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PSYCHOANALYSIS AND THE TREATMENT OF PSYCHOSIS: A BOOK REVIEW ESSAY

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TREATING THE “UNTREATABLE”: HEALING IN THE
REALMS OF MADNESS. By Ira Steinman. London: Karnac,
2009. 207 pp.

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THE PSYCHOTIC WAVELENGTH: A PSYCHOANALYTIC
PERSPECTIVE FOR PSYCHIATRY. By Richard Lucas. London/
New York: Routledge, 2009. 335 pp.

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When I was a first-year resident in psychiatry at University of Rochester Medical Center, I spent a four-month rotation at the Rochester State Hospital to learn about chronic, severe mental illness. One of my responsibilities was to interview 250 of the long-term patients housed there and write a “six-month progress note” on each of them. (I use the term *housed* because, although everyone seemed kind and caring, resources were scarce and the patients received little or no definitive treatment.)

One of the patients I interviewed was a regressed, disheveled, schizophrenic man in his late thirties who wore a wild stare and displayed palpable physical tension. I was informed that he had not spoken an intelligible sentence in a very long time. I introduced myself, asked how he

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was doing, and asked if I might be able to help him in some way. He spewed out an emotional torrent of disorganized, disconnected verbiage that was utterly incomprehensible. I tried hard to discern some kind of thread in the profusion of words he was spraying in my direction, but was unable to make out anything at all. After a while, I said: "I'm sorry, Mr. Adams. I've tried to understand what you're telling me, but I just don't know what you're saying."

What happened next startled the psychiatric nurse who was accompanying me—to such an extent that she stumbled backward and knocked over a cart laden with instruments and medication containers, which fell to the floor with a loud clatter. Mr. Adams had spoken his first intelligible sentence in seven years! "You're the first honest psychiatrist I've ever met," he said to me. "What do you mean?" I asked. "The others *say* they understand me," he replied, in an increasingly agitated tone of voice, "but they—" and here he erupted into a flurry of word salad. He flew into a sputtering rage and had to be led off by a big, burly aide who had been standing nearby.

Before he departed, I said, in all innocence and naiveté, calmly but firmly: "Look how angry you are! Maybe that's part of your problem. Maybe you get *so* angry that it scares you—and then you speak in a way that makes sure that no one can understand you and everyone stays away from you." He only growled and muttered as the aide led him away.

About ten days later, as I was standing in the hall talking to some nursing students whom I was expected to teach, I felt a tap on my shoulder. It was Mr. Adams. "Hi, doc," he said, "how are you?" We chatted for a while, during which he told me that he had thought about what I had said to him about his fear of his anger, and had concluded that I was right. He asked if we could talk about it.

From that point on, Mr. Adams and I spoke for a while almost every day. He told me about experiences he had had with people in the past that still bothered him, and we came to understand the self-protective function served by some of his psychotic symptoms. Although he was by no means "cured," the hypercritical voices that had been tormenting him for years eased up in their relentless attacks upon him, and his condition significantly improved.

A few days before my rotation was to come to an end, Mr. Adams walked by me and snarled, "I heard you're leaving; I don't care!" "Yes you do," I said, "You do care." His physiognomy softened, and he said, "You're right. I do. Thanks for your help. I'll miss you." I did go back and visit him a number of times.

There have been other psychotic patients—during my stint at the state hospital, when I was at Strong Memorial Hospital, and throughout my clinical experience since then—with whom I have been able to work psychodynamically. The vast majority of them have been able to make good use of this work and have made significant gains in their struggles with illness. I am fortunate to have had a first-rate psychiatric residency at a time when psychoanalytic understanding was valued in most psychiatric training programs. It has been sad for me, as it has been for many of my colleagues, to observe the shift that has taken place in psychiatric training away from a psychodynamic orientation and toward a predominantly pharmacological and behavioral one.

