Individual Psychotherapy of Schizophrenia

by Gaetano Benedetti

Abstract

The work of the author and others in the field of psychotherapy of schizophrenia is said to have demonstrated that understanding the patient requires a special therapeutic relationship which is different from that in the psychoanalysis of neurosis because it implies an intrapsychic process that can be described as follows: Parts of the ill personality are introjected by the psychotherapist and parts of his personality are adopted by the patient, as shown by the fact that the dreams and the unconscious fantasies and striving of the therapist reflect the anxieties of the patient, and the dreams of the latter are structured by the inner movements of the former, as if there were a partially shared identity between them both. This phenomenon is called "identification." The psychotherapy of schizophrenia reveals realms of existence in which understanding is not only a function of personality, but also a transformation of personality by the act of being near the patient.

A sensitive understanding of a life history which has led to schizophrenia does not constitute proof that some biological causes were not also present. The recent work of Rosenthal et al. (1968) has pointed to the existence of a hereditary transmission of the illness, which is an important alternative to the etiological theories of psychological and family influences. An intertwining of psychological influences with biological predispositions has long been postulated by Manfred Bleuler (1954) to be at the roots of schizophrenia.

At the beginning of this century, Eugen Bleuler (1911) theorized that many schizophrenic symptoms are due to the psychological reaction of the personality to the unknown process of the disease. This was the first step of psychodynamic thinking in modern psychiatry. The second step was taken by Jung (1907), who, at Burgholzli, continued this line of thought in his thesis that schizophrenic symptoms can be cured by psychotherapy. He stressed the psychogenetic point of view. We have discovered since then that the working through of the psychological "secondary" symptoms can also affect the very basis of the disease, even its "primary" symptoms (Benedetti 1975).

The third step was also taken in Switzerland by Ludwig Binswanger (1957), who demonstrated that every psychotic symptom is so connected with every other as to form a schizophrenic "world" of its own, which can be explored only by means of psychological research. It seems that splitting and autism, as Manfred Bleuler (1972) pointed out, lie at the very core of the whole schizophrenic psychopathology, and are its fundamental symptoms. As the central

1 The importance of the hereditary factor is, of course, controversial. According to the most recent research of Tienari (in press), the mental health of the adopted-away offspring of schizophrenics is largely dependent upon the mental health of the adoptive families.

2 I owe to Manfred Bleuler the concept that schizophrenia is an illness caused by the continuous intertwining of psycho-traumatic life histories and biological predispositions, and I am indebted to him for his constant encouragement of my work.

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events of schizophrenia are a multiple splitting of the ego (Spaltung) and its autistic retreat from the world, psychotherapy aims at the creation of a therapeutic integration of the patient, which does not work on the social level alone (as does sociotherapy and social rehabilitation) but goes deep into the unconscious, so that within the patient an intra-psychic synthesis can be fostered through the mirror of what happens in the dual patient-therapist field (Benedetti 1975).

Such an integration is attempted by means of the capability of the therapeutic person to enter into the world of the schizophrenic, using shared symbols of the patient, the therapist's creative fantasies, as well as ego-nourishing dynamic interpretations, all of which stimulate from within the psychotic world the necessary psychosynthetic forces (Benedetti 1975).

Such psychotherapy is, therefore, that point of integration where psychoanalysis merges with psychosynthesis, and where the development of the patient and the self-realization of his therapist are symmetrical phenomena. Only if the psychotherapist can himself take a step toward his own individualization (individuation, Jung), through the encounter with his patient, is the latter also able to construct his new sane world within that of his therapeutic partner (Benedetti 1975).

The Psychotherapeutic Relationship in the Individual Treatment of Schizophrenia

Individual psychotherapy of the schizophrenic patient begins with the "entrance" of the psychotherapist into the actual situation and into the world of his partner. "Entrance" is something that all psychotherapists of the schizophrenic ill have experienced and described, although with different words, as something fundamental. They speak of participation (Sullivan 1962), therapeutic love (Rosen 1953), relatedness (Arieti 1955), therapeutic symbiosis (Searles 1964), intentionality (Schultz-Hencke 1952), identification (Benedetti 1975a, 1975b, 1978, 1979), etc. I believe that such a relation is not only symbolic, as is transference, but also symbolizing, as is reality itself. Only in this way can the relationship create a dual world of experience which goes far beyond what can be clinically grasped, and which also contributes to the "individuation" of the psychotherapist himself. Entrance into the actual situation and into the world of the ill is experienced by the psychotherapist as a gift given to him by the patient himself and by his own unconscious, but it can also be trained and stimulated by our meditation. This situation of entrance, once it has arisen, reveals itself on different levels, which can all either coexist simultaneously or appear singly.

