratory investigations showed no acute metabolic abnormalities.

The family described prolonged home confinement prior to admission, during which episodes of aggression intensified and self-care deteriorated. The patient was unable to remain alone safely and required continuous monitoring.

3.3.3. Treatment Course and Clinical Evolution

Pharmacological management included Clozapine 400 mg daily, Amisulpride 400 mg daily, and Flupentixol depot 20 mg every two weeks. Previous trials of Quetiapine up to 800 mg had been ineffective. Due to persistent aggression and minimal improvement, a course of twelve electroconvulsive therapy sessions was initiated. Over the course of ECT, the patient showed observable improvements in agitation, sleep regularity, and behavioral control. Although verbal coherence remained extremely limited, her ability to tolerate staff interactions improved, and the frequency of aggressive episodes decreased.

Following the acute phase of treatment, the patient regained partial capacity for self-care under supervision, including basic grooming and participation in structured routine activities. However, disorganization, emotional blunting, and cognitive impairment remained prominent. Her behavior fluctuated, with periods of relative calm alternating with resurgence of compulsive eating and agitation, especially in unstructured settings.

3.3.4. Distinction between Observed Data and Interpretative Formulations

The clinical presentation was dominated by observable behaviors reflecting regression to a very low functional level. These included disorganized motor activity, repetitive gestures, compulsive ingestion of food, and episodic aggression without identifiable triggers. The patient's limited verbal output and inability to engage in symbolic communication were consistently documented throughout hospitalization.

From a neuropsychiatric perspective, the rapid cognitive decline, disorganization, and poor response to antipsychotics raise the possibility of neurodevelopmental or structural contributions. Although no neuroimaging was available, clinical features suggested potential frontotemporal involvement. This remains a clinical hypothesis rather than a confirmed etiological explanation.

Psychodynamic formulations may help contextualize the patient's relational behavior. Her aggression toward caregivers, particularly female staff, might reflect unresolved dependency needs or internalized conflict with maternal figures. Similarly, compulsive eating behavior may represent attempts to regulate internal tension through sensory or instinctual channels. These interpretations are theoretical constructs intended to support clinical understanding and do not represent directly verifiable mechanisms.

The partial response to ECT indicates that biological modulation played an important role in decreasing agitation and enabling minimal relational contact. This improvement highlights the interaction between severe psychotic disorganization and neurobiological dysregulation.

3.3.5. Prognosis and Clinical Considerations

The prognosis remains poor, given the severity of disorganization, limited cognitive reserve, and chronic illness course. Nevertheless, the stabilization achieved after ECT suggests that combined somatic and pharmacological interventions can create a limited window for improved functioning and reduced aggression.

Long-term care will require consistent pharmacological treatment, structured routines, and high levels of supervision. Opportunities for psychotherapeutic engagement are minimal due to impaired symbolic functioning. Family involvement remains essential, both for safety and for maintenance of routines that support partial stability. The case illustrates a form of psychosis in which affective inversion and behavioral regression profoundly limit the capacity for interpersonal engagement, emphasizing the need for sustained interdisciplinary management and realistic expectations regarding recovery.

3.4. Case 4: Paranoid Schizophrenia and the Psychodynamics of Affective Inversion: From Attachment to Delusional Surveillance.

Table 4. Overview of Diagnostic Profile, Relational Context, and Key Symptoms in Case 4

Category	Detail
Age/Gender	34/F
Diagnosis	Paranoid Schizophrenia with Erotomanic and Persecutory Delusions
Onset	Early adulthood; relapse after treatment discontinuation
Substance Use	None reported
Family Dynamics	Emotionally distant authoritarian father; overprotective mother; dependency conflicts
Key Symptoms	Erotomanic delusions, persecutory delusions, ideas of reference, auditory hallucinations, hypervigilance
Insight	Fluctuating, partial during remission
Treatment History	Long-term antipsychotics, mood stabilizers, supportive psychotherapy
Prognosis	Fair with adherence; risk of relapse under stress

3.4.1. Clinical Background and Developmental History

This case concerns a 34-year-old woman diagnosed with paranoid schizophrenia, whose illness evolved following a traumatic romantic separation. Her psychiatric symptoms emerged against a background of a rigid and conflictual family environment. She grew up as an only child in a middle-class household characterized by a distant and authoritarian father and an overprotective mother who provided emotional support inconsistently.

