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Short-focus psychodynamic oriented psychotherapy as treatment optimization technique in involution psychoses

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Aim of the research. This article is based on the results of empirical experience and a pre-conducted study of the effectiveness of treatment of patients with mental disorders that manifested in the middle period of life (45-60 years). These findings provide an algorithm of short-term psychodynamic oriented psychotherapy focuses on such kind of patients.

Materials and Methods. In order to optimize the psychotherapeutic process, this article suggests to use differentiated therapeutic tactics and interpretive techniques, according to the specific phase of therapy. Each of these tactics and techniques should be focused and correspond to the actual experience of the patient. The proposed method of psychotherapy is a "method of choice" for the treatment of involutional psychosis in combination with medication. With sufficient qualifications of the therapist, this technique can be used both during the active existence of symptoms of psychosis, and within the limits of remission.

Results. The research findings illustrate that the central focus of the experiences of patients with mental disorders manifested in the middle period of life (45-60 years) is the need to come to terms with their own lives (with the circumstances of the internal and external realities). According to this fact, the central focus of the therapeutic work with such patients should be formulated in the same way.

The treatment process of this central focus occurs in six psychotherapeutic phases, each of which develops its thematic aspect. These phases can be conditionally placed in the following sequence: 1) the phase “building trust with the therapist”; 2) the phase of “making claims to/in the inner circle”; 3) the phase of “memories of one’s own achievements and good times” (the phase of “relative validation / verification” of the positive moments of one’s life, and therefore the positive qualities of one’s own personality); 4) the phase of “rethinking your life and understanding your own part in it”; 5) the phase “understanding the connection between one’s own life and a current illness”; 6) the phase of “forgiveness of oneself for the mistakes, finding new values in life”.

Conclusions. We have shown that the central focus of the experiences of patients with mental disorders manifested in the middle period of life (45-60 years) is the need to reconcile with their own lives. According to this fact, the central focus of therapeutic work with such patients should be object-oriented reconciliation with the circumstances of internal and external realities. The psychotherapeutic process proceeds in six separated phases. The therapist should differentiate therapeutic tactics and interpretive techniques in each of these phases. The therapist`s methods should be congruent with the actual focus of the patient's experiences and the patient's level of the integration of the Ego.

Introduction

The psychoanalytic paradigm allows us to conceptualize involutional psychosis as a result of the decompensation of a narcissistic personality structure when it encounters the existential problems of aging [1]. Involution is a time “taking stock”, which has to do with the need to be aware of the

finite nature of one's existence, one's physical, psychological vulnerability, loneliness and lack of professional and personal actualization. The symptoms of involutional depression or paranoia-like symptoms in this context are a form of the patient's resistance of this awareness, since they allow coping with the traumatic reality in a pathological and non-constructive way, and avoiding the need to reflect on the extent of the changes and one's helplessness in front of these changes. The defensive fragmentation of the self creates the conditions for "re-touching" the subjective attitude to life and makes it impossible to balance the responsibility for their failures (in the case of involutional depression) and the positioning of this responsibility on the people around (in case of involutional paranoia). Thus one of the key aims of psychodynamic psychotherapy is the initiation of the gradual integration of the Self, that would result in constructing a concept that can be understood by the patient and is subjectively meaningful, and allows the patient to restore and clarify the connections between the three basic levels: "the personality", "the life that the patient 'directed'" and the current life situation (including the mental disorder). Integrative and disintegrative processes of the Self are actualized through a dialogue between the patient and the analyst, and also within the context of the internal dimension of this dialogue, that is within the patient's independent reflections about the circumstances of his or her life, the motives and consequences of his or her actions. The flip side of this claim is the acknowledgment of the fact that in the dialogue with the analyst, the patient spontaneously (without being induced by the analyst) actualizes important experiences of the patient that are meaningfully related to, and reflect the mental state of, the patient. These experiences create a spectrum of meanings and condense around certain themes, that can be named and each represents a specific variation of the central focus of experience that has to do with the existential problems of aging. Thus, the formulation of the central focus of experience and the description of its specific variations is an important and relevant problem of treating mental disorders related to involution and can be underlined as the main aim of this stage of working with them.