I shall describe only three of them:

1. Therapeutic dreams arise and show us our unconscious concern with the patient, as has recently been so beautifully illustrated by Isotti (1978). They lack the classical dichotomy between latent and manifest content, postulated by Freud (1925) for all dreams because they serve therapeutic communication and can therefore be used to reinforce it. The two following examples may illustrate this:

A patient feared the eyes of his therapist. He felt that he was being hypnotized and killed by them. The following night the therapist dreamed that he saw the eyes of his patient, which were staring at him. They were enormous and terrible, as the therapist's eyes had been in the patient's experience. The therapist trembled with anxiety, but could withstand the look because it seemed to him, in his dream, to be that of eternity itself. We see here a reversal of the death experience of the patient into a fearful, but grandiose life experience of the therapist.

Another therapist dreamed:

I found myself together with an incurable schizophrenic in a gloomy, lonely, and cheerless room. Only few words were spoken. Suddenly it was as if a curtain lifted; a second level of reality appeared (the psychotherapeutic transformation of the phenomenon of a splitting between a first and a second level of symbolization). In a vision of eternity the patient appeared to me as a hero, as leader of many shining knights charging into infinity. Astonished, I looked at this picture, and I suddenly knew that both levels, that of the psychotic reality and that of the transcendental vision were complementary in C. G. Jung's sense of the word.

2. Some negative feelings of the patient, of which he is not aware and cannot verbalize, are perceived by the therapist as his own. In this way he experiences the patient's unconscious by sensing it within his own being. For example, it can happen that the patient can realize his own latent aggressivity only after his therapist, who has not yet discovered it, wonders about his own aggressive mood, which seems to him to be without any cause. In one supervision I controlled a problematic counter-transference of a therapist, who felt disgusted by her patient, without, however, finding any reason for it. I guessed that such a feeling could be the manifest sign of her capability to come in touch with some "disgusting" parts of the patient's unconscious.

3. Therapeutic communication is used as mirror of what happens in the actual situation of the patient. In the following example the therapist's dream (1925), illustrates this: the therapist was afraid of the patient's eyes and trembled with anxiety, but could withstand the look because it seemed to him to be that of eternity itself. We see here a reversal of the death experience of the patient into a fearful, but grandiose life experience of the therapist.

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After the therapist could, with the help of my interpretation, overcome her anxious countertransference, the patient (a girl) became conscious of a sexual problem, which disgusted her (and no longer the therapist). She (the patient) then dreamed of a loathsome man, whose features became more and more gross and repulsive, and who urinated into the glasses of people at the table. At this point it became possible to work through the patient's sexual disturbance. But this problem only came to light through the transient therapeutic "appersonation" (Appersonierung) which was no rejection of the patient's sexuality, but the sign that the therapist's unconscious had merged with that of the patient, in order to structure it.

We see also that a psychoanalytical phenomenon becomes, in the therapeutic identification with the patient, a way of "taking over" his existence. "Taking over" here means that the patient's unconscious is not discovered by the interpretation of verbal signals, as in the psychoanalyses of neurosis, but it must be carried mutually by both the patient and his therapist in order to become articulated. Whereas, in classical psychoanalysis, transference is an alternation of actual reality and must be shown as such to the patient, mutual identification is the ground for a dual reality in psychotic autism. It sometimes seems that even the schizophrenic unconscious is disintegrated, as Freud (1925) himself surmised when he spoke of the loss of intrapsychic images in the psychotic unconscious. This must therefore not only become discovered, but first be born as a structure out of the act of a primary duality which lies at the very roots of psychic life.

Without a therapeutic "receiver," the patient's sensations are so far disorganized, fragmented, depersonalized, and derealized that they can never be transformed into structured ego experiences. They are not simply repressed as fantasies or affects, as in neurosis, but they disintegrate into parts of sentences, to voices, and abstruse meanings in the psychotic world.

3. The autistic schizophrenic symbols become, in the language of the therapist, dualized symbols of insight and communication. They are still the old ones, but they are filled with new life, the identity of the therapist-patient. For instance, a patient who felt influenced by everything says now, in the psychotherapy, that she is "thrown around" by the therapist's words—these are now the "influencing machine" (Tausk 1919), which, however, have a new role, do not persecute, but protect the patient.

The counteridentification of the patient with his therapeutic parts by means of the acceptance of the therapist's interpretations appears to be possible only to the same degree that the therapist, on his part, identifies with the introjected fragmented experiences of his patient. In the psychotherapy of schizophrenia, the patient learns to distinguish between object and self, to sense his surroundings, and to organize his fragmented ego functions by means of the therapist's allowing himself to be used as symbiotic object. The recovery or the improvement of the patient does not occur only on the level of adaptation to social norms by overcoming resistances toward them, but rather as a change in the therapist himself, in the adapting of the therapist to the patient and the potential humanity of his existence.

The range of psychopathological facts is narrowed by this discovery, as many things, which at first seem to be meaningless in psychosis, acquire significance in that special area of reality which is formed by the mutual introduction and projection processes of the patient and his therapist, as if there were a third reality between the healthy one of the detached observer and the psychotic, irrational one of the patient.

The concept of what is reality, psychodynamically seen, in the dual experience of therapy defies logical definitions. The point, however, is that the classical psychopathological processes of appersonation and transivity become, ultimately, the very forces of separation between the self and the world, in that they are used in the therapeutic symbiosis. But we should not forget that the very therapeutic "weapon" of the identification grows out of the knowledge that therapeutic countertransference can also be very harmful, if it does not serve the interests of the patient. It has been shown that in the therapy of schizophrenia, the unconscious countertransference of the therapist can be the unconscious cause of many behavior patterns of the patient (Searles 1964). This broadens the concept of schizophrenia as pure transmission or introduction of irrationality. Not only the family (Lidz 1968) or society (Basaglia 1968) but also our psychiatric unconscious plays a role here. Schizophrenia can also be considered as the internalization of the irrationality of all existence.

It is one central paradox of the psychotherapy of psychosis that it uses the same autistic symbols which form the basis of the schizophrenic psychopathology in order to create a means of communication with the patient. The paradox is also that we psychotherapists must give up our "delusional possession of reality" (Siirala 1972), our clinical demands and expectancies, our hierarchical privileges of normality, our tenden-
cies to exercise a cognitive power over the ill, and our needs to adapt the patients to ourselves—in order to share with them the great symbols of the psychosis and the desperate attempts of the ill toward self-realization.

Therapeutic entrance into the actual situation is in psychosis more important than is the reconstruction of the past in the psychoanalysis of neurosis; it is the therapist's message to the patient. I must discuss now an objection to such a personal therapeutic approach which has been raised by many authors. Laing (1959) for example speaks of the danger of an "implosion," that is, the dissolving of the schizophrenic ego when confronted with our emotions. Frieda Fromm-Reichmann (1950) also tells us that any offer of love or friendship to the mentally ill should be avoided. I agree, of course, with these authors insofar as they warn against a superficial emotional approach to the patient, which can only be sensed by him as a demand from us. The matter is different, however, if "therapeutic love" means our readiness to be with the patient in his world of death. Our messages to the patient convey that we do not expect anything from him, that we want only to be with him in his dreams, fantasies, and terrifying experiences.

A therapist, for example, listens to a patient who feels surrounded by screaming devils; he tells the patient that he, too, is there; and, by leaping into the demonic circle, forces the patient to perceive his presence in the very core of his psychotic world. Another patient relates a frightening hallucination in which he is overwhelmed by a flood of water. The therapist "sees" the deluge, "la creux de la vague" (in French also the term for impending catastrophe), and he braces himself to withstand this vision. In another case the therapist relates to his suicidal patient his own dream, in which the latter throws himself out of the window; in an attempt to save her, the therapist runs to the window and can hold her in the air with his eyes. The patient said, after hearing this dream, that she was then no longer able to kill herself.

I do not deny that even this mutual dwelling in death can be rejected by the patient. But in my experience the patient longs for nothing as much as he does the object of his resistance, his therapist. Only then can the death which has been taken over by the therapist be overcome by the patient. The patient asks fearfully whether the therapist is still alive, whether he eats and sleeps well, whether he still exists, for if the therapist exists, so, too, can he.

My point here is that the therapist does not first try to rationalize the symptoms of the psychotic patient, but wants to be together with him within his symptoms. The first step of the psychotherapy is this dualized psychopathology. This was well expressed by a patient who, during her psychosis, had a terror of the world as if it were a train bearing down upon her. During psychotherapy she developed a "therapeutic hallucination" in which she heard the therapist tell her to lie between the rails. She asked, frightened, how she could do this. The hallucinated therapist answered that he would lie between the rails with her.

I call this mutual process "identification" and "counteridentification," and I mean that the fragmented patient's ego finds its own identity by identification with the integrated ego of the therapist.

At the end of this process, the psychopathological phenomenon of "transitivism" is transformed into an act of psychotherapeutic mutuality. This is shown by the following dream of a patient, in which an animal lay bound in a stall, dying of hunger and thirst. "What good fortune that you have come to save me in the last minute," cried the animal to the patient, as she began to cut its ropes. In this dream the patient had assumed the role of the therapist, as it was as if she herself had cut the ropes to save herself. This identification was only possible because the therapist had often identified with the suffering of the patient and had thereby experienced himself as the bound animal.

