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Crucial Problems in Psychotherapy of Schizophrenia

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This paper is an attempt to summarize some of the most important problems I have encountered in a 20-year-old psychotherapeutic experience with schizophrenic patients.

According to modern interpretation, schizophrenia is a disease resulting from the **interplay** of **biological** and **psychodynamic** factors. The former lays down those **childhood reactions** which form the inner world and determine social reactions. The latter consists of the **ongoing psychogenic** experience, based on information from outside, and which organises those underlying psychobiological structures which process them. This working hypothesis is the main basis of my presentation. Of course, I cannot unfold the complex problem of psychotherapy of schizophrenia in the tremendously wide range of modern psychiatry, which includes group therapy, family therapy, community therapy, therapy in a hospital setting, and rehabilitation. Within this paper I shall try to reach the roots of the problem by confining myself to one topic alone. This will be, according to my major personal experience, that of **individual therapy**. Do not think that individual therapy is an old-fashioned approach because it can help only a few patients. It is **crucial** in that it gives us insight into the structure of schizophrenia and enables us to conceive of a philosophy of treatment outside of individual psychotherapy. I shall begin with some basic considerations.

Today even biologically oriented colleagues no longer ignore the fact that it is hardly possible to reduce schizophrenic illness to the findings of elementary biology alone. A biologically oriented psychiatrist like Weitbrecht thinks, for instance, that schizophrenia cannot be explained by Huber's theory of energetic-potential loss because the psychotic disturbance takes place on a very high ego level, having to do with the most complex inner life of the patient. At best, only from a very differentiated point of view could psychobiology come into question, wherein it would concern itself with such functions of the ego as how processes of symbolization and conceptualization relate with one's image of the world and of oneself.

If psychodynamics are relevant for understanding the schizophrenic patient, we are faced first of all with the question of the difference between neurotic and schizophrenic individuals. Is it possible to understand the schizophrenic patient in the same way as we understand the neurotic one? Or are there unique psychodynamic mechanisms specific for schizophrenia?

What are the main differences in the treatment techniques of these two groups of patients?

Let us look at these questions more closely. I should like to begin with the statement of **Jung**, based on his long experience, that schizophrenic patients suffer from the **same conflicts and complexes** as neurotic individuals.

It is now possible, however, to add that **basic interpersonal deficiencies** play a more important role in schizophreniathan similar problems which are found at the oedipal level of neurosis. At the roots of schizophrenia there is more than conflict; there is a “malnutrition” and therefore a **basic malformatio**n of the patient's ego.

Can we fully grasp, in a psychological way, this kind of malformation? As one participant observer, Sullivan, put it, one is impressed by the depth and the destructiveness of schizophrenic ego deficiencies. However, the impression cannot be ignored that a special form of **intrapsychic elaboration** of the psychogenetic material triggers off the specific schizophrenic mechanisms and makes it difficult for us to identify with them. This pathologic elaboration works like a barrier between the contents of the disease, which we describe in our language, and our understanding of the psychotic forms, especially Bleuler's primary symptoms. We can speculate upon their psychological origins, but our firsthand experience of them is not a truly psychodynamic one, because **with such symptoms** the **patient remains a stranger** to us. Rumke's formulation of the “praecox feeling” runs in this direction. Is it possible to “understand” phenomena which appear to be outside the basic mechanisms of our mind?

One example, which appears to be most familiar and frequent, concerns the meaning of **relatedness**, of closeness, and of **object relation** for the schizophrenic patient. I am impressed by the frequent feeling of the schizophrenic, even if he is unable to verbalize it fully, that the **mere presence of persons around him**, or of his being related to significant partners, is a **danger** for him. This feeling may be expressed in different ways. It is expressed not only through the well-known aspects of his psychotic behavior, like mutism and negativism, but also, for instance, through delusions, in which the patient experiences every human contact as a way of being sucked up and destroyed by the world. If the patient is able to communicate, he tells us of his fear of dissolving into others, so that he can no longer recognize himself as a separate ego. Sometimes he experiences such feelings in a concrete manner; for example, he feels that his body becomes smaller and smaller, until it no longer exists. A patient tells us, in the course of psychotherapy, that he is not living on his own account, but only through the image that the psychotherapist has of him. He has no "card of identity"; he is "created" by others. If the relationship with the therapist is a negative one, this may be experienced as persecution.