On the other hand the formulation of the central focus of the patient's experience could also be an "orientational – structural hypotheses" [2], that is worked through in different variations at each phase or stage of the therapy, is constantly checked and clarified, taking into account the current experience of the patient and the dynamics in the patient-analyst relationship. Thus, this procedure (formulating the central focus) has an immediate effect on the therapist's technical position, for instance, maintains the selective nature of the therapist's active attention – and leads to the therapist interpreting certain material and ignoring other kinds of material. Based on the focal hypotheses, the analyst chooses from the material generated by the patient the material that will be introduced into play in the shared psychotherapeutic space or will remain on the margins, without much attention being paid to it [3]. This style of working will be in line with the real framework of working with patients with involutional problems, that have been temporarily hospitalized, when adhering to the ideal technical "parameters" of psychoanalytic psychotherapy as described by K. Isler e.g. the position of free-floating attention, work through any and all material, and a high frequency of sessions, is simply impossible. Therefore the formulation of the main focus in psychodynamic psychotherapy of patients with involutional problems has an important methodological role, since it structures the psychotherapy and gives it direction and dynamics to the therapy itself, and also forces its results a bit.

Patients with involutional psychosis are incapable of making the connection between the current life situation (the illness) with the life they have led (as the paranoid vector of experience) or are unable to accept, or integrate, their real lives in their subjective life history, and are also unable to find meaning in the lives they lead (as the depressive vector of experience)[4]. Thus without going into the details of the factors that determine the mental state of these patients, we might formulate the main focus of their experience, and thus the focus of the therapeutic work in the following way: in lay terms - the need to come to terms with one's life (with the circumstances of external and internal realities; in the language of academic psychology - the need to reconcile one's attitudes to the outside world and about oneself); in the language of psychoanalysis - the need to integrate object and Self representations [5].

The therapeutic process of integrating the self runs parallel to the gradual working through of the focus that has been formulated above, and has certain general patterns and is described through specific variations of themes of this central focus, which in turn form the stages of the process[6].

If all the conditions protecting the variable of space, time and content of the psychotherapeutic sessions have been fulfilled and a sufficient level of the anaclitic –diasphoric transference is gently encouraged and effectively maintained [7], the integrative dialogue will develop fairly spontaneously, but also predictably as a movement through certain stages/phases (The terms “phase of psychotherapy” and “stage of psychotherapy” are used as synonyms in this context). Each stage has specific parameters of the content and the relationship, for instance in the working through of various experiences in the context of a certain level of transference. Thus the movement from one phase to another [8]. Thus the movement from one phase to another is determined by the change of the dominant theme in the patient’s experience and the transformation of the affect, that accompanies the working through of these experiences.

The communication interactions between the therapist and the patient are structured between two points: the object-related and self-related attitudes of the patient. What is meant here is the working through of themes that have to do with analysis and interactions with the outside world, the internal objects and the patient’s own self in turn. The order of working through the main topics is determined by the cycle of changes between the points mentioned above with a decreasing distance between them, that is to say with the tendency of Self-related and object-related attitudes becoming closer, which allows the reconciliation of these opposites and the gradual integration of the whole identity. Based on our experience, in the course of each cycle there is a return to the basic ideas and key experiences that have been articulated during the previous stages of therapy, including the initial interview, however each time at a higher cognitive level and with more diverse emotions. That is to say that in the oscillation between the object-oriented and the self-oriented attitudes there is a cyclical working through the central focus of the experience of the patient of the involutional patients in all its variations. In other words, all the variations of central focus create a particular continuum of meanings, which previous phases include in an undifferentiated/germinating/ folded upstate all the key themes that will unfold, will be worked through and differentiated in the course of further therapy.

At the same time, the differentiation of separate phases in the course of therapy is rather relative. On the one hand, it is rather difficult to draw boundary lines in the space of the relationship, wherein the processes of communication and reflection are not always structured as clear transitions or qualitative jumps. Meaningful themes and their affective echoes do not end suddenly; they are actualized in cycles and die down gradually in the course of cathartic articulation and psychotherapeutic working through. On the other hand, the above-mentioned phases may come one after another in a clear sequence, as well as chaotically between one session and another as well as within one session. For instance, starting with the initial interview, a sequence of stages may be reproduced rather vividly, but within shorter spans of time and thus more superficially, than during later therapy. Moreover, the length of the phases isn’t uniform and differs with every patient. It is determined by the patient’s psychic organization, affective and cognitive resources and finally by specific life experiences.