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It was delightful, therefore, to come upon Ira Steinman's wise, wonderful, lively, and engaging book, *Treating the "Untreatable": Healing in the Realms of Madness*. Steinman has dedicated himself to working psychodynamically with severely ill, schizophrenic, bipolar, and multiple-personality patients. His description of his work is clear, hard-headed, convincing, and inspirational. *Treating the "Untreatable"* is filled with rich clinical detail that is both fascinating and a distinct pleasure to read.

Steinman begins by observing that humane institutions that employ judiciously administered medications together with group and individual psychotherapy are not only few in number at present, but are rapidly disappearing. Even in the best of them, furthermore, the treating personnel do not generally delve deeply into the meaning of psychotic delusions and hallucinations. For many years, he has worked intensively on an outpatient basis with psychotic patients, a large number of whom previously spent years in one or more of those institutions without achieving a major change in their condition. His approach has revolved around the expectation that helping these patients understand the origin and func-

tions of their psychotic symptoms is the most effective way of helping them become able to relinquish them.

Not only is the symbolic meaning to the patient of the content of delusions and hallucinations explored, but a rigorous attempt is made to try to figure out how, why, and when psychotic thinking began, and under what emotional and life circumstances. [p. 20]

The “defensive retreat from psychological conflict, painful reality, and powerful affects” is made clear to the patients, so that they can come “to accept and work through the chaotic feelings of neediness, fear, fury, guilt, and despair which often preceded the development of delusions and hallucinations” (p. 29).

Steinman emphasizes the value not only of helping the patient understand his or her need for these psychotic mechanisms—especially “to diminish loneliness and assuage terror” (p. 29)—but also of reaching back with the patient to when and where these mechanisms began to be employed. He makes the cogent observation, furthermore, that even when there are neurophysiological deficits and disturbances that predispose one to the development of psychosis, the symptoms that develop always have genetic, historical significance and centrally important dynamic meaning.

Crucially important is the knowledge—to be gleaned through repeated interactions—that even psychotic patients transfer the past to the present and repeat past developmental stages and interactions in their relationships, delusions, and schizophrenic productions. If anything, the psychotic patient’s transference reactions are more dramatic and extreme . . . [and they] . . . can be dealt with by the usual therapeutic technique of exploring and dynamically understanding these intense phenomena. [pp. 30-31]

What is brought to the surface in the course of exploring the origin and meaning of psychotic manifestations can be terrifying to the patient, and can lead to chaotic outbursts and suicidal impulses. A therapist who carries out this kind of treatment has to stand by the patient very closely during difficult times, although this can prove extremely demanding on

both participants in the treatment process. Steinman appreciates the value of antipsychotic medications, but he tries to wean the patient off them as quickly (or at times as slowly) as possible. He is also prepared to rehospitalize patients at times of crisis, although he attempts to keep the hospital stays as short as possible.

Most of the pages of this book are filled with clinical examples that dramatically illustrate the author's therapeutic approach (one possible cavil is that the book is quite short on general and theoretical explanation). Daphne, for example, a 50-year-old woman diagnosed as schizoaffective, was unable for years to hold a job because of erratic, eruptive behavior, which alienated even her children from her. She had been hospitalized thirty-five times and had made a number of serious suicide attempts before Steinman began to work with her. She often sat mutely, staring into space, during their early sessions.

Daphne was very surprised when Steinman asked her to please tell him what she was staring at, as no psychiatrist had ever asked her that before. They explored at length the meaning and origins of her intermittent, delusional communication with an imaginary companion who had been part of her life since early childhood. "Mary" was a "good" friend who had accompanied her when she dissociated away from her depressive, at times abusive mother and from the alcoholic father who repeatedly molested her from the time she turned four years of age. At other times, Mary was a "bad" friend who encouraged her in childhood to try to do away with the baby sister who stole the meager attention she received from her mother, and who periodically pushed her to try to kill herself.

The treatment was prolonged and stormy. Suicidal inclinations emerged, which necessitated four brief hospitalizations. Despite this, Daphne made such good use of her intensive, dynamic psychotherapy that she "returned to work, had ten good years with her husband before his death, and was reconciled with her children" (p. 59). She remained "essentially delusion-free" (p. 60) during the twenty-five years that led up to the publication of this book. Her previous psychiatrist-psychoanalyst was "chagrined" that he had not pursued the kind of vigorous treatment Steinman described; he regretted having maintained the erroneous be-

lief that “one had to treat severely disturbed patients with kid gloves, not with intensive psychodynamic psychotherapy” (p. 60).