Interpretation and Resistance In the Psychotherapy of Schizophrenia

Another fundamental point concerns the problem of psychodynamic interpretation. We can reach the core of the question by asking ourselves, how we can distinguish between therapeutic interpretations in schizophrenia and in neurosis.

1. Interpretations in the psychotherapy of schizophrenia can hardly grasp the connections of an individual psychogenesis in such an exhaustive manner that they could really explain why conflicts must be carried out by the patient in a schizophrenic way. Interpretations are, therefore, "operational" in nature, in that they do not discover a specificity of psychodynamics at the roots of schizophrenia. They give rather pictures of the dynamic and existential situations between the patient and his therapist. They can also be formed by therapeutic fantasies without, therefore, being untrue, because they unfold in this way the therapeutic relationship. Interpretations translate schizophrenic processes into psychogenetic events in order to give to the patient the key to the structuring of his psychotic ex-
periences, as they are mirrored back to him by the therapist.

2. Interpretations are concerned not only with drives and instinctual needs of the patients, as in neurosis, but also with what I would call "structural needs" of the schizophrenic ego. I mean by these the needs of the patients to distinguish between egoic and alien, to grasp the frontiers of their own egos, to structure associations in time and space, to find an intrapsychic coherence, and so on. To understand such conditions demands a new level of psychodynamics which does not exist in neurosis, and which must be reached by the psychotherapist by being with the patient in the depth of his abnormal psychology.

3. The psychotherapy of psychosis is different from the psychoanalysis of neurosis because of the different emphasis put on the resistances of the patients.

Freud taught us that we can often overcome neurotic resistances by describing them to the patient. This presupposes a healthy part of the ego which can work with us and look on the sick part of itself. Only those few schizophrenics who are similar to neurotics are able to do this.

Most schizophrenics are so dependent upon their own autistic, delusional, aggressive, paranoid behavior, that their clinging to their systems and symptoms is more than a resistance; it seems to be an attempt at survival by means of organizing a last psychotic identity in the vacuum of their "nonexistence."

The patient, for instance, who has become disintegrated by the intrapsychic presence of a "bad object," projects this upon his therapist by feeling persecuted by him. In this way he tries to get rid of the "bad object" in order to experience himself as a unity. A second autistic patient refuses a surrounding world which dissolves him, in order to slip into a safe protected corner of himself. A third patient, who cannot develop any loving connection to the world and to himself, tries to compensate this lack with the delusion of love.

It would be naive to assume that it could be of use to the ill to be confronted with the psychodynamics of such phenomena as the knowledge of them would be for him only a tiny reality that could not fill the terrible vacuum within himself.

We may, however, reach the patient if we convey to him, through our interpretations, the feeling that we accept and understand his resistances as necessary expressions of himself which permit us to know his world and so to relate to it. We do not merely wish to reduce his resistance to psychological mechanisms.

In this connection I remember a patient who idealized me as God himself. It was of no use to reduce this delusional transference to the loss of her beloved mother during childhood. She maintained that the origin of her feelings toward me was the actual dual reality. The patient was, however, impressed by my interpretation that I felt myself to be for her the mirror of a radiating metaphysical sun, which could reach her through me in order to become, later, a part of herself. If such interpretations are aimed at putting ourselves into the psychotic world of the patient, then this psychotic world must become valuable to us as a message of a human longing for personal existence.

The Psychotic Relevance of This Work

The essential significance of this work does not lie, of course, on a statistical level. One is faced with the fact that in individual treatment of psychosis, from 2 to 8 hours weekly are needed, so that only a small number of cases can be benefited. We are then confronted with the dilemma that either, as in some cases, the clinical results of the great therapeutic engagement do not go far beyond what one could reasonably expect from the normal course of the sickness, or else the medical satisfaction for the healing of chronic patients, who otherwise seemed incurable, is counteracted by the objection that our successful cases belong to a small privileged group of patients, compared with the majority of schizophrenics.

Of course, suffering people all belong to the most discriminated against human beings. How can one, however, justify the great efforts of the individual psychotherapy of the few when thousands are excluded? We must realize that the social benefits of this work do lie on another level.

1. The psychiatrist with experience from the individual psychotherapy of psychosis develops a sensitivity which also enables him to better master other psychotherapeutic tasks of his daily activities, such as short treatments, long-term counseling, group psychotherapies, single consultations, etc. It has been my experience that the knowledge acquired from individual psychotherapy can permeate many fields of psychiatry, insofar as they are ready for such influence.

2. A second point lies in the fact that this work with a few patients can tell us more, from the dynamic point of view, about the essence of schizophrenia than the more descriptive form of observing thousands of cases in a psychiatric institute.

3. Lastly, I would like to mention a point which goes beyond specific psychiatric interest. Individual treatment is a human challenge to us, and permits a personal view of the suffering individual, which belongs to the
great experiences of what the human being is.

References


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