Materials and Methods

Between January 2003 and December 2007, over 300 patients of involutional age (45-60 years) were examined. These patients had a preliminary diagnosis of "involutional psychosis". They were in a psychiatric hospital for the first time or in relapse (provided that the psychosis manifested itself after 45 years). The dominated final diagnoses, qualified in accordance with the categories and criteria available in the ICD-10 was F33.1. “Recurrent depressive disorder, current episode moderate” and F22.8. “Other persistent delusional disorders”. Patients with: severe somatic diseases and endocrine disorders with marked cerebral atherosclerosis, with the consequences of

posttraumatic cerebrovascular accident, or with severe or recurrent history of craniocerebral trauma, were excluded from the research. Therefore, a final pilot sample of 234 patients was formed for a wider study of involutional psychosis as a psychosomatic problem. All the patients were in a state of active manifestation of psychotic symptoms.

In order to check the effectiveness of the proposed psychotherapeutic technique, we formed two additional experimental subgroups from the final experimental sample: subgroup I (62 cases receiving the psychotherapy and accustomed drug treatment proposed in the study) and subgroup II (44 cases receiving only standard treatment: accustomed medical treatment and available in-patient form of psychotherapy).

Each group received a standard examination before (T1 time point) and after (T2 time point) stages of treatment.

In the course of our work we discovered certain patterns of the structuring of stages of psychodynamic psychotherapy with involutional patients, which can be described as the following tendencies: a) the tendency to become stuck in the first stages of therapy and b) the gradual nature of becoming ready to move on to later stages c) the need to work through final stages of psychotherapy in out-patient format. These characteristics of the dynamics of psychotherapy are primarily determined by the extent of the fragmentation of the Self of the patient: at the initial stages of therapy, the Ego is fragmented to the greatest extent, which corresponds to the psychotic experience of a fragmented Self (involutional paranoid states or involutional depression). The existing differences between the usage of the terms Ego and Self within different schools of psychoanalysis requires clarification of meaning of the above-mentioned terms in the context of this research, Ego in this study is part of the structure of the psyche, which can be described objectively, while “Self” points to the subject’s feeling of himself in his own fantasies [9]. As V. Lyoh points out the formation and existence of the reality principle that regulates the life of the mind and the generally the behavior of the organism” [10]. While Self describes the aspects of the experience of one’s own person, awareness of oneself [10]. In the hypothetical space between the Ego and the Self exist processes of reflective reality testing, representing the reality in the internal world of the subject and using adaptive strategies that correspond to the representations of reality in the internal world. On one hand all this is the basis of the existence of the Self as a coherent experience of oneself, on the other hand, they are conditioned by the needs and the current state of the Self. There is a dialectic relationship between the Ego and the Self, so the deficiency in the functioning of the Ego creates difficulties with coherent experience of self, e.g. the fragmentation/splitting/diffuse state of the Self, and deficiencies in the experience of the integration and coherence of the Self, which disrupts the development of mature Ego mechanisms. The apparent contradiction is removed when you remember that the formation of the core of the Self in an interactive field, when a caregiving object fulfills the function of an auxiliary Ego for the child, by helping maintain the coherence of the child’s Self and thus encouraged the development and maturation of the Ego- function). Therefore even while initiating the integrative dialogue, one cannot hope to achieve quick results. Instead, as the Ego-functions are restored, the patient’s process of reflection on his or her experience encounters fewer obstacles and is served by a more integrated ego, and, thus, this opens access to deeper levels of work and to gradual movement to the next stages of therapy. Therefore, the presence of stages in psychotherapy implies not a constant interchange between one state and another, but rather the tendency towards a greater integration of the Self, towards a greater maturity or restoration of Ego function, which runs parallel to the working through of key life experiences (in other words by gradually working through of the central focus of experience).

Results

The structure of psychodynamic psychotherapy of involutional patients described above was created on the basis of empirical experience. The presence of phases in the psychotherapeutic

process points primarily towards the patient's experience, which moves along the central spectrum of meaning. The patient moves along this spectrum with arbitrary speed, provided that the patient is encouraged (induced) and the process of healing is supported. The themes of each of the stages develop some partial aspect of the central psychotherapeutic focus, namely the integration of the Self and the reconciliation with the internal and external realities. Reflecting on various aspects of the patient's own experience leads to the ability to work through the complete theme that is the focus – emotionally painful and existentially meaningful reason for psychotic decompensation.

However, along with that, the empirical experience we have received allows us to claim that the strictly outlined variations on the central focus of the experience of involutional patients, create specific "mandatory" themes, that have to be worked through therapeutically, in order to integrate the fragmented Self of these patients. Therefore the phases outlined in the therapeutic process create a specific "thematic framework" or "skeleton" of short-term psychodynamic psychotherapy of the basic psychological conflict, with a central focus on the patient's mental health disorder that manifested in the involutional stage of life. The combination of the clearly delineated "thematic framework" of psychotherapy with the appropriate psychotherapeutic and interpretative technique of the physician may be seen as a measured and pathogenetically justified method of psychotherapy of the mentioned conditions (from the perspective of the psychogenesis of the illness), which can be written down in the form of a structured psychotherapeutic sequence of stages (See Table 1).

Phase of therapy	Transference level	Focus of the patient's experience	Therapeutic tactic	Interpretative technique
I. Developing trust for the therapist	Initial positive transference	Unresolved conflict «hope against despair»	The initiation and support of the positive transference.	Gentle supportive interventions, the empathetic feeling of the subjective world view of the patient.
II. The draining of negative experiences	The initial positive transference. The formation of the narcissistic transference/	The cathartic freeing of the affect from the accumulated tension related to the disappointment with one's own life, through the projective positioning of responsibility for this in the people of their surroundings.	The use of flash techniques to verify their immediate experience, by focusing the content of what the patient says and gentle probing narration of the inverse side of the flip side of the experience.	Gentle supportive interventions Flash-technique
III. Positive memories	Primary positive transference. Narcissistic transference	The need to feel one's Self as a source of constructive activity.	Empathetically following the patient, verbalizing of the experiences of the more integrated Ego and a more coherent Self.	Flash –technique
IV. The Re-thinking of one's own life and understanding one'sownrole in it.	The transference of object cathexis	Attempts to accept the responsibility for one's own life, adjusting the concept of the world and oneself.	Tracing the oscillation between the paranoid-schizoid and depressive positions.	Carrying out supportive flash interventions of the, in instances when there is a return to the paranoid –schizoid position and flash interpretations of unconscious content in case of the transition to the depressive position. Gradual movement to the use of O.Kernberg's expressive technique.
V. The pattern of the dynamics of psychodynamic psychotherapy with patients with mental	The transference of object cathexis. The formation of higher levels of transference (classic neurotic	Accepting responsibility not just for the entire trajectory of life, but also for the current situation.	Step–by–step articulation of the key experience and drawing it out to the level of a coherent concept that	O. Kernberg's expressive technique.

disorders that manifest in involutional stages of life.	transference, and gentle polite transference)		the patient is conscious of.	
VI. “The phase of forgiving oneself for the mistakes made and finding new values in life”	Classic neurotic transference. Gentle and polite transference, the development of transference of the “artificially normal Self”	The resolution of the conflict between hope and despair.	Verbalizing the patient’s experience, including the experiences related to the current level of transference. The end of psychotherapy.	O. Kernberg’s expressive technique

Table 1. *The pattern of the dynamics of psychodynamic psychotherapy with patients with mental disorders that manifest in involutional stages of life*

Discussion

At each of the stages of psychodynamic psychotherapy, we used the appropriate therapeutic tactics, that correspond with the current focus of experiences of the patient (the specific variations of the central focus). We will briefly outline each phase and its basic parameters.

The phase "of developing trust for the therapist"

The initiation and support of initial positive transference (anaclitic-diasphoric relationship) correlate with the ability of the patient to trust the analyst and contains the swings in the relationship towards mistrust, and the subsequent return to the previous level of emotional openness due to the gentle supportive interventions by the therapists. It is important to point out that developing trust in narcissistic involutional patients at the start of therapy is possible through a certain formality of relationship with the therapist that are characteristic of the early stages of working with the patient. Close and emotionally intense relationships cause in patients fear of closeness and dependence, and the envy and mistrust. Instead, the first contact with the patient is still fairly formal and superficial and preconsiously is perceived as not particularly meaningful and therefore safe. At the same time, the therapist utilizes flash interpretations to demonstrate that there is no intention to question the patient's worldview as the people around the patient have done, which would damage the patient's self-esteem. The therapist's response demonstrates to the patient that the patient is being heard and understood, that he/she supports the patient's feeling of being capable and competent. The tactic described above creates the conditions for the activation of the anaclitic diastrophic relationship, in which the patient is able to make use of the therapist as a "useful", but not terribly important object (as a safe container and support for his or her fragmented Self.) without having a need to feel at a conscious and preconscious level attachment and gratitude towards the therapist. Thus the first phase of psychotherapy involves the simultaneous neutralization of the negative expectations of the patient and the establishment of a trust for the therapist.

The doubts

The focus of experience: the doubts, the oscillation between hoping for help and lack faith the possibility of getting it. (The basic conflict of "hope against despair"). Therefore in the case of involutional depression, the patient complains of a lack of support, but at the same time, they reject the help offered. (Sherpanye symptom). In the involutional paranoid states – the patient doubts that he/she can be heard, but still tries to talk about him/herself to the doctors. The patient is afraid of being heard and getting help since it will break down the defenses against becoming fully cognizant of the real-life situation. The compromise advantage of psychotic symptoms is that balancing in the point of ambivalence protects against both the realization of the current life situation and their internal situation.

The patient's experiences at this stage are fragmented to the greatest degree and are closer to the

Self-oriented extreme - the patient is deep in his subjective reality and is trying to articulate it either for the first time or in repetition. The formation of the anaclytical-diasphoric system, the appearance in the patient of a preconscious idea that the therapist is a useful but not terribly emotional significant object, pushes the pendulum of the experience in the object-oriented direction. In this case, the patients that suffer from involutional depression this push and the subsequent movement is harder to achieve than for the patients who suffer from involutional paranoid states. The former may be classified as Self-oriented in contrast with the object-oriented state in case of the latter, as the latter disorder must include an external object that the intolerable parts of the patient's own self are projected into, while with involutional depression the relationships with people are removed from the relational level. The patients are sorting out their relationship with themselves, or their destinies (with providence).

Gentle supportive interventions and flash interpretations

The therapeutic tactic consists of gentle supportive interventions and flash interpretations, that initiate a positive transference in particular by listening and sympathizing the experiences in the form that the patients present them (trying to empathetically feel what the patient's subjective depressive or paranoid worldview), by demonstrating polite neutrality regarding the negative expectations of the client, refraining from confrontations with the client or interventions that attack their unhealthy beliefs.

The phase "airing grievances with the people closest to them"

The phase "airing grievances with the people closest to them" could be characterized as draining negative experiences. The patient is able to freely express his images and anxieties, born out of the unconscious feeling of "the collapse of their life or the failure of their life strategy" voiced to the therapist, but projects the responsibility for it onto the immediate surrounding, thus draining negative experiences that the patient isn't able to deal with yet. Containing the patient's frustrating experiences by the therapist frees the patient from the rigid fixation on frustrating experiences and the tension that follows them thus opening the way to the next stage of integrative dialogue.

Harbingers of this stage can be seen in the previous stage when the patient introduces the psychotherapist to his view of the world – a world that is hostile, unreliable, aggressive, incapable of understanding as well as dangerous. During the previous stage, these experiences were generalized and applied to the entire world. At this stage, the theme of grievance dominates and simultaneously is focused on the people in the patient’s immediate surroundings, which demonstrates a greater stability of the Self and allows the patient a more differentiated working through of negative experiences, compared to the level of the first stage. Similarly, this phase is also a prototype for further more differentiated working through the relationship with people around them at the 4^{th} stage of therapy in the context of the patient’s reflections about his effect on “the curve of their life” and they're taking back of their projections.

Cathartic release of accumulated tension

The focus of the patients’ experiences is the cathartic release of accumulated tension related to the disappointments in their life. “Sorting out the relationship” with their people surrounding them and the circumstances of their life (fate, providence), that correspond to working at the object-related end of the meaning continuum of the central focus. In the course of this phase depressive patients relativize their own feeling of incompetence (using the formula “how can I be good if I am surrounded by villains and scumbags?”), paranoid patients show both in actions and words an identification with the idealized ego, which replaces the normal functioning of the Super-Ego (resulting in the formation of a split view of the world, where the patient represents the positive side and other people mostly the negative). Therefore, in any case, we are talking about the self-assertion of the patient, rebuilding the patient’s self-esteem, which opens the way to the next stage.

Flash interventions

The therapeutic tactic of using flash interventions to verify the immediate experience of the patient by focusing on the meaning of what the patient says and the gentle, testing the narration of the flip side of experiences described above. In the case of involutional paranoid states – about the unconscious identification exclusively with a strong/positive part of the role.

The phase of remembering one's own achievements and the good times of positive moments, that is of one's positive qualities

Through the articulation and reflection on this kind of experience a feeling of competence is renewed, which creates the conditions for increasing the integration of the Self. This, in turn, makes it possible to work at more involved levels of meaning in the context of a more profound transference.

Self as a source of constructive activity

The focus of the experience is the patient's need to feel one's own Self as a source of constructive activity, that occurs through the actualization of the memories of being capable, of achievements and successes. The activation of the Self-oriented positions, which exists in this phase of psychotherapy serves a double function: it prepares the patient for the next difficult stage of psychotherapy and at the same time defends against moving to the next stage.

Following the patient

The therapeutic tactic: empathetically following the patient, aiming the flash techniques at articulating the emotional experiences of the more integrated ego and a more whole Self, which the patient experiences during the therapy session.

As in the case of the second phase, the harbingers of these themes can be seen in the previous stages of therapy, for instance in the first stage when the patient receives proof of being treated kindly and taken seriously by the therapist, or during the second stage when the patient while describing an awful surrounding describes him- or herself as better than the environment. The third phase itself also includes the harbingers of the fourth phase and prepares the patient at the level of taking back projections and the integration of the whole Self, which is the core of a positive self- perception.

The phase "of rethinking one's life and understanding of one's role in it"

Using the terms of object relations, it is possible to qualify this phase as the formation of the first shaky and unstable experience with the modality of the depressive position (M. Klein, W. Bion) [11].

Taking and reversing the acceptance of the projections

The focus of the patient's experience is to take and reverse the acceptance of the projections and adjusting the view of the world and oneself, that is to say, the broadening and differentiation and harmonization of the system of Self and object representations. In depressive patients, the defensive "pseudo negative" concept of himself and the world is augmented by the acceptance of the realistic aspects of himself, which include both the positive and negative components, which leads to the repairing of their concept of the surrounding world. The system of object and self-repression of paranoid patients is repaired in a similar way, however, it happens faster in the context of themes of reliability and the lack of it of oneself and one's partners.

Tracking the patient's positions

The therapeutic tactic: to track the patients' between the schizoid-paranoid position and the depressive position, to carry out supportive flash interventions of two types. When the patient returns to the former position, the flash interventions focus on the patients gaining an understanding of the content of their messages, when the patient moves to the latter position the focus is on understanding the unconscious content of the experience. As the Self becomes more integrated and the ego –functions become stronger, and as therefore as the time spent in the depressive stance becomes longer, flash interventions developed by V. Lyoh [12] are gradually replaced by the O.Kernberg's expressive technique [13].

This stage includes experiences in a more differentiated and complete fashion, the harbingers to which could be observed in the previous stages, so here it is possible to observe the repetition of the central theme of therapy - the conflict between making peace with oneself and one's life (one's internal world, and/or the world around) with the internal object (in the language of the theory of object relations), that happens in the general direction of experiences of separation of the rapprochement sub-phase described by M. Mahler [14]. The difference is the qualitatively more profound, more differentiated approach of working through these issues, using the examples of various life experiences, including the experiences in therapy. The main themes of the fourth phase are structured around the object-related extreme, and in the process of going through this stage the themes to begin moving towards Self-oriented experiences. When the therapy is successful "the distance" between these two extremes decreases – the struggle of these two opposites becomes less intense, there is more coherence and the patient is able to make peace between opposite experiences and attitudes.

The phase of "acknowledging the relationship between one's life and the current illness"

This phase means accepting responsibility not only for the entire course of life but also for the current situation of illness. This phase is accompanied by mourning for lost opportunities that prepare the ground for the final stage of therapy. At this particular stage, the previous flickering experience of the depressive position turns into the stable experience of this modality (M. Klein, W. Bion). What we are talking about is the movement from a state of splitting and projecting the undesirable parts of yourself into outside objects (which is characteristic of the experience of the paranoid-schizoid position that dominated at the earlier stages of therapy) to turning around and taking back projections, as well as reflections on and the acceptance of one's wholeness and therefore the responsibility for one's own life. This transition never occurs as a straightforward deliberate movement from one point to another. The psychic maturation is accompanied by the oscillation between the above-mentioned positions, the temporary return to the previous levels of fragmentation of the Self and the gradual movement towards greater integration despite the psychic pain that accompanies the awareness of the reality of life.

The thematic conflict of the variations of the central focus of previous stages of therapy, folded between the extremes of object-related and Self-oriented stances, tends during the fifth stage towards the smallest range of oscillation between these stages, and thus they are closest together and there is a gradual reconciliation with one's life, the world, and the internal objects.

The focus of the experience of the depressive and paranoid patients during this phase completely aligns: "in this world that isn't the best of all possible worlds, but isn't the worst"; "a person that is so imperfect, but sufficiently capable person like me, could have built a better life, so that I wouldn't end up at this point in my life in the hospital or being ill".

Expressive technique

The therapy tactic: expressive technique aimed at the gradual articulation of the key experience described above, and the gradual transition to a consistent formulation, that the patient is able to acknowledge and fully grasp. An assessment of the level transference is also required, if the previous stages of therapy have gone constructively, the transference to the level of classic neurotic transference, a mild positive transference and also to the level of “artificially normal Self” (V. Lyoh) [8].

The phase of "forgiving oneself for the mistakes made and finding new values in life"

The resolution of the basic conflict of “integrity of Self against despair” according to E. Eriksson is resolved during this stage. A constructive resolution of this dilemma in the context of an individual life story is possible as “post-narcissistic love of the human Ego…”, the experience that carries a certain order and spiritual meaning, regardless of the price that has been paid for them” [15].

At this stage the extremes of the spectrum are as close as they ever have been, the oscillation between the object-oriented and Self-oriented extremes ceases to exist and transform into a dialectic “unity of opposites”. Therefore (in an ideal situation) the personal identity is complete and a way towards a new way of relating to oneself, to the world and to outside objects opens up.

Return to the conflict of “hope against despair”

The focus of the patient’s experience is similar to the first stage, the patients return to the conflict of “hope against despair”, but this time with a more functional Ego and a more integrated Self. Constructively going through this phase concludes the formation of a sufficiently integrated and stable Self, and also leads to finding the existential sense of one’s own life.

Verbalization of the patient’s experience

The therapeutic tactic: using the expressive technique to verbalize the patient’s experience, including the experiences related to the current level of transference and the prospect of ending the psychotherapy.

In parallel to the themes of the stages of therapy described above, the levels of the unconscious process of transference determine the fantasies and the emotional background of the relationship between psychotherapist and the patient. The first and second stages unfold within the context of a primary positive transference (from Gitelson’s anaclitic-diatrophic relationship [7]), which is followed by the initiation and further development of narcissistic transference. The said transference implies a relationship to object, wherein the object can only be experienced as “being like me or conforming, agreeing with me”, while any deviation from with illusionary sameness or identity are seen by analysis and as an attack since it disrupts the fantasy of omnipotence. The technical response of the analyst to these kinds of archaic feelings is a position of mirroring: the analyst uses supportive flash interventions that draw the patient’s focus to the conscious content of what the patient is saying. With this it is as if the analyst allows the patient to use him as an object, similarly to the way as the mother (caregiver) of a child does at the early stages of development, when they go along with the child’s needs and expectations as much as possible. As B. Brandhaft and R.D. Stolopow [16] point out, these Self-object relations are necessary to maintain the stability and coherence of one’s own Self. Like a very small child, narcissistic patients with a reactively fragmented self has a need for objects that mirror them – they have to the “glint in their parents’ eyes” when they interact or communicate. This compensates the lack of ability to self-regulate and initiates the synthesis of an integrated Self, around a core of positive feeling about oneself. At this stage, it is equally important that the analyst sticks to the setting that he established with regard to the punctuality of the beginning and end of sessions and the frequency of sessions, in order to sustain the narcissistic transference. This stabilizes the self-esteem of involutional patients and acts

as a catalyst for the processes of integration.

If the analyst has succeeded in establishing an anaclitic-diatrophic relationship with the help of flash interventions and has managed to find the optimal setting to cater to the narcissistic transference, the transference of object cathexis starts to dominate. This corresponds to the movement towards the fourth phase of therapy. At this level of transference, the patient produces alternations between externalization and projective identifications of split-off Self, and object representations. Sometimes the patient's experiences may be so massive and the primitive defense mechanisms are so powerful that they negate the analyst's ability to maintain the therapeutic stance, forces the therapist to get emotionally too involved in the analysis's story and become a participant in a joint enactment of unconscious constellations. The analyst in the context of the counter-transference may react with acceptance and the acting out of the offered roles. (J. Sandler [17]) or alternatively, attempting to maintain the therapeutic position becomes completely closed off to the feeling of the patient and the analyst's own emotional responses. Both positions are technical mistakes since neither of them enables the patient to reflect on his unconscious experience. The solution to this problem is possible by the analyst maintaining the stance of therapeutic splitting (see the paragraphs on the working alliance) – a combination of being emotionally open and professionally attentive to one's own feelings. At this stage of the therapy the flash interventions mentioned above, according to V. Lyoh [12] may be replaced by O. Kernberg's "expressive technique", that is aimed at the integration of the Self – and object – relationships, and thus all internalized object relationships" [13], «the development of integrated, reliable more comprehensive and positive feeling towards oneself [18].

The three above mentioned forms of transference have no symbolic dimension and unfold exclusively on the plain of feelings and affects, so in the theory of psychoanalytic psychotherapy they are considered "quasi-psychotic". The psychotherapy of involutional psychosis includes long-term work with the analyst at these levels of transference. But if the analyst is able to adequately contain and work through the patient's transference at the initial stages, then there is a chance for the development of the upper levels of transference (classic neurotic transference, mild and polite transference and also the transference of the "artificially normal Self" and the progression of therapy into the fifth and sixth stage.

The proposed method of psychotherapy is a "method of choice" for the treatment of involutional psychosis in combination with medication. With sufficient qualifications of the therapist, this technique can be used both during the active existence of symptoms of psychosis and within the limits of remission.

Conclusions

To summarize briefly:

1. The central focus of the experiences of patients with mental disorders manifested in the middle period of life (45-60 years) and, accordingly, the central focus of therapeutic work with them can be formulated as follows: the need for reconciliation with their own lives (with the circumstances of internal and external realities);
2. The processing of the focus mentioned above takes place in 6 psychotherapeutic phases. Each of them develops it's a partial thematic aspect. The phases mentioned above can be placed in the following order:
    1. Of building trust in the therapist;
    2. Of airing grievances with the people closest to them;
    3. Of remembering one's own achievements and positive moments of the "good times" and thus of one's positive qualities;
    4. Of rethinking one's life and understanding of one's role in it;
    5. Of acknowledging the relationship between one's life and the current illness;

6. Of forgiving oneself for the mistakes made and finding new values in life.

3. The first and second phases unfold in the context of the initial positive transference, the development of narcissistic transference; the third and fourth phases are characterized by activation of the transference of object cathexis; the above mentioned forms of transference are "quasi-psychotic", that is, they do not have a symbolic "as if“ dimension "and unfold exclusively on the level of feelings and affects; if it is possible to effectively contain the patient’s experience of the patient at these levels, then there is a chance for the formation of the upper layers of the transference (classic neurotic, gentle and polite, as well as the transfer of and illusionary normal Ego) and the transition of the psychotherapy to the fifth and sixth phases;
4. In each phase of the psychotherapeutic process the therapist must apply appropriate therapeutic tactics and interpretative techniques that are consistent with the actual focus of the patient's experiences and the degree of integration of his Ego; the combination of the previously outlined thematic "framework" of psychotherapy with the appropriate therapeutic tactics and of the doctor’s interpretative technique can be considered as valid and (in terms of psychogenic disease) a patho-genetically grounded method of treatment of patients with mental disorders that manifest in the involutional stage of life.

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