Some of the vignettes in the book are tantalizingly brief, leaving the reader yearning to know more about the patients described. Also, Steinman’s interventions tend to sound perfectly timed, crisp, and dramatically on target. I should have liked to read about his struggles to grasp what was going on, about the interventions that did *not* hit the target, and about the slow, difficult, groping efforts to make emotional contact with the extremely mistrustful and wary patient population on whom he reports—which I know from experience had to play a huge part in his work with them.

I should also have liked to hear about the role of empathy, understanding, compassion, and human caring in contributing to good results. The patients the author describes were hungry for safe human contact. What he does tell of his clinical work very much points to the important role played by his coming across to his patients as decent, caring, and above all respectful—not only of them as human beings, but also as capable individuals whom he believed in. Many of these patients had had prior experiences with mental health professionals who seemed to view them as helpless, defective, and hopeless.

I found myself somewhat startled by Steinman’s accounts of several severely regressed, very poorly functioning, long-time schizophrenics who apparently gave up their psychotic symptoms in just six to eight months of treatment, and who maintained their gains for years thereafter. I cannot help but wonder whether some of them may have hidden their psychotic symptoms rather than truly given them up. On the other hand, I have treated some extremely paranoid individuals who were able to get over their paranoid delusions after twelve to eighteen months of treatment and remained free of them for years afterward. None of these patients appeared to be schizophrenic, however.

This brings me to another important dimension of working with very seriously disturbed patients. Steinman correctly observes that the therapist’s goals may not necessarily coincide with those of the patient. A reduction of symptoms may be as wonderful a result for some people as total removal of them is for others.

Occasionally, a markedly delusional patient comes along who is both so intelligent and so intractably paranoid that the best that can be hoped for in the course of a short-term psychotherapy is a type of therapeutic impasse, where the patient saves face and insists on the correctness of paranoid beliefs, while clinical improvement occurs. Such a stalemate is unsatisfactory for the therapist, but may be of crucial help to the patient in terms of work, relationships, and involvement in life. [p. 74]

I am reminded of another experience I had at Rochester State Hospital. The superintendent of the hospital was a warm, humane, wonderful man who truly cared about the patients. When I arrived, he gave me a list of seven patients in whom he hoped I would take particular interest. He felt that they had potential for much more clinical improvement than they had been showing, and he hoped that something might click with one or more of them that might enable me to be of real help to them. Unfortunately, none of them showed any indication of an interest in working with me while I was there. To my great surprise, however, one of them approached the superintendent after I had left, saying that he thought I might be able to help him. Arrangements were made for Mr. Brown, as I shall call him, to enroll in the outpatient clinic at Strong Memorial Hospital (my next rotation site) and to begin twice-weekly psychotherapy with me. He paid the minimum fee of one dollar per session and walked the two miles between the two hospitals each time he came, even during Rochester's harsh winters, in order to save the bus fare.

The treatment went very well for six or seven months, during which Mr. Brown—a man in his early thirties who had been hospitalized for about ten years with a diagnosis of chronic, undifferentiated schizophrenia—worked with me at trying to understand the origin and meaning of his extreme anxiety, social isolation, and subtly paranoid symptoms. He became less and less withdrawn and isolated, and more and more interested in intellectual pursuits, than had been possible for him for many years. He began to make home visits for the first time in a long while, and started to look up some old friends from the past.

Then everything seemed to come to a halt. Mr. Brown became increasingly hesitant and even silent during his sessions. We tried together

to figure out what had happened, but seemed to get nowhere. Finally, something dawned on me. The next time we met, I told him I had an idea: "When you asked to come into treatment with me, [the superintendent] was excited and hopeful, and I was flattered. You thought I might be able to help you. I also got excited—I was going to cure you of your schizophrenia. But I never asked you what *you* wanted. I think that might be the problem."

"I'm glad you mentioned that," said Mr. Brown. "That *is* the problem. You want me to get out of the state hospital. But I'm never going to leave the hospital; I'm going to spend the rest of my life there. What I want is for you to help me become less anxious. I'm anxious all the time—all I do is pace all day. I started making a rug in O.T. six months ago, but I've only been able to finish two inches of it. Please help me so I can feel better and be able to do more . . . but I'm never going to leave the hospital."

A subsequent visit to me by the patient's parents made it clear that they did not want him to be discharged either, and they had no intention of letting anyone make them change their minds about this.

Mr. Brown and I adjusted our sights, and progress resumed in the treatment. I scaled back my therapeutic zeal, and he, to his credit, allowed me to encourage him to raise his own goals to a meaningful extent. By the time his treatment ended, about a year later, he had finished his rug and two others, was taking a greatly reduced amount of medication, was elected president of the patient council, and had become the regular left fielder of the hospital softball team (which competed in a league whose teams were not all hospital based). He also convinced his parents to agree to regular, biweekly weekend visits back home with them, and got them to assist him in looking for some kind of part-time work.

A large number of the patients Steinman describes in *Treating the "Untreatable"* eventually revealed to him that they had been sexually, physically, and/or emotionally abused as children. When he helped them recognize that there was an understandable genetic and dynamic link between these experiences and the content of their delusions and hallucinations, they could see that these disconcerting symptoms actually made sense, rather than being bizarre, foreign, or incomprehensible.

Steinman's willingness to side with them in feeling anger at their abusers enabled them, furthermore, to regain ownership of the human emotions from which they had been desperately fleeing for many years. He was then often able to help his patients recognize that the psychotic mechanisms they had been using did not truly contain or reduce the terrors that bedeviled them, and that much more effective ways with which to deal with them were available. He also helped them understand that the delusions and hallucinations themselves contributed significantly to the loneliness and isolation from which they suffered, even though the delusions and hallucinations gave the illusion of connecting these lonely patients with other people.

I found myself, as I read the clinical vignettes recorded in this book, wondering to what extent the success of the treatments derived from gains that the patients—some of whom had been ill for a very long time—had obtained from various earlier treatment experiences that had enabled them to summon the courage and the will to end their withdrawn isolation and definitively tackle their problems. I also wondered to what extent it was Steinman's enthusiasm, courage, and determination that inspired them to succeed. My inevitable conclusion, of course, is that no one factor suffices on its own, and that a combination of things must have helped his patients. At times, furthermore, enlisting the assistance of an equally courageous, caring, and determined family member also played an important part in facilitating progress in treatment.

Once again, I find myself thinking back to Rochester State Hospital, to a young male patient in his early twenties who was mute and catatonic. Charles could not speak to me, but—being an artist by vocation—he demonstrated his desire for help first by showing me paintings he had already done, and then by producing more paintings to show me. I hazarded guesses from the content of the paintings about the emotions swirling within him, behind the impassive mask he wore. Gradually, Charles began to speak and we could have more conventional therapy sessions.

One day, he was moodily silent and then angrily blurted: "You're the only person who sees my real self! Everyone else only sees what I show them. You're stealing my soul!" From that point on, he objected to having sessions with me, but I refused to give up on his treatment. I even

traveled back to the state hospital to see him for sessions after I rotated to another hospital.

In an attempt to get away from me, Charles misbehaved in order to get himself transferred to units for more and more seriously disturbed patients. He finally ended up in what was known in the hospital as “The Snake Pit,” where patients paced naked, masturbating, frothing, and growling in rage, guarded by the biggest, burliest aides in the institution. An aide would lock up the two of us in an interviewing room when I came for his therapy session, in order to keep me safe from the other wild and dangerous patients.

At this point, Charles gave up his flight from treatment and resumed working collaboratively with me. He rapidly improved and became well enough to leave the hospital within another six months. He expressed deep gratitude for my belief in him and for my persistent refusal to give up on his treatment. Seeing these attributes in me, he said, had enabled him to appreciate his own self and to fight against his illness. Interestingly, I met Charles again by chance a year after the treatment ended, at an art show, where he was exhibiting some of his work. Two of the paintings I saw there, each with a “sold” tag on it, were ones he had done as part of our work together.

I include references to my experiences as a psychiatry resident in this essay because of my deep appreciation that those who trained me, at a general hospital and at a state hospital, viewed psychotic patients as human beings who were often just as capable as nonpsychotic ones of participating in intensive, dynamically oriented psychotherapy that could lead to a successful outcome. Training based on this viewpoint enabled me to go on to successfully treat a good number of such patients over the course of my career as a psychiatrist and psychoanalyst.

At times, Steinman was able to apprise his patients that the very paranoia that expressed their anxious distancing from their families and from people in general simultaneously kept them connected to others. George, for example, had been ill for a quarter of a century, and had spent ten years in a leading psychiatric hospital, where the consensus opinion was that he would have to reside there for the rest of his life. Steinman enabled him to recognize that his paranoid conviction that his father had enlisted the aid of the Mafia to observe and control his

every move served surreptitiously to provide him with the illusion that his father had not abandoned him, but was actually maintaining constant, vigilant contact with him.

Even though George was convinced he perceived the world as it was, I [indicated to him that] . . . our task was to help him understand how he got to see things as he did. I told him that I didn't expect him automatically to give up his beliefs, since they must mean something to him. Wasn't it curious, I went on, that he was so lonely and cut off from his family and friends, yet believed that "the Family" and his father followed his every move? Could the extent of his paranoid beliefs be a reflection of his loneliness? Could the paranoia be his way of trying to maintain contact with his family or other people? [p. 123]

George was dubious at first, but then agreed to explore the possibility that Steinman was correct. Not surprisingly, they discovered that behind George's fear of his father was rage toward him—a rage that terrified George. When the two of them explored George's powerful delusions—first, that a television personality was in continuous personal contact with him; then that a famous movie star was in love with him; and then that a female psychiatrist who had once treated him was not only in love with him, but was even prepared to leave her husband to marry him—George finally realized how empty these beliefs were. This led to his giving up his delusional solution to preoedipal and oedipal conflicts in favor of healthier, more reality-bound solutions—although his first reaction to the debunking of the delusional connection he felt with the television personality was to fill the emptiness within himself with alcohol and drugs, necessitating a hospitalization for detoxification. (This episode graphically illustrates Steinman's willingness to take risks, as well as the consequences that can follow when a treatment misfires.)

In the course of their trip toward a healthier level of functioning for George, Steinman accompanied him on an exploratory peregrination through the world of "Georgeland," in which George was the favored child of a fatherly "Unconscious God" who even at times loved him, unlike his ever-critical and unappreciative actual father. He came to recognize that the Christ-like suffering to which he had subjected himself was not really appreciated by his father.

George was doing whatever he could to hold on to the experience of love he felt when held by "God the Father." If not his father's most loved child, he was his god's favorite . . . Slowly, he began to see that the "Unconscious God" devoted to George was a compensation for his perceived position of being less favored in his family . . . More and more clearly, George began to see that he had been following his own promptings and wishes for a close relationship in his own family, and that he had not been following the dictates of an "Unconscious God." [pp. 134-135]

George became able to progressively abandon the delusional alternative world to which he had retreated in order to escape the pain he experienced in the external world of reality. George continued in outpatient therapy with Steinman during the fifteen years that led up to the writing of this book. During that time, he established a good relationship with his father and stepmother and lived almost exclusively in the real world, retreating only briefly to his delusional one at times when he was under great stress. He was not "cured," but he was greatly improved. How many of our neurotic patients do better than that?

It is important to note that the author does not arrogate to dynamic psychotherapy the sole, or even always the central, role in the treatment of psychosis. He recognizes that antipsychotic medication is necessary most of the time, and that social support, work with patients' families, and hospitalization are necessary for many psychotic patients. What he laments is the tendency to underestimate the capacity of a large number of psychotic patients to make use of intensive, exploratory psychotherapy to understand and gain control over the terrible illnesses from which they have been suffering.

It is one thing to diagnose and medicate and treat with supportive psychotherapy and social technique. But if this is not enough, and it certainly was not enough in George's case, one must unwind the threads that entwine the patient's delusions. The skein, the warp and weft of encircling and debilitating intrapsychic yarn must be unraveled . . . Why was this method, in conjunction with the judicious use of antipsychotics, not employed in [his] many years in treatment settings? I believe that it has to do with our field having become convinced that anti-

psychotic medication is all we can do for severely psychotic patients: at best, we can medicate, reality test, and help with social adjustments. Furthermore, young psychiatrists have no experience treating such patients with psychodynamic techniques, and older colleagues (who for the most part have not tried it) doubt that it can be done. [p. 143]

Steinman can be critiqued for only scantily addressing the literature on psychodynamic treatment of psychotic patients and for the lack of a rich theoretical section in his book. Nevertheless, his effort to demonstrate the effectiveness of psychodynamic psychotherapy for psychotic patients by providing multiple, convincing clinical examples is quite successful, and we can be very grateful to him for it.

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Fortunately, *The Psychotic Wavelength: A Psychoanalytic Perspective for Psychiatry*, also appeared in 2009. Written by the British psychiatrist and psychoanalyst Richard Lucas, who has himself devoted a lifetime to working with psychotic patients, this book contains the extensive literature review and theoretical perspective that is lacking in Steinman's book, so that the two volumes complement each other admirably. Lucas, too, is determined to facilitate understanding of the effectiveness of treating severely disturbed people with psychodynamic psychotherapy.

In *The Psychotic Wavelength*, the author stresses the wide variation among psychotic patients in the ability to successfully participate in intensive psychotherapy—a variation that is, of course, just as wide among neurotic patients. Lucas's experience confirms for him the correctness of Bion's (1967) observation that there is a more or less powerful, non-psychotic dimension within psychotic individuals to which a therapist can speak, and which can be engaged in the struggle to overcome the dominance of the psychotic dimension within the individual's psychological organization. He strongly disagrees with those who believe that psychotics are unable to think logically and are incapable of working with dynamic principles to wrestle with their emotional problems, and he presents multiple clinical vignettes to demonstrate the cogency of his contention.

Lucas, like Steinman, contends, furthermore, that much more can be accomplished in the treatment of psychotic patients than what he perceives as the very limited or even spurious results obtainable from cognitive-behavioral therapy. He seriously questions the assertion that people can be induced to give up entrenched, intensely self-protective delusions in ten formulaically programmed sessions. When that seems to occur, he maintains, the delusions have merely gone underground. He quotes Britton (2009), who, in a volume coedited by Lucas, “distinguishes between beliefs that have merely been surmounted and those that have been worked through and relinquished” (p. 41).

Lucas also points out that CBT outcomes can often be understood via the observation that “many psychoses resolve through a flight into health, by identification with an idealized parental figure” (pp. 42-43). This mechanism dovetails with something else about psychosis to which the author gives emphasis in this book, namely, that “the commonest symptoms of schizophrenia are not auditory hallucinations or paranoid delusions, encountered in some 60% of cases, but denial and rationalization, found in over 95% of cases” (p. 30). Intensive therapy is required to obtain meaningful, lasting results.

Lucas provides a condensed summary of the theoretical underpinning of intensive psychotherapy of psychotic patients as it tends to be viewed in Great Britain. He describes Klein’s (1975a, 1975b) concept of lifelong oscillation between paranoid-schizoid projection of “phantasmized” envious, destructive, spoliating attacks upon the maternal sources of all good things, so that they are perceived as persecutory (organizing the structure of paranoid delusions), on the one hand, and depressive, guilty, self-accusatory attacks upon the self in punishment for those destructive inclinations (generating the suicidal inclinations of schizophrenics), on the other hand.

Klein as well as Segal, Lucas indicates, stressed the importance of manic defenses that produce grandiose “feelings of triumph, control, and contempt . . . to protect the individual from experiencing severe underlying anxiety of psychic pain, whether predominantly persecutory or depressive in nature” (p. 67). The concept of manic reparation can help explain instances of sudden, apparent recovery from a schizophrenic or major depressive decompensation. Segal (e.g., 1981) also distinguished

between true, metaphorical symbolism and concrete “symbolic equation” of internal reality with actual external reality.

Rosenfeld (1965) observed that psychotic patients experience transference reactions, although they tend to be concrete in nature, and that these transference expressions can respond to analytic interpretation. He emphasized, however, that the paranoid-schizoid splitting and projection that occurs in psychotics is greatly confused, so that the patient has much difficulty distinguishing between self and other and between good and bad. Steiner (1993) emphasized the significance in psychosis of a desperate retreat from intense, overwhelming anxiety and pain to an idealized, delusional world that protects against the threat of disintegration and annihilation (Lucas, p. 79). Enormous therapeutic effort is required, therefore, to convince the patient of the necessity of leaving that world.

Lucas puts great stock in the importance of Bion’s (1967) emphasis upon distinguishing between the psychotic and the nonpsychotic self and upon strengthening the latter so that it can deal more effectively with the psychotic self. Lucas cites Bion’s view that:

The psychotic part cannot think (lacks the capacity for symbolic thought); it can only fragment and expel. If the expelled parts come back, individuals experience this as an assault by actual objects. The more they aggressively fragment the particles coming back at them, the more they experience them as increasingly hostile. [Lucas, p. 91]

It is necessary to promote emotional strengthening and integration, and to advance to higher-level, symbolic thought, in order to empower the psychotic patient to apprehend and deal with destructive forces emanating from the psychotic part of his or her psychological structure. Bion (1967) believed that everyone begins in early life with a psychotic part that aggressively attacks and attempts to destroy all disturbing elements, both internal and external, with initial inability to distinguish between what is internal and what is external. A nonpsychotic, reality-oriented part develops, beginning very early, that grows larger and larger over time, with increasing divergence between the two, until the gulf between the two parts becomes so great that it is unbridgeable. (Unbridgeable

except, perhaps—it seems to me—in certain controlled ways in exceptionally talented, creative, artistic individuals.)

In those who will eventually become psychotic, the nonpsychotic part does not develop sufficiently enough to dominate, control, and adumbrate the psychotic part—but there is always, to a greater or lesser extent, *some* nonpsychotic structure, and it is this which the therapist must address (Lucas, pp. 91-93). Bion also made reference to the nonpsychotic part of a patient being concerned with neurotic conflict while “the psychotic personality was concerned with the problem of repair of the ego” (Lucas, p. 161).

Lucas briefly summarizes Bion’s theoretical explanation of hallucinations, derived from his clinical experience, by picturing an infant who expects the arrival of a nurturing breast but encounters a “no-breast” or absent breast. The author posits an infant who is unable to tolerate this experience and therefore evacuates the painful image of “bad breast” in the form of a hallucination of it—in contrast to the emotionally stronger baby who develops increasing tolerance for frustration, associated with the development of thought; i.e., this baby comforts him- or herself by thinking of a (good) breast. The mother plays a crucial role. A mother who accepts split-off, bad contents and detoxifies them via her reverie, according to Bion, facilitates the child’s increasingly capability of reaccepting and reinternalizing the detoxified elements. Without this process of maternal containment of hostile projections, the infant experiences *nameless dread*. The implications for therapeutic technique are clear.

Lucas also applauds the clinically derived conclusions about schizophrenia made by Freeman, Cameron, and McGhie (1959). At the core of this illness, according to these three co-authors, is dissolution of the personality, with regression to early, primitive modes of psychological functioning, dominated by primary rather than secondary processes, to deal with stress and overload. Lucas agrees with Freeman, Cameron, and McGhie that biological factors play a major role in schizophrenia, necessitating the administration of antipsychotic medication. Although psychotherapy is necessary to mitigate and control psychotic mechanisms, it is unