The Psychotherapy of Schizophrenia: Semrad’s Contributions to Current Psychoanalytic Concepts

Gerald Adler

Abstract

Elvin Semrad’s contributions to the understanding and psychotherapy of schizophrenia are described. The author defines the principles that guided Semrad in his theoretical understanding of schizophrenic patients, and elaborates the practical application of these principles. Semrad’s contributions are related to recent work by Winnicott and Kohut on the holding environment and on the self-object and narcissistic transferences. The author’s formulations about the relationship of schizophrenic regressions to borderline and narcissistic personalities, and the relevance of Semrad’s work to these concepts, are reviewed.

The tasks for a psychotherapist who wishes to discuss the psychotherapy of schizophrenia can be defined to include (1) presenting a theoretical framework that defines his understanding of the basic issues for the schizophrenic, including the process of change in treatment, and (2) relating this framework to the literature about the theory and therapy of schizophrenia and other primitive disorders. Some of these tasks are particularly difficult—no theoretical model, for example, is inclusive enough to be used successfully by a therapist. In addition, much of the recent literature about primitive patients is so new that its utility still must be clarified when applied to schizophrenics. However, the contributions of Freud, Jung, Bleuler, Sullivan, and Fromm-Reichmann are illuminated and enriched when re-examined after studying recent contributions to ego psychology and object relations theory, and the concepts of the formation of the self.

In fact, attempts to synthesize the literature about the treatment of schizophrenia pose a dilemma; the task is impossible, and yet a framework begins to emerge that supports a continuum from psychosis through borderline and narcissistic personality disorders to the neurotic spectrum, with specific therapeutic principles deriving from this framework. I shall explore some of these issues in this article and relate them to the relevant treatment tasks. In particular, I shall attempt to relate the contributions of Elvin Semrad to some of the recent theoretical and clinical approaches to primitive patients, including schizophrenics.

Psychiatric residents coming to Boston for their training usually had no difficulty finding many 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. However, anyone who worked as a psychiatric resident at the Massachusetts Mental Health Center would obviously have 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. Since he published relatively little,

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Reprint requests should be addressed to Dr. Adler at Department of Psychiatry, Tufts University School of Medicine, 171 Harrison Ave., Boston, MA 02111.
his work is known by few people outside of Boston who are not students of the psychoanalytic psychotherapeutic approach to schizophrenics. But, in Boston, Semrad was a figure that a trainee would have to struggle with, or against, as he tried to learn and ultimately define what came from Semrad, his other teachers, himself, and his attempts to use the literature to integrate what he was learning. 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 who have studied schizophrenics, 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 to the degree that he had, cut through all theoretical frameworks, and involved experiential, existential issues, as well as an approach that directly addressed ego and self-concepts.

As an aid in defining some of the major treatment issues with schizophrenics, I shall outline some of the major tenets of Semrad’s approach (Semrad 1954, 1969; Khantzian, Dalsimer, and Semrad 1969):

1. Support through effective, empathic human contact—Semrad’s interviews demonstrated that the 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, though that contact might only exist for part of an interview.

2. With adequate support and an affective, empathic sharing of emotional pain, the person could not be psychotic, 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 secondarily to an unbearable reality, usually a loss, real or fantasied, in a vulnerable individual. Supportively helping the person bear that loss counteracts the schizophrenic’s avoidance defenses. These defenses 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 (i.e., 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 defenses 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 defenses of schizophrenics, implied in what I have already outlined, help them remain 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 excite-
ment of observing the impact of 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 self-object 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. Although Kohut (1977, pp. 192–193) describes psychotic, borderlines, schizoids, and paranoid personalities as unable to form self-object transferences "that can be therapeutically managed by interpretation and working through," his principles do indeed apply to these patients who can over time develop narcissistic or self-object transferences as shall be described. To use these concepts, I have to define a little more clearly a framework in which to view the schizophrenic regression. I believe that many schizophrenics have a vulnerability, present before their decompensation, that leaves them functioning somewhere in the sphere of patients defined as borderline or narcissistic personality disorder. In stating that their personality is premorbidly borderline or narcissistic, I want to emphasize their requirements to feel held and sustained within a relationship. Kohut has described a framework that helps in this delineation: the concepts of the self-object, narcissistic or self-object transferences, and the cohesiveness of the self. For Kohut, the essence of the patient with a narcissistic personality is the sense of his incompleteness without the presence of a relationship with another person who performs certain basic fantasied or real functions for the patient that the patient feels to be lacking in himself. Thus, the self-object concept defines a patient's relationship with the therapist in which the patient may be partially fused with the therapist (along a complex developmental continuum) while the therapist is seen as possessing features or performing functions that the patient does not possess. These functions can relate to aspects of the patient's grandiosity, needs to be appreciated and approved by the therapist ("mirrored" in Kohut's vocabulary), and needs to idealize the therapist.

The narcissistic or self-object transferences, the mirror and idealizing transferences that Kohut describes, are the specific manifestations of the patient's self-object need and the therapist's self-object function in the therapy. When successful, these transferences are part of a stable therapeutic situation in which the patient has a cohesive self, feels sustained, whole, appreciated, understood, and comfortable. When these narcissistic or self-object transferences are tenuously threatened and easily broken down, as in the borderline when anger erupts, the patient has a feeling of increasing anxiety, fragmentation, and panic, accompanied by varying degrees of frightening aloneness. The borderline's desperate clinging needs and demands are often the result of the breakdown of these narcissistic transferences; in fact, the borderline can be defined in part as someone who is incapable of maintaining stable narcissistic or self-object transferences in therapy.

Many schizophrenics function effectively before the onset of their psychosis, in part because they have a relationship with someone that provides the self-object 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 self-object transferences may often be lower on the developmental scale and involve more merger and fusion when compared to the premorbid primitive transferences with their somewhat greater self and object differentiation. The therapist's empathic understanding of the self-object 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 self-object 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 transferences and self-object formulations. Winnicott is describing the vulnerabilities of primitive patients because of the 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 of establishing an environment that provides the necessary support and holding. This holding environment includes the reestablishment of primitive narcissistic transferences that also allow a re-living of past disappointments and an exploration of recent losses and their manifestations in the transference.

However, schizophrenic patients pose particular problems in their capacity to form stable idealizing and mirror transferences and their ability to feel sustained or safely held. In fact, by definition, at the point that they achieve stable narcissistic or self-object transferences in therapy, they are no longer schizophrenic. The intensity of their fears of involvement with people and their capacity to shut them out, as well as their terror of engulfment (defined by Burnham, Gladstone, and Gibson (1969) as the schizophrenic's need-fear dilemma), pose particular problems for the therapist. In addition, their use of primitive avoidance defenses and their serious problems in reality testing present challenges to therapists, particularly in outpatient settings. The development of stable primitive transferences occurs only gradually; at first they appear transiently while the patient feels supported and understood—for example, at those times when the therapist is able to support the patient sufficiently and make affective contact. These momentary narcissistic or self-object transferences dissolve at the point that the 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 so readily, especially early in treatment, specific approaches have to be used to support the patient during these times which also provide the patient with models that ultimately can be internalized; the result in part leads to a greater capacity for the patient to form a stable narcissistic or self-object transference.

In therapeutic work with schizophrenics and in supervision of trainees working with them, techniques and principles which derive from Semrad's style can be delineated and usefully applied. Many of them address the patient's defective ego capacities, terror of human relationshipships, helplessness, ambivalence, and confusion, and provide what Semrad called a corrective ego experience.

Semrad had a vast array of techniques that responded to the patient's fear, through the support of the patient's autonomy; he always presented himself as a model that looked at something. He constantly reminded the patient that the patient had an observing ego, though rudimentary, and expected the patient to assume optimal responsibility for his feelings, wishes, and predicament. Such a position maintained a supportive autonomous stance which balanced the affective contact and closeness that focused on emotional pain, affect, and loss, including the pursuit of minute details of the loss as part of the work.

I shall define some of these therapeutic principles that derive from Semrad's teaching and writing and that relate specifically to the treatment of the schizophrenic patient; these principles support the gradual growth of ego capacities that are absent or have been regressively lost in the schizophrenic. In particular, they address the fragmented self, the ego defects, and the defective object-relations of these patients, and ultimately strengthen the patient's capacity gradually to develop more stable narcissistic or self-object transferences.

Support the Development of an Observing Ego

Pursuing such a course, the therapist repeatedly asks the patient: What did you observe in yourself? What did you observe in the other person? He supports the capacity to look at, rather than deny something, and presents a model for the ultimate identification with the therapist's
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: a move can be linked with the urge to kill, while catatonia is the compromise that prevents any destructiveness from occurring, but keeps 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 his synthesizing capacity which 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 statement, "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

Avery 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, since 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 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 defenses by expecting details which 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, since the schizophrenic is terrified of his anger or rage. The 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, and a rudimentary ego structure 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, may be heard as anything but a statement about the patient as a murderer.

**Defining “Problems”**

As part 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 only view himself 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 stated explicitly as well as implicitly. 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 only tolerate varying degrees 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. Schizophrenics often feel hopeless and helpless—during the more acute manifestations of their difficulties, but also during the depressive, neurasthenic phase that accompanies recovery. At such times, it is easy for the therapist to feel submerged in the despair, or angrily and nonempathically to confront the patient, e.g., for his laziness, lack of initiative, or unwillingness to work. All these responses are manifestation of the intense countertransference feelings that appear as part of all therapists' work with these patients.

**The Therapist's Role**

The results of the venture to treat schizophrenic patients psychotherapeutically depend on many factors—the patient's past, his biological vulnerabilities, his early environment, and the nature of his present predicament. The person of the therapist is also important—the therapist's personality, his countertransference feelings, how he uses these feelings, and his formulation of the treatment process. The intensity of the schizophrenic's feelings, the desperateness of his defenses, the ways he protects himself against human relationships, and the kinds of transferences that emerge inevitably arouse intense feelings in the therapist. The therapist who cannot allow himself to be aware of the intensity of his responses to the schizophrenic may be partly repudiating the elements of his own existence and feelings that are similar to the schizophrenic's and the bad-mother experiences from his own past (Searles 1975). The therapist may be uncomfortable in acknowledging his own murderous, sadistic rage, which emerges in response to the patient's hate. He may withdraw in the face of the schizophrenic's anger, or in response to the nonhuman way he is treated by the patient. In addition, the narcissistic transferences, which have merger or fusion as a major component, may leave the therapist feeling alone and bored. The inevitable hopelessness, helplessness, and despair that these patients experience in therapy will inevitably be felt by the therapist.

The therapist's freedom to be conscious of these complex and painful feelings permits him to understand what the patient is experiencing, to define the nature of the transference, and to have a personal signal mechanism that alerts him to potential dangers in his work with the patient. For example, awareness of his hatred for his patient can tell the therapist that the patient may be hating him, as well as warn him that he can sadistically retaliate or withdraw from the patient. This signal function of countertransference can also help the therapist assess suicidal dangers or serious acting out risks.
Suicidal risk is greatest when the patient’s fury elicits the therapist's countertransference hate without the therapist’s awareness of it, or the dangers of it (Maltberger and Buie 1974). The countertransference signal function allows the therapist to take corrective action through assessing the patient's needs at that moment and his own capacity to respond to them.

The personality characteristics of the therapists who work with schizophrenics are obviously important, though difficult to study. What are the personality requirements that motivate a therapist to work with such difficult patients, be willing to be verbally assaulted or abused, ignored, or to cease to exist as a separate human being for them? What experiences, both in childhood and in adult years, allow a therapist to be firmly available and nonabandoning for a patient in spite of the sharing of pain, despair, and hopelessness? I shall not attempt to define further at this time what motivates therapists to treat schizophrenics, except to observe that therapists can grow to be increasingly effective through their struggles to understand, their personal therapeutic experiences, and the uses they make of their teachers as models for identification.

An important determinant of a therapist’s approach to the schizophrenic patient is his formulation of the process of change that occurs in psychotherapy. In defining the ego defects, arrests in development of a cohesive self, and the precipitants that lead to the schizophrenic regression, an internalization process must be postulated as a major factor in psychotherapeutic change. The therapist’s belief about the roles of anger, mourning, and transference in the internalization process will relate to his choice of feelings and relationships to explore in therapy. Semrad certainly emphasized the internalization processes that were secondary to mourning and the grief and anger associated with it, as well as the corrective ego experiences that the patient experienced with the stable, dependable, nonretaliatory therapist.

Internalization of aspects of the therapist and the therapeutic interaction that the patient needs can occur around two basic experiences: (1) the slow discovery and experiencing that murderous rage does not kill; and (2) the flourishing of the narcissistic or self-object transfers within the holding environment (Adler and Buie, in press), both of which can also be defined in Semrad’s framework of the corrective ego experience.

The repeated emergence of primitive rage, in controlled or emotionally laden verbal ways, helps the patient find out that there is a distinction between doing and feeling. As he discovers that the therapist is still there, he also experiences a relationship in which there is no retaliation in response to his rage. The result of this process is a gradual diminution of this rage, as abandonment and aloneness are felt less often, and concomitantly, as a slow internalization of the undestroyed object occurs.

The gradual reestablishment of primitive stable self-object transfers allows the patient to return to areas in which the development of a cohesive self was arrested. The revival of these transferences and the ability increasingly to look at them leads to an internalization of functions not previously assimilated from early objects. Kohut calls this process transmuting internalization.

Through these two processes an internalization occurs of the therapist as someone who empathizes, holds, collaborates, and helps the patient observe, make decisions, assume responsibility, and test reality. Semrad’s clinical and theoretical stance provided such a model both to schizophrenic patients and to therapists who worked with them.

When psychotherapy with the schizophrenic is successful, even though change is slow and incomplete, the human elements of patient and therapist are both reaffirmed and validated. The shared growth for both includes the willingness of two people to risk years of work without assurance that results will be readily evident. It also includes the satisfaction, shared some of the time, that the journey was real and not in vain.

References


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The Author

Gerald Adler, M.D., is Professor of Psychiatry and Director of Training in Adult Psychiatry, Department of Psychiatry, Tufts University School of Medicine, Boston, Mass. He is also a member of the Faculty, Boston Psychoanalytic Institute.

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