# Psychotherapy of Schizophrenia

## Semrad's Contributions

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Psychiatric residents coming to Boston for their training usually had no difficulty finding excellent supervisors who encouraged them to work with primitive patients and to read the basic papers of therapists who had struggled themselves with these patients. But anyone who worked as a psychiatric resident at the Massachusetts Mental Health Center would have had one major influence—Elvin Semrad. Semrad was a unique figure in American psychiatry. His influence in Boston was profound, largely based upon the impact of his clinical teaching, which included interviews of patients in the presence of staff. Because he published relatively little, his work is known by few people outside Boston who are not students of the psychoanalytic psychotherapeutic approach to schizophrenics. But in Boston, Semrad was a figure that a trainee would have had to struggle with, or against, as he tried to learn and ultimately define what came from Semrad, from his other teachers, and from himself. This process often occurred with significant personal pain, despair, envy, and also, for many, satisfaction.

To integrate Semrad's contributions with some of the recent work of other clinicians and theoreticians, I shall first define Elvin Semrad's clinical stance, style, and theoretical framework. Perhaps one of Semrad's contributions was that as a "natural" he transcended all frameworks while using aspects of many. By calling him a "natural," I mean that Semrad had an intuitive, empathic gift that he used to contact and sustain people in a clinical situation while he focused on their emotional pain. This capacity, which Semrad implied required much personal work to develop, cut through all theoretical frameworks.

Here are some of the major tenets of Semrad's approach (Semrad 1954,1969; Khantzian, Dalsimer, and Semrad 1969):

1. Semrad's interviews demonstrated that support through empathic understanding of another person's pain can very often permit a withdrawn or confused schizophrenic to make affective contact with another person, although that contact might exist only for part of an interview.

2. With adequate support and an empathic sharing of emotional pain, the patient's psychosis

could be profoundly altered, at least during the moments of that empathic contact; that is, schizophrenic disorganization coexists only with difficulty with an empathic human relationship that adequately supports.

3. The schizophrenic's decompensation often occurs secondary to loss, real or fantasied. Supportively helping the person bear that loss counteracts the schizophrenic avoidance devices. These devices can also be viewed as part of the regression that occurs with the schizophrenic's inability to bear sadness as well as the rage following the loss or disappointment. The therapist's support allows the sadness to be borne, permitting a mourning process to occur in which the individual "acknowledges, bears, and puts into perspective" the painful reality. Once the person has carried out this process or has the capacity to carry out this process by himself (that is, to mourn or bear sadness), the person is no longer schizophrenic. Before he can reach that point, he also has to put his rage into perspective and learn that it does not have to destroy.

4. Part of the process of helping the schizophrenic patient address his avoidance devices and his helplessness is an approach that stresses the patient's responsibility for his dilemma. Semrad asking a confused schizophrenic how he "arranged it for himself to come to the hospital" is a classic example.

5. Good treatment of schizophrenia requires optimal support and optimal frustration. This is what Semrad called "giving with one hand and taking away with the other."

6. Schizophrenics in particular have difficulty integrating affects. They tend to avoid acknowledging what they have felt, or partially acknowledge it by attempting to keep it separate from the awareness of the bodily feeling that is a component of that affect and that is often a part of an unassimilated introject. Semrad's style—the "tour of the body," asking a patient, organ by organ, exactly where he experienced a feeling—was directed toward helping the patient become aware of a feeling and its bodily components, in part as an aid in learning to acknowledge and bear uncomfortable, but human, feelings.

7. The avoidance devices of schizophrenics make them vague and unclear about specific events and feelings; much of the psychotherapeutic work includes the support and persistence of the therapist in assisting the patient to spell out the details of what he does not want to think or talk about or look at.

8. Successful treatment occurs when the therapist, who has transiently become a substitute for the lost object, is no longer necessary because those attributes of the therapist that the patient likes and needs have become a part of the patient. The schizophrenic patient remains vulnerable to the degree that this internalization process is incomplete.

This partial and oversimplified statement of Semrad's therapeutic stance does not capture the excitement of observing one human being's caring wish to help another expressed with such seeming ease, simplicity, and effectiveness.

How, then, can we use Semrad's style and framework, and relate them to some other major theoretical and clinical frameworks, in a way that can add further clarity to aspects of clinical work with schizophrenics?

Several frames of reference that have much in common with Semrad's clinical style are useful in defining the establishment of a safe, trusting environment that allows the patient sufficient comfort, sustenance, and gratification to make the therapeutic work possible. Winnicott's (1965) "holding environment" concepts and Kohut's (1971, 1977) concepts of narcissistic or "selfobject" transferences are particularly applicable to work with schizophrenic patients, although these concepts have been described in the literature more often in defining treatment issues with borderline and narcissistic personality disorders. Indeed, I believe that many schizophrenics have a vulnerability, present before their decompensation, that leaves them functioning somewhere in the sphere of patients defined as having borderline or narcissistic personalities.

Many schizophrenics function effectively before the onset of their psychosis in part because they have a relationship with someone that provides the selfobject qualities they require. When that relationship is lost, the severe fragmentation of the self that is characteristic of the schizophrenic process occurs. The psychotherapeutic approach to the schizophrenic requires a setting in which the therapist helps the patient reestablish the narcissistic transferences that sustained him in the past. After the onset of schizophrenia, these narcissistic or selfobject transferences are often lower on the developmental scale and involve more merger and fusion when compared with the premorbid primitive transferences, with their somewhat greater self and object differentiation. The therapist's empathic understanding of the selfobject role he serves in these transferences, as well as his grasp of the patient's distrust, vulnerabilities, pain, disorganization, and other specific needs and fears, helps create the necessary therapeutic setting. The awareness that the schizophrenic has an exquisite tendency to fragment and retreat to more primitive defenses and styles of relating provides the therapist with the empathic framework in which he can decide how much support, silence, activity, clarification, or interpretation is

appropriate and necessary from moment to moment and session to session. Semrad's empathic style provided the support and holding that allowed the spectrum of narcissistic or selfobject transferences to unfold, if only at first during the interview with him. The experience for the patient (as well as for the observers in the room during an interview with the patient) was one of being enclosed in a warm matrix while some of the most painful feelings and experiences of a person's life were explored.

Winnicott's models of the holding environment and good-enough mothering complement Kohut's selfobject formulations. Winnicott described the vulnerabilities of primitive patients caused by failures of support and holding in childhood. These vulnerabilities derive from parental figures who were unable, for a variety of reasons, to respond adequately to the phase-specific needs of the growing child. The childhood failures in good-enough mothering and the holding environment in part account for the vulnerabilities in future schizophrenics. The therapeutic task in working with already schizophrenic patients consists in establishing an environment that provides the necessary support and holding. This holding environment includes the reestablishment of primitive selfobject transferences that allow a reliving of past disappointments and an exploration of recent losses and their manifestations in the transference.

The development of stable primitive transferences occurs only gradually; at first they appear transiently when the patient feels supported and understood. These momentary narcissistic or selfobject transferences dissolve at the point that affect, wish, impulse, longing, or fear overwhelms the patient's tenuous capacity to maintain the primitive transference. Because the schizophrenic patient has such a propensity to fragment, especially early in treatment, supportive approaches are essential. They also provide the patient with models that ultimately can be internalized; the result, in turn, is a greater capacity for the patient to form stable primitive transferences.

In therapeutic work with schizophrenics and in supervision of trainees working with them, techniques and principles that derive from Semrad's style can be usefully applied.

Many of them address the patient's defective ego capacities, terror of human relationships, helplessness, ambivalence, and confusion and provide what Semrad called a corrective ego experience.

## Decision-Making Deficiencies

An important aspect of a schizophrenic's difficulties is his inability to synthesize opposing aspects of himself, such as his many and conflicting self and object representations, while keeping inside and outside clearly defined. The incapacitating ambivalence described by Bleuler illustrates this process; it is an aspect of fragmentation and a lack of synthetic ego functioning. The catatonic stupor can be a manifestation of a terrifying indecision: To move can be linked with the urge to kill. Catatonia is thus the compromise that prevents destructiveness from occurring by keeping the patient in perpetual immobility.

The therapeutic position that focuses on the schizophrenic's difficulties in decision-making presents an approach in which the therapist's questions provide the model for weighing the factors that become part of a decision. The therapist in this process functions in part as an "auxiliary ego," using that synthesizing capacity that the patient lacks. The insight that indecision is itself a decision is a major step in this process; it also confronts the patient with his own responsibility for the position he is in. Semrad's question, "How did you arrange it for yourself?" illustrates this stance. The repeated clarification of the patient's confusion —how he intends to do something or get something he thinks he wants, and how he decided that he wanted something in the first place—supports this decision-making capacity, which can develop slowly over a long period of time.

## The Paradoxical Position

Weisman (1965) has stated that a major task in all psychotherapy is the unmasking of the paradoxes and contradictions in a person's feelings, fantasies, and beliefs. This approach is particularly useful in the psychotherapy of schizophrenia, because these patients have major difficulties with their contradictory and unintegrated self and object representations, contradictory fragments of a disorganized self, and beliefs that may totally disagree with other beliefs that they stated moments before. These paradoxes are supported by their uses of denial, projection, distortion, and splitting, which, in part, are their ways of not allowing themselves to think about or face their confusion.

A useful therapeutic stance can be one in which the therapist allows himself to become confused and shares his confusion with the patient. It can take the form of "I don't understand. First you have told

me that this is the perfect job for you, and now you tell me that it's the worst possible job. " The therapist, in this role, accomplishes certain specific functions: He confronts the avoidance devices by expecting details that the patient would rather not remember, he allows a useful projection to occur by feeling and expressing the patient's confusion, and he provides a model of someone with an ego capacity to bear and ultimately to synthesize contradictory affects, thoughts, experiences, and beliefs.

### Acknowledgment of the Fear before the Wish

A basic principle in most psychoanalytically oriented psychotherapy is that fears are examined before wishes. This approach is defined as part of defense analysis; it states that the patient must be comfortable with the meaning of his reluctance to talk about something before he can discuss the wishes or impulses behind the fear, shame, or guilt. In the psychotherapy of schizophrenia, this formulation is particularly important, because the schizophrenic is terrified of his own rage. This rage is often the unbearable affect that precipitated the schizophrenic regression, and is equated by the patient with murder and killing. To tell the confused schizophrenic that he is angry may be heard by him as a statement that he is a murderer. The exploration of his fears or guilt about his anger presents a way of allowing him to achieve the beginnings of some distance between himself and his terrifying impulses. At the height of the patient's terror over his rage, however, no statement about his anger, no matter how tactfully formulated, can be heard as anything but a statement about the patient as a murderer.

### Defining "Problems"

Because of the schizophrenic's fragmented self, loss of ego boundaries, inability to observe, and incapacity to see himself in anything but all-or-nothing terms, he can view himself only as totally bad or, when manically delusional, as totally perfect and omnipotent. The therapeutic stance that attempts to label the confusing material the patient presents, and to put this material into categories of problems, ultimately helps the patient develop precursors of the capacity to observe, maintain some distance from himself, define clearer ego boundaries, and gradually bear the complexities of his various feelings. Again, the patient has the therapist as a model for identification who can sort out the complexities of another human being's feelings without running, condemning, or rejecting.

## Responsibility Position

The therapist's expectation that the patient will assume responsibility for his past, present, and future has already been mentioned. Although the therapist can empathically respond to the fact that the patient has had real and painful disappointments in his past and is in a difficult and often seemingly hopeless current situation, he cannot allow the patient to seduce him from the stance that the patient has had and has a major responsibility for the genesis and solution of his problems. This position does not mean that the therapist loses his empathic sense that the patient can tolerate only a certain amount of confrontation about his responsibility. And he remembers the patient's need to feel the therapist's support as the patient faces his role in his life story and the resolution of the disorganizing pain in it.

It was Elvin Semrad's gift to be able to balance the patient's need for support with the human need for autonomy. A "natural" indeed.