Premorbid functioning indicated high academic achievement but marked social withdrawal and difficulty sustaining friendships. In early adulthood, she entered an intense and emotionally dependent romantic relationship. Following the breakup, she

experienced insomnia, anxiety, ruminative thoughts, and increasing preoccupation with her former partner's perceived actions. These early symptoms preceded the first documented psychotic episode in 2020.

3.4.2. Presenting Symptoms and Observed Behavior

At admission, the patient exhibited persecutory delusions, erotomanic beliefs, auditory hallucinations, hypervigilance, and fluctuating insight. Observable behaviors included repetitive checking of surroundings, verbal defensiveness, intrusive attempts to contact her former partner, and withdrawal from daily activities.

She reported that her ex-partner was surveilling her through "implanted devices" and "coded messages" seen on television or online platforms. She interpreted coincidences in numbers, music, or gestures as signs of communication or warning. During hospitalization, she presented with rapid shifts in emotional expression, alternating between tearfulness, agitation, and intense alarm.

Her thinking remained largely organized at the formal level, yet interpretations were idiosyncratic and resistant to correction. She maintained detailed narratives linking her ex-partner to state institutions, surveillance, and spiritual retribution. She also described periods of fasting intended to "purify" the connection with him. Family members reported escalating nocturnal behavior, refusal of food, social isolation, and aggressive outbursts when contradicted.

Mental status examination revealed persecutory and erotomanic delusions, ideas of reference, auditory hallucinations in the form of whispers, and partial insight during moments of decreased stress. She was disheveled, fatigued, and displayed intermittent psychomotor agitation.

3.4.3. Treatment Course and Clinical Evolution

Pharmacological management included Clozapine 200 mg daily, Risperidone 4 mg daily, Valproate 1000 mg daily, and Lorazepam 2 mg for agitation. Gradual symptomatic improvement was observed during hospitalization. Agitation and paranoid arousal decreased, sleep patterns stabilized, and she began engaging more consistently in supportive psychotherapy sessions.

However, the core delusional content persisted in attenuated form. Although she could acknowledge implausibility during periods of lower emotional intensity, her beliefs remained partially fixed, especially those related to surveillance and spiritual significance. She remained ambivalent toward her former partner, expressing alternating fear, resentment, and longing.

Family therapy sessions emphasized communication boundaries and reduction of expressed emotion. The patient's parents reported a longstanding pattern of dependency and conflict that intensified after the breakup and contributed to recurrent relapses in stress-related contexts.

3.4.4. Distinction between Observed Data and Interpretative Formulations

The patient's observable behavior included persistent attempts to contact her former partner, ritualized fasting, avoidance of perceived surveillance sources, and episodes of agitation. Her verbal reports consistently linked her symptoms to themes of control, betrayal, and a continuing emotional bond.

From a behavioral standpoint, the erotomanic and persecutory delusions structured her environment and guided her actions. Formal thought processes were generally coherent, yet her interpretations of ordinary stimuli were distorted by personal symbolic meaning.

Psychodynamic formulations may help contextualize the relational component of her symptomatology. The instability in her early family environment, particularly paternal emotional distance, may have shaped vulnerabilities in attachment that resurfaced during the breakup. The subsequent transformation of attachment into persecutory beliefs can be conceptualized as affective inversion, a framework in which dependency and longing become expressed through suspicion and defensive hostility. This

interpretation is intended to organize clinical understanding and does not imply direct causation.

Her fasting rituals, described as purification efforts, may represent attempts to impose structure and regain a sense of agency during periods of emotional overwhelm. Such behaviors were consistently observed but their underlying motivation remains a clinical hypothesis.

The coexistence of formal thought integrity with strongly idiosyncratic interpretations is characteristic of paranoid schizophrenia and complicates insight-oriented work. While psychodynamic interpretations assist in understanding relational themes, they remain theoretical constructs applied in conjunction with observable data.

3.4.5. Prognosis and Clinical Considerations

The prognosis is fair with treatment adherence, but relapse risk remains elevated during interpersonal stress or medication discontinuation. Persistent delusional themes, fluctuating insight, and longstanding relational vulnerabilities increase the likelihood of recurrent psychotic episodes.

Long-term management requires stable pharmacological treatment, continued supportive psychotherapy, and structured family involvement. Treatment goals include reinforcing boundaries, developing emotional regulation skills, and progressively differentiating affective experience from delusional elaboration. The case underscores the relational dimension of psychosis, in which attachment disruption can intensify perceptual distortions and contribute to sustained affective inversion.

3.5. Case 5: Internalized Persecution and Affective Inversion in Schizoaffective Disorder: When Love Turns into Guilt and Self-Punishment.

Table 5. Overview of Diagnostic Profile, Relational Context, and Key Symptoms in Case 5

Category	Detail
Age/Gender	42/M
Diagnosis	Schizoaffective Disorder, Depressive Type
Onset	Early twenties; recurrent episodes over two decades
Substance Use	None reported
Family Dynamics	Authoritarian and emotionally distant father; strong dependency on mother; unresolved grief after paternal loss
Key Symptoms	Psychotic depression, guilt-related delusions, internalized persecution, auditory hallucinations (paternal voice), somatic delusions, obsessive guilt, self-punitive rituals, suicidal ideation
Insight	Limited to partial; fluctuating with treatment
Treatment History	Long-term antipsychotics, mood stabilizers, antidepressant, supportive psychotherapy, occupational rehabilitation
Prognosis	Moderate with adherence; risk of relapse under interpersonal stress

3.5.1. Clinical Background and Developmental History

This case concerns a 42-year-old male diagnosed with schizoaffective disorder, depressive type, with a 20-year history of recurrent depressive and psychotic episodes. His psychiatric symptoms first emerged in his early twenties, shortly after the sudden death of his father. The father was described as authoritarian and emotionally distant, while the patient maintained an idealized representation of him. The loss precipitated intense guilt, feelings of inadequacy, and early psychotic features characterized by accusatory auditory hallucinations attributed to the paternal figure.

Following this initial episode, the patient experienced alternating periods of partial remission and relapse. Over the years, he maintained intermittent employment as an accountant but relied heavily on his mother for daily support. Stressful situations, in-

terpersonal conflict, or perceived failure consistently triggered recurrences of depressive and psychotic symptoms. He has no history of substance use, significant medical comorbidities, or neurological disorders.

3.5.2. Presenting Symptoms and Observed Behavior

The most recent hospitalization occurred after a suicide attempt by medication overdose. At admission, the patient appeared withdrawn, with downcast gaze, psychomotor retardation, and slow, monotonous speech. His affect was markedly depressed, and he expressed persistent themes of guilt and self-blame. He stated that "others suffer because of me" and referred repeatedly to moral wrongdoing without specifying concrete events.

Auditory hallucinations were present in the form of a condemning paternal voice, perceived as issuing accusations of failure and betrayal. He also reported somatic sensations consistent with somatic delusions, such as the belief that his internal organs were deteriorating or contaminated. Observable behaviors included compulsive prayer, prolonged periods of immobility, refusal of food during depressive peaks, and repetitive cleansing rituals intended to "purify" himself.

During mental status examination, thought processes were generally coherent but dominated by guilt-related delusions and nihilistic themes. Insight fluctuated, with occasional acknowledgment that "my mind may be exaggerating," followed by rapid return to self-blaming ideation. The patient remained socially isolated, avoided eye contact, and required encouragement to participate in basic daily tasks.

3.5.3. Treatment Course and Clinical Evolution

Pharmacological treatment consisted of Clozapine 150 mg daily, Venlafaxine 150 mg daily, and Valproate 900 mg daily, along with supportive psychotherapy. Over several weeks, the patient demonstrated gradual improvement in mood, reduced intensity of hallucinations, and increased engagement in occupational activities.

By the third week, psychomotor retardation diminished, appetite improved, and the patient began participating in group activities. Hallucinations resolved by week five, although residual guilt ideation persisted. Insight increased modestly, with the patient recognizing that his thoughts "may not always reflect reality," though he remained preoccupied with moral self-evaluation. Family involvement supported adherence and provided a more structured daily routine.

3.5.4. Distinction between Observed Data and Interpretative Formulations

bservable clinical data demonstrated a pattern of depressive withdrawal, self-punitive behavior, and internalized accusations attributed to hallucinated paternal authority. His compulsive rituals, avoidance of food, and suicidal action were consistent with severe affective disturbance and psychotic distress.

At an interpretative level, these patterns can be understood through the concept of affective inversion. Instead of directing hostility outward, the patient redirected it inward, manifesting as self-criticism, guilt, and self-punishment. This formulation is consistent with classical descriptions of psychotic depression in which internalized aggression contributes to suicidality. However, it remains a clinical interpretation and not a directly observable mechanism.

His persistent association of suffering with moral wrongdoing may reflect longstanding internal schemas shaped by an emotionally distant paternal relationship. While this conceptual framework can help clinicians understand the structure of his symptoms, it does not imply causality and should be regarded as a supplementary interpretative tool.

The reliance on prayer and the use of cleansing rituals were consistently observed and may represent attempts to regulate emotional distress through structured, familiar patterns. Their symbolic meaning is a clinical hypothesis intended to contextualize his experience, not an empirically confirmed explanation.

3.5.5. Prognosis and Clinical Considerations

The patient's prognosis is moderate with strict treatment adherence. Improvement during hospitalization suggests that combined pharmacological and psychological interventions can reduce symptom severity and restore partial functioning. Continued vulnerability is expected due to chronic guilt-related ideation, dependency on maternal support, and limited tolerance to interpersonal stress.

Long-term stability will require sustained antipsychotic and antidepressant treatment, regular psychotherapeutic follow-up, and structured psychosocial support. Interventions should focus on improving emotional regulation, enhancing self-compassion, and helping the patient differentiate delusion-driven guilt from realistic concerns. Collaboration with the family is essential to maintain consistent routines and prevent excessive reassurance cycles that may reinforce dependency.

This case highlights a form of affective inversion in which dependency and unresolved grief become reorganized into self-directed hostility, contributing to recurrent depressive and psychotic exacerbations. Understanding these dynamics supports a more integrated therapeutic approach tailored to both biological and relational vulnerabilities.

Table 6. Comparative Synthesis of Affective Inversion Patterns Across the Five Cases

Case	Primary Diagnosis	Attachment Figure Involved	Observed Pattern of Affective Inversion	Core Relational Theme	Key Behaviors Illustrating the Pattern
Case 1	Affective schizophrenia + cannabis use	Mother	Oscillation between dependency and hostility; caregiver perceived as both protector and persecutor	Ambivalent maternal attachment	Food refusal, accusations of poisoning, seeking help then aggression
Case 2	Paranoid schizophrenia + hearing impairment	Father / spiritual authority	Fear–dependency oscillation; spiritualized paternal figure becomes source of condemnation	Moral judgment, guilt, paternal distance	Self-injury, ritualized prayer, attack under command hallucinations
Case 3	Hebephrenic schizophrenia	Female caregivers (mother/staff)	Dependency expressed through aggression; caregiver becomes intrusive threat	Primitive dependency, regression	Disorganized aggression, compulsive eating, inability to self-care
Case 4	Paranoid schizophrenia	Ex-partner	Longing transformed into suspicion and persecutory narrative	Abandonment fear, relational rupture	Repetitive checking, attempts to contact ex-partner, fasting
Case 5	Schizoaffective disorder	Internalized father	Idealized paternal figure becomes condemning voice	Internalized guilt, self-punishment	Suicidal attempt, prayer rituals, self-criticism

To enhance conceptual clarity and facilitate comparison across the five cases, we provide a synthesis table summarizing the core configurations of affective inversion, associated relational themes, and key observable behaviors. This table highlights recurring patterns while preserving the qualitative and non-generalizable nature of the case series.

4. Discussion

Affective inversion provides a unifying lens for understanding how attachment, dependency, aggression, and meaning collapse and then reorganize within severe psychotic illness. In our series, the emotional vector repeatedly turned against those who had once anchored the patient's inner world, transforming proximity into threat and care into control. This inversion was not a rhetorical flourish but a dynamic pattern that shaped behavior, symptom formation, and treatment response across cases. It emerged not only in explicit persecutory beliefs about parents or partners but also in

ritualized refusals, somatic self punishments, and moralized narratives that offered coherence when psychic integration faltered [12].

The first case illustrated the conjunction of early abandonment, heavy cannabis exposure, and a maternal relationship saturated with ambivalence. Dependency that could not be symbolized returned as accusations of poisoning and as purification rituals that displaced unbearable reliance into vigilant hostility. Improvement with antipsychotic treatment tempered agitation yet left deep relational mistrust largely intact, underscoring that symptom control does not dissolve the inverted bond. The second case demonstrated how sensory deprivation and religious symbolism can scaffold delusional meaning [13]. Deafness limited auditory attunement during development and later provided a fertile context in which internal voices acquired divine and demonic significance. The assault on the estranged father condensed longing, resentment, and the fantasy of moral repair into a single act, a stark enactment of inverted attachment that therapy needed to translate back into communicable grief [14].

The third case pushed inversion to the edge of symbolic collapse. Hebephrenic disorganization reduced communication to drives and fragments, leaving feeding and rage as the only available languages. Here, electroconvulsive therapy reopened a narrow corridor for environmental adequacy and family contact, even as higher order representation remained thin. The fourth case mapped the conversion of romantic attachment into surveillance and moral accusation. Erotomanic and persecutory themes preserved a relationship through delusional control when loss could not be mourned, a defensive substitution of vigilance for intimacy. The fifth case moved the vector inward. Rather than project aggression onto an external object, the patient turned love into guilt and condemnation, illustrating an internalized persecutory authority that demanded expiation and tempted self annihilation. Across the series, then, the same grammar recurred in different dialects. Where dependency could not be mentalized, it returned as threat, either directed outward toward caregivers or inward as moral self attack [15].

These presentations align with contemporary evidence that attachment insecurity, childhood adversity, and negative self other schemas contribute to psychosis vulnerability and persistence. They also resonate with findings that psychological flexibility and mentalization capacities modulate adaptation under stress [16]. The clinical thrust is clear. Pharmacology and somatic treatments are necessary to reduce positive symptom load, and in selected refractory contexts augmentation with electroconvulsive therapy can be decisive, but none of these alone restores relational meaning [17].

Two practice implications follow. First, the formulation must be explicitly relational. Treatment planning should ask not only what the patient believes but whom the belief concerns and which developmental injuries and loyalties it protects. In case one, effective work hinged on helping the family recognize how refusal of food recapitulated dependency terror. In case two, therapy needed to respect the patient's spiritual language while differentiating faith from delusion, and family psychoeducation had to lower emotional heat around paternal ambivalence. In case three, biological intervention created space for low arousal caregiving routines that contained impulses when symbolization was unavailable. In case four, supportive psychotherapy targeted the equivalence the patient drew between being watched and being loved, while boundaries with the ex partner were rebuilt through structured family work. In case five, psychotherapy softened a punitive inner authority and replaced ritualized expiation with tolerable self compassion, which in turn reduced suicidal pressure [18].

Second, family focused interventions deserve priority. Affective inversion endangers caregivers, burns out families, and destabilizes adherence. Psychoeducation and skills based work can reduce expressed emotion, interrupt the cycle of accusation and countercontrol, and lower relapse risk [19]. The cases repeatedly showed that pharmacologic stabilization without relational recalibration left the inverted template un-

touched, permitting rapid reescalation under stress. Work with families should therefore be framed not as an adjunct but as a core element of care when the object of delusion is a parent or partner.

There are cultural and existential dimensions that clinicians must hold with nuance. Religious content may provide patients with dignity and purpose while also amplifying persecutory logic. The task is not to discredit belief but to enlarge the patient's symbolic repertoire so that guilt, longing, and powerlessness can be spoken without requiring cosmic persecution to justify them. Substance use demands equal attention. In our first case, intensive cannabis exposure interacted with vulnerability and relational fear, lowering the threshold for decompensation and tightening the knot of mistrust. Motivational and family based strategies for cessation are essential to any durable plan [20].

Methodologically, this series carries limitations that temper generalization. It draws from a single tertiary hospital over a single year, involves a small number of purposefully selected cases, and relies on retrospective charting combined with clinical interviews rather than a uniform battery of dimensional measures [21]. Neuroimaging and neurocognitive data were unavailable in some instances, notably in the hebephrenic presentation where an organic contribution is plausible. Follow up windows, while clinically meaningful, did not extend long enough to establish durability of relational change [22]. The interpretive framework is psychodynamic and systemic, which illuminates meaning but is vulnerable to selection and confirmation biases if not paired with standardized outcome metrics.

These constraints do not diminish the central signal that threads the five narratives. When attachment fails under the strain of psychosis, the mind often preserves connection through inversion. The very person who embodies safety is recast as a persecutor, or the love that sustains identity is recoded as guilt that demands self punishment. Such patterns are not epiphenomena. They are the living architecture of the illness and they determine whether pharmacologic gains translate into life gains. Psychodynamic thinking matters here because it keeps sight of what symptoms are doing for the psyche. It helps teams interpret hostility as a displaced plea, rituals as improvised governance of chaos, and religious severity as a moral scaffolding that can be respected even as its delusional claims are gently loosened. It also organizes the treatment milieu, reminding staff that calm structure and predictable limits are not merely managerial but reparative [23].

The clinical horizon suggested by these cases is therefore integrative, multidimensional, and deeply humane. It requires the clinician to move beyond the binary of symptom control versus relapse prevention and to embrace a framework where recovery is understood as the gradual restoration of meaning, attachment, and agency. Pharmacological and somatic treatments remain indispensable in providing biological stability, but their effect must be nested within a broader relational and existential rehabilitation. Antipsychotic medication and electroconvulsive therapy can reopen channels of perception and reduce hallucinatory intensity, yet without a parallel reconstruction of relational safety, these improvements remain structurally fragile.

Attachment-informed psychotherapy represents the cornerstone of this wider horizon. Its primary goal is not interpretation in the classical sense, but containment—the creation of a stable interpersonal space where persecutory anxiety can be transformed into communicable experience. The therapist assumes the function of a reliable other who does not retaliate, withdraw, or impose, thereby modeling an alternative to the internal persecutory object. Through gradual exposure to a consistent relational rhythm, the patient learns that ambivalence can be tolerated and that dependency does not necessarily lead to control or humiliation. Over time, this new internal model begins to replace the inverted one, and aggression loses its organizing power [23].

Family work remains equally essential. The caregiver is often both the recipient and the trigger of inverted affect, living inside a cycle of fear, guilt, and hypervigilance. Psychoeducation should therefore move beyond factual instruction about illness and

address the emotional burden carried by relatives. Structured sessions can help families differentiate between the person and the symptom, respond without accusation, and re-establish clear but empathic boundaries [24]. By lowering expressed emotion and introducing predictable routines, family interventions reduce relapse risk and repair the damaged channels of communication through which trust once flowed. In some cases, brief systemic interventions focused on alliance-building can prevent retraumatization within the household, while ongoing family therapy offers a longitudinal container for grief and adaptation.

A further clinical task involves the translation of persecutory narratives back into dependency needs that can be safely expressed. Many psychotic statements conceal an unmet request for proximity or reassurance. When a patient says, "My mother wants to poison me," the underlying message may be, "I need her, but she terrifies me." The clinician's role is to hear the need without reinforcing the delusion, to name the emotional logic without validating the false belief. This delicate operation requires attunement and humility: to find language that bridges two realities without collapsing into either. Such translation not only humanizes the psychotic world but also restores the patient's capacity for dialogue, replacing surveillance and accusation with cautious curiosity about emotional life [25].

Vigilance, another defining feature of affective inversion, must be redirected rather than suppressed. Hypervigilance once served a protective function; it maintained psychic coherence in the face of perceived chaos. In therapy, this vigilance can be channeled toward collaborative safety planning, helping patients learn to anticipate stressors, recognize early signs of relapse, and co-construct responses that preserve autonomy [25]. By shifting the focus from external threat to internal regulation, the clinician transforms paranoia into awareness. This reframing empowers the patient without dismissing their experience of danger, offering a bridge between subjective reality and objective safety [26].

Spirituality, often entwined with delusional content, deserves careful engagement. Religious imagery may provide patients with meaning and coherence when all other narratives collapse. The clinician's task is not to pathologize belief but to expand it—to widen the symbolic field beyond persecution and expiation so that faith becomes a container for compassion rather than guilt. Collaborative dialogue with spiritual counselors, when appropriate, can support this expansion and prevent isolation within rigid systems of belief [27].

Substance use, present in several of our cases, represents a modifiable but often neglected amplifier of risk [28]. Psychoeducation, motivational interviewing, and harm-reduction strategies should be systematically integrated into treatment. Cannabis and alcohol frequently blur ego boundaries and intensify affective instability, feeding the very inversion that therapy seeks to undo. Sustained recovery requires that these patterns be addressed not as moral failings but as maladaptive attempts to self-regulate intolerable affect [29, 30].

Evaluation of progress must also evolve. Symptom counts and standardized scales remain important but insufficient. More meaningful metrics include the patient's ability to maintain eye contact without fear, to express ambivalence without aggression, and to tolerate proximity without withdrawal. Improvement is measured in moments of shared presence, in the slow rebuilding of reciprocity and trust. Each instance where the patient remains in the same room with a loved one without perceiving threat signifies a micro-restoration of the relational field that psychosis had fragmented.

Ultimately, the ambition of treatment in affective inversion extends beyond remission toward reintegration. It seeks to re-establish the capacity for genuine connection, to transform survival mechanisms into living relationships, and to return meaning to experience. The psychotic person, once trapped in a world where love equals danger and closeness equals control, learns through carefully structured therapeutic work that dependency can coexist with autonomy, and that care can exist without persecution. This process is slow, non-linear, and fragile, yet it is the only path toward authentic

recovery. The clinician's task is to sustain this fragile bridge between biological stabilization and relational rebirth, holding the tension between the reality of illness and the possibility of healing.

When affective inversion has stolen intimacy and agency, the duty of psychiatry is not merely to silence the voices but to restore the capacity to listen and to be heard. The combination of pharmacological stability, psychodynamic insight, and systemic empathy offers the most coherent and compassionate response to this challenge. Recovery, in this light, is not defined by the absence of symptoms but by the re-emergence of the human capacity to relate, to trust, and to hope.

5. Conclusions

Affective inversion reveals the paradox at the heart of psychosis: when the need for love and safety becomes unbearable, it is transformed into fear, hostility, or guilt. Across the five cases, attachment and dependency reversed into aggression, persecution, or self-punishment, each preserving connection through distortion rather than through trust. This mechanism is not simply symptomatic but represents a desperate reorganization of the relational world in the face of psychic collapse.

Effective treatment therefore demands more than pharmacological stabilization. It requires a psychodynamic and systemic understanding that restores meaning to symptoms and recognizes hostility as a disguised form of attachment. Antipsychotics and somatic therapies reopen space for dialogue, but it is within that dialogue, between patient, family, and clinician, that true recovery begins.

The cases described here show that even in the most chaotic psychotic landscapes, remnants of the human capacity for attachment survive. They persist beneath layers of persecution and guilt, waiting to be met with recognition. To treat affective inversion is to touch that hidden continuity, to help the patient rebuild a world where others are no longer enemies, and the self no longer a stranger. It is to restore dialogue where silence reigned, meaning where confusion dominated, and dignity where despair once stood. In this restoration lies the essence of psychiatric healing: the affirmation that even when the psyche turns love into hatred, the capacity for transformation endures.

The psychodynamic perspective provides psychiatry with the language to translate persecution into longing, guilt into care, and silence into contact. To treat affective inversion is to help the patient rediscover that love need not destroy autonomy and that connection can exist without threat. In this rediscovery lies not only the essence of healing but the re-emergence of the human capacity for trust and belonging.

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