Within a positive transference, the patient may say that he can live only thanks to that which flows from his therapist, but that, however, does not belong to him.

Surely it is possible to grasp the **deep psychodynamic meaning** of such

psychotic experiences through an analysis of those early familial interactions that first put on a firm ground the identity of the child. But it would **not** make any **therapeutic** sense to transmit to the disintegrating patient such psychogenetic speculations if our interpretations would **miss** the real, essential point. Keeping in mind that the **malnutrition** of the psychotic ego is a very **early**, **preverbal** phenomenon, we can understand that the **therapeutic** agent would also have a strong **preverbal** component. The **deep concern** that we feel for the patient, and which we try to convey to him through our interpretations, and the feeling that he is a most valuable object for us must permeate our **so-called countertransference before** any therapeutic action can take place.

I feel completely **helpless in describing** this. It has been my experience that those colleagues who have gone through such situations will understand me without further explanation. Those others, who have not had such experiences, will not fully understand me. There are, for instance, experiences of identity which occur in the dreams of the therapist. There are even extrasensory irrational experiences at some deep level of transference. The therapist listens to his patient, who tells him a desperate dream: the house is burning, the patient calls for help by telephone, but it is too late. Later on, the therapist hears the voice of his patient, while thinking about this encounter with him. He then transmits this hallucinatory experience to his patient, who is impressed and decides that he is, in some way, within the therapist, or that the therapist is with him. Now, what such things mean is only the very simple fact that the same patient, who, as we have said, is **dissolving**, is becoming smaller and smaller, is now becoming greater and greater, **substantial** and heavy, through the psychic symbiosis with his therapist.

But if we are completely "normal," then this feeling of dissolving as a psychic identity is no longer within the realm of those psychopathological experiences we can identify with. It is quite another thing than the loneliness of the neurotic individual and quite another thing than the fear of object loss, which we know especially well from reactive depressive patients. The **potential hostility of the love object** in this case has nothing to do with its reliability, with the mental attitudes of the partner toward the patient. The **object** is often **feared** by the **very fact of its being different**.

How can we understand this? Is it possible to discover something in the prepsychotic life history of the patient that contributes to this kind of ego disturbance? I have often observed, as have such authors as Alanen, Arieti, Lidz, Stierlin, Wynne, and many other researchers, that **disturbances in communication during childhood** *were* a first step to schizophrenic **deformations of self-identity** and the resulting feelings of **depersonalization**. We can clearly find such situations in the history of many schizophrenic families. **Closeness** results in situations of **defenselessness** for the child, in which he suddenly finds himself **taken advantage of** because of the ambivalent attitudes of his significant others. Closeness becomes an all-too-great identification with the **demanding and weak** side of the **adult**. Closeness may also result in situations where the affective working through of aggressions is impossible. It appears,

therefore, that such chronic experiences can lead, step by step, to that **deep insecurity** of self every time situations of closeness, of being related to others, occur. At first the ego may react with **signals of anxiety**, anticipating loss of worth and of love. The more such anxiety signals fail to build up adequate, **neurotic** resistances of a psychodynamic nature, the more **depressive** conditions tend to develop—which often can be found by scrutinizing closely the antecedents of schizophrenia. Finally, this course of mood disturbance reaches a **turning point**, after which the ego **experiences** such events no longer as changes of the external world, but as transformations of its own inner structure. The problem of the ego is then an intrasystemic one, which must be viewed as **psychostructural** rather than only psychodynamic.

It is surely possible that the **first steps** along such a process of destructuring are of a psychodynamic nature, as psychoanalytic researchers such as Fairbairn, Guntrip, and Mahler assume. The common opinion found in the writings of these authors is that the **earliest function of the ego** does not lie in mediation between the id,reality, and the superego and the satisfaction of elementary biological needs such as warmth, hunger, and thirst, but that it lies primarily In the **formation of psychic structure**. This includes the organization of stimuli and reflexes around a growing nucleus of belonging, of **oneness**, of being a whole, a self. It seems that the **mother is experienced** by the infant at this early stage of life as a **continuation** of the infantile self. The integration with mother therefore supplies the ego with a narcissistic feeling of omnipotence, which later forms the basis for self-confidence and world mastery.

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Let us look again at this difference between the psychotic and the neurotic, by starting with an example. A patient, in the **psychotic** phase of his psychotherapy, claimed that he was being made by me. He felt he was not himself but only lifeless matter, which became alive only through my words; this mediated life, however, was not his own, because he himself absolutely did not exist. Note the fact that this utterance could not be understood as a problem of transference or countertransference, but really meant a **catastrophic** feeling of **not being a person**. Outside of therapy, the lifeless matter was nothing; in therapy it was mirrored life.

The same patient told me, some months later in the **postpsychotic**, let us say, neurotic, phase of his psychotherapy, that he felt influenced by my interpretations. By this, the patient did not mean any paranoid influencing, but only a neurotic resistance to understanding interpretations. This was quite within the realm of **normal psychosis**.

Owing to the fact that the **same word** —"influence," "influencing"—was used by the patient to describe, at different times of his development, both psychotic and neurotic feelings, should we assume that only a gradual difference, namely in quantity rather than quality, separated these two conditions?

However, along the continuous path of development from the neurotic to the psychotic pole, or vice versa, we find a point where we can no longer exactly identify with the experiences of the patient. This possibility of identification

is expressed in the German language with the word ***einfuhlen*** (roughly, "to have a sympathetic understanding; empathy"), which I therefore will use in my present discussion. We can, for instance, understand intellectually the fact that the patient feels made by me, but we cannot *einfühlen* into this state of mind. The not *einfühlbarer* ("nonexperienceable") character of the schizophrenic experience was a fashionable expression of classic psychiatry. But through the "understanding" psychology *(die verstehende Psychiatrie)* everything became ***einfühlbar***.

However, this German word can be used in two different ways.

1/ In one sense, it means that we always can **appreciate the suffering out of which** the patient speaks to us or the conflicts and deficiencies that lead to his lack of ego integration.

2/In another sense, we can **put ourselves into the experiences** of the patient, making them ours. However, this last identification is not fully possible in the encounter with the schizophrenic patient, because his feelings do **not** procede from that **integrative ego** system which is the source of language, of logic and of the structure of minds. Only some fragments of his ego are able to feel, and therefore much is **nearly incommunicable**.

This is the reason why the **psychotic** experience is **not possible to fully understand** and to **identify** with, **even** for the patient after his recovery. The difference between the **neurotic** experience of being occasionally **overdirected** by the words of the therapist// and the **psychotic** experience of

"**being made**" by them is that in the latter there is a **loss of the ego**; the ego cathexis, so to speak, **dissolves**. That is the **qualitative turning point**, which perhaps results from a quantitative crescendo, but is not only a gradual continuation of the previous state.

3/ I should now like to use the word *einfühlbar* in a third context. In the course of a group therapeutic session, a patient put forward some **complaints**, all of which came out of a neurotic feeling of **weakness** or **social failure**.

After he had finished speaking, a second patient argued that he felt himself **cheated** and **frustrated by** the remarks of the **first** patient. Notwithstanding the astonishment of the first group member, he stubbornly repeated that this was **like blackmail** to him.

The group asked him to explain his feeling, which was for them *uneinfühlbar*, that is, which none of them could identify with.

But he could not add anything. Moreover, he felt the others were unable to understand him.

Of course, the group concluded that this second patient was not able to put himself into the feelings of other persons and acted out his own *uneinfühlbar* reactions.

I had the opportunity to speak privately to this patient, and a many-sided picture slowly arose, which I can only summarize here.

As a child the patient suffered because he lived within a very **frustrating family** structure. He was **never able to express** his own counteraggressions, especially toward his mother. He felt **guilty** every time he felt aggressive, because his **mother** had an **easily injured**, sensitive, weak side, which at the same time he also wanted to **protect**. The **mother often complained** — just like the first patient in the group — of her social failure and feeling of helplessness, without gaining insight into the ways she manipulated others, and especially

her child, through this very weakness. However, she **also loved** the child in her own way, so that he could not free himself from this **double-bind communication**. It may be that he admired his mother for her surface selflessness and was therefore caught by the positive aspects of the symbiotic relationship. However, he **unconsciously hated** all the more the worship imposed upon him and felt it as blackmail.

When the patient reacted to the complaints of his fellow patient with the unusual feeling of being cheated and blackmailed, he only **transferred** this from his unconscious attitude toward his mother.

However, this projection **lacked** those characteristics found in most **neurotic** transferences, that is, the similarity of the two figures to each other. The two situations, that of the group and that of his childhood, were extremely dissimilar, owing to the fact that our **first patient did not** have a personality like the mother's and also had not addressed himself to the second patient. The **confusion of these two figures**, the mother and the first patient, simply arose from the **tiny fact** of their both complaining. If a transference is triggered by such a little chance occurrence, by an **occasional aspect of reality**, probably due to a strong predisposition to mix objects, events, and feelings, then we get a picture of such a person being self-centered and surely autistic. Since the reality—which we grasped in our interview with the patient—could not be sensed under normal circumstances, the patient's behavior appeared to the group not as a transference, but as something fully *uneinfühlbar*.

This third sense of the word *uneinfuhlbar* lies, therefore, between the poles first mentioned. It is not completely absurd, but it is not easily graspable, as in neurosis. It needs a **special kind of understanding** which goes beyond social boundaries, sometimes impossible even within a routine psychiatric consultation. It may be most possible in the mirror of a psychotherapeutic process. These considerations raise the problem of transference and confront us with the classic question of whether schizophrenics are **?able** to make **transference relationships**.

It is well known that **Freud** considered the schizophrenias to be "**narcissistic neuroses**", as contrasted with the so-called **transference neurosis**. This thesis was rooted in the peculiar theory that object **representations** that are repressed into the unconscious in neurosis //are lost in the unconscious depths of the schizophrenic patient. Accordingly, the patient is then not able to transfer the

unconscious imago of his father, for instance, upon the psychotherapist because such an imago has disintegrated on the unconscious level.

However, the great majority of researchers — from Federn to Rosen, from Sechehaye to Fromm-Reichmann — are now convinced that the schizophrenic patient **does make transferences**. Fromm-Reichmann has even said that psychiatric transference is not readily discernible because it is magnified upon the whole reality.

However, the **problem of schizophrenic transference** cannot be examined without considering the problem of **schizophrenic autism**, which is its counterpart. Can we now see this problem of autism from the inner standpoint of the patient's experience? Only a few schizophrenic patients, those who are

capable of introspection, are able to describe such experiences. Therefore, such infrequent observations are all the more impressive and valuable.

For example, a schizophrenic patient told me that he was able to **distinguish** between his inner refusal of the world, which was part of his broader ego activity, // and his specific autistic loss of contact. The former was, for him, the consequence of some conflict,// but the specific autistic experience appeared to him to be different from a conflict; it was as if an important link was missing in the psychic chain which usually connects the individual with the world. In the latter the patient sensed that other people were friendly to him, but he himself had to remain indifferent to them, "helplessly alone."*

In the face of such problems, the **psychotherapeutic** task in schizophrenia appears completely different from that in neurosis. The task is not to find a special way to interpret transference, but to **account** for a **new phenomenon**, that of autism, which is deeply intertwined with that of transference. The point is that the disorganized schizophrenic ego is often not able to perform that set of mental operations that is necessary to really understand and introject the therapist's interpretations.

Instead, we must try to **come into touch with the patient** in such a way as to counteract his deep loss of contact. We must **create that missing link**, mentioned by the patient, which, according to the terminology of Federn, could be named the **ego cathexis of reality**. However, to come into emotional touch with the schizophrenic patient is a **hard** task because of his extreme fear of contact and, especially, because of his real dissolving in the face of others.

Therefore we must accept **reaching** him **only within his symptoms** using his symptoms, as necessary channels through which to approach him.

Schizophrenic symptoms are not only attempts of the patient to **communicate** something,//+ but are also his ways of **deending himself from contact**.

The **defensive** capacity characteristic of all schizophrenic symptoms rests on the fact that psychotic symptoms are, according to their **basic linguistic structure**, not completely translatable into logical operations of the mind. Therefore, we can never "possess" logically a schizophrenic communication and the patient within it. Only in this condition of **never being grasped** by others through intellectual operations can he **escape that contact** || which he is **seeking**. This kind of defense is of utmost importance for the **psychic survival** of the patient. Instead of trying to take his symptoms away from him, we therefore **must live with him** in the symptoms, that is, react emotionally to the kind of affects contained in the symptoms. Later in this paper I will try to explain this by using examples.

In the meantime, it is evident that the prospective **meaning of a symptom** can change if a **therapeutic** element becomes **introjected** into it.

A patient's **somatic hallucination** that his brain was split into two different halves, a normal

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* This "splitting" between oneself and the world is one aspect of the intrasystemic ego splitting. That is why both Eugen Bleuler and Minkowski were right, as Manfred Bleuler put it, in considering both splitting and autism as the primary symptoms.

and a syphilitic one, >> was transformed into a dramatic somatic hallucination in which the direction toward **past** changed into that toward **future**. The patient now hallucinated, after long psychotherapy, a hole in his stomach through which a mystic, unreal **sunshine**, shining on the ceiling of his room, **filled him** with living matter. This was the **end of his chronic psychosis**. The unreal experience

of being filled with sun-matter was indeed the psychotic mirror of a powerful reality, which used psychosis only to overcome it. Instead of seeing such symptoms as the expression of acting out—which means the sterile repetition of the psychopathological past—we could define this **healing psychotic process** as an "hallucinating in" of a powerful new future, which could not be transmitted by the tiny vehicle of words, and whose reality was founded in the therapeutic psychic symbiosis of therapist and patient.

We must take into account the **limits of psychoanalysis** in the psychic treatment of schizophrenia. If we assume that a psychodynamic stress **overburdens** the weak synthesizing power of the schizophrenic ego, then we could also think that an analysis—which in theory dissolves the cause of the stress—would relieve the patient.

However, analytic experience has sufficiently shown us that such a relief is achieved only by passing through a **long series of transitory stresses**, such as resistances, transference experiences, interpretations and the like. These, if they are at all understood by the patient, are **often sensed as attacks** against him. All this overburdens the ego of the schizophrenic in such a way that many a patient even believes that it is the **treatment which makes him ill**. Freud also knew well that the **weak psychotic ego** was not able to bear the work of psychoanalysis.

It is well known how often **psychotic decompensations**, delusional transferences, and ideas of persecution occur in the **course** of psychoanalysis of schizophrenic patients. Reports of such therapeutic experiences were so convincing that many analysts came to believe that it would be a major mistake to start psychoanalysis with a neurotic patient who was suffering from a beginning or latent schizophrenia.

The **divided and disintegrating schizophrenic ego** is too lacking in that integrative strength necessary to confront in a constructive way his **own inner** complexes and conflicts.

The ego becomes, instead, either **dissolved** or **rendered helpless** by these same conflicts that he is trying to face with our help.

When we become aware of this danger, we should be **prudent** in the use of analytic means. Psychotherapy of schizophrenia exists within the **contradictory dialectic** that it wishes to approach that psychic kernel of the patient which at the same time cannot bear any approach.

Let us look more closely at the danger which, for example, the **interpretation** of an infantile sexual complex can arouse. I once told a **borderline** patient, who lived in an intense and ambivalent relationship with his girl friend, that his relationship to her contained some oedipal traits, a trace of that ambivalence which was once experienced by him in his relationship with his mother. (A neurotic would either become thoughtful about such an interpretation or reject it. It may be that he would accept it on a purely rational

level, which would also be resistance.) The reaction of my patient, however, was surprising even to me, but characteristic for the schizophrenic condition.

At first he **said nothing**.>> The next day he told me that my interpretations had put him into a **panic**, though not because of the content. It had caused him a feeling of a "**loss of structure inside**." The idea that the **present** time could be **entangled** with elements from the **past** was **unbearable** to him, as he felt that such a mixture of present and past would not be real at all. His **relationship** to his girl friend was therefore something **unreal**, and he feared that he had been cheating her by offering her something unreal. He also now suffered from the feeling that he would not succeed in distinguishing between two similar but different things, such as the present and the past experience. It appeared to him as if he were caught in a **contamination** of two different levels which transformed his psychic structure into an amorphous mass.

This patient obviously reacted to my objectively correct interpretation with **depersonalization**. Can we understand this feeling of depersonalization purely as a defense against the insight? We can not, since our classic concept of resistance means that the ego is defending itself by means of that behavior, whereas the depersonalization of our patient indicated a worsening of the intrapsychic situation, namely, an incipient **dissolution of the ego**.

In contrast to the very sick schizophrenic patient, who is not capable of introspection, our patient was still moving on the **fringe of reality**; he sensed the closeness of his underlying identity confusion and therefore became highly anxious.

Another limit in the use of psychoanalysis in the psychotherapy of schizophrenics is the problem of the **analysis of resistance**.

Freud showed that we can **remove** a resistance **by showing** it to the neurotic patient. But, of course, the neurotic patient will not give up his resistance at once. He cannot do this, because resistance is woven into the structure of his life style. At first the patient will become angry, will feel himself misunderstood, will protest. >> Then such factors as a progressive transformation of his ego, the insight into the goals of analysis, and his experiencing our sincere interest toward him will gradually be able to overcome his resistance.

// But the **schizophrenic** patient **cannot** have a **goal** at all, or a feeling of **hope**. He is **unable** to get in touch with our concern for him. His feeling of not being understood magnifies itself into the conviction of being **rejected** or even **persecuted**.

The problem is, then, how to make it possible to **?achieve communication** within the limits of such **resistance**.

Consider the following example. A female patient refused to speak with her therapist because she claimed that she did not live on earth, but in a soap bubble.

The therapist then began to speak to her about her necessity for living in this soap bubble, that is, in something which expressed to her the full fragility and uncertainty of her existence. Thus, the therapist did not interpret the soap bubble as a **resistance**, but understood it as an **expression of the security needs** of his patient. Only then, when this symbol—which might have appeared to others as only a **bizarre symptom** of negativism or isolation — **received a legitimate place** in the common thought

of patient and therapist, did the latter make a positive movement. He then **expressed a wish** for a **golden thread which would connec**t him to the soap bubble, that is, to the existence of his patient.

At this point the patient began to experience a communication with a person who **did not take away her limits** through his wishes for contact // but, instead appreciated, even her resistance and considered it as a valuable aspect. This appreciation does not mean, of course, an attempt only to reassure the patient, but has a deeper purpose. It implies that a **resistance**, which has the **function of supporting a crumbling wall** — the patient's ego—would fade away by itself if the therapist assumes that supporting function himself.

The uncovering of psychopathology is necessary in neurosis. The patient is able to start **observing** himself.// But such an uncovering means to the **schizophrenic** patient a **new shattering of his weak ego**. He lacks that healthy ground to stand upon in order to observe himself. He is always in the danger of toppling into the pit of his problems.

Therefore, the uncovering of his psychopathological **past** is **meaningful** to him only if he can grasp the ways he had **come to misunderstand himself** through being misunderstood.

We do not only say to him, for example, that he was **dependent upon his mother**, //+but also that his **mother did not sufficiently encourage** her growing son.

We do not say to him that **he hated his father**,//+ but that he **had to hate** his father who had **rejected** him and that he could not realize this without becoming crippled by guilt.

We do not tell him that he had been **unable to feel secure** about his **real sexual identity**,//+ but rather that he **did not get the opportunity** to **trust his sexual identity**. We do not tell him that he has behaved antisocially, but rather that he was never able to understand because of the impossibility for him to grasp his self-identity in the responses of society. We do not tell him that he had had weak object relations, but instead that no partner had loved him in such a way that he could have developed object relationships. And this is true, at least on the operational level. At the end bf a session the patient is never left alone with an unsolved problem; a partial solution is always offered to him. No psychopathological trait of his personality is ever uncovered without indicating those moments in his life which had contributed to his difficulty. We must stress that thepsychotherapy of schizophrenia distinguishes itself from the psychotherapy of neurosis in that it stretches itself into the future. It does not only analyze the past, but also offers to the patient constructive alternatives to change it. It is, therefore, psychosynthesis no less than psychoanalysis.

A most important step in the psychotherapy of schizophrenia is the affirmation of the personality of the patient through the great symbols, which emerge from the depths of the patients

themselves. The instrument which enables us to come in touch with the great images of the unconscious of the patient is our capacity to become caught by them, without being divided by them as the patient is, and to tell the patient what they mean to us. We show the patient the impact of his symbols upon us, not only his dynamic position in the face of them. We do not only clarify the unconscious of the patient, but we ao try to integrate it into ours.

This can be better understood by an example. A patient experienced her ego splitting by means of an image of two hostile armies clashing against each other. She expressed her desperate attempt at holding the two warring parts of herself together with the belief that she was not allowed to close her eyes even for a moment, because in that case the world would go under. In other words, by means of a hypercathexis of her attention she tried to save her self-identity. However, an interpretation of the inner conflict alone would not have been sufficient, as our experience in such cases shows us. The therapist simply said to the patient that she was allowed to sleep because the therapist would remain awake for her. This was, of course, not a psychogenetic explanation, not a psychoanalytic attempt at showing the patient how the two armies were to be considered as two conflicting parts of her personality. The answer of the therapist was not a picture of the psychic situation, but an attempt to put himself into the situation, to take over himself that integrating role which the patient missed and which she had tried to replace by keeping her eyes open and her attention tense.

We can say at this point that we do not only interpret the psychotic images to the patient, but that we are interpreted to the patient through the way in which we respond to the images, symbols and symptoms of the patient. We can see with this last point the full difference between the psychoanalysis of neurosis and the individualpsychotherapy of schizophrenia. In the first, the stress is put upon understanding the symptoms and interpreting them to the patient. Of course, this very process ofinterpretation cannot go forward without a deep emotional involvement, which has to be interpreted. In the psychotherapy of schizophrenia we use the same means of understanding and interpreting. However, we interpret in different parameters. We treat, for example, as I have tried to show, resistance and transference in different ways. Even the content of our interpretations is different, because we must make clear to the patient especially the intertangled ways, how his feeling of reality confusion and his distortions are rooted in a desperate failure of sensing and grasping the limits and the structure of his own self in the confusing mirror of past experience. But this different emphasis in interpretation is not enough for treating the schizophrenic patients. Integration is the very goal of therapy, and the therapist becomes integrating by his readiness to stay with his patient in the fantastic and terrifying situations of psychosis: in death and the hope for life, in the soap bubble, in the labyrinth, in face of the sphinx, on the verge of falling down into the abyss. The therapeutic fantasy is a powerful agent, but it means specifically the capability of the therapist to disintegrate into the shared world of the patient and then to reintegrate himself within the patient. The therapist becomes a mirror of the disintegrated parts of his patient and organizes them, in that he is also a pathic object of the psychosis of this patient. This is symbolic realization too. But it is only verbal, and it is more than symbolic. It realizes more than usual the oral, anal or agressive needs of the schizophrenic patient; it realizes conquering existence and integrating existence in a person and in a personal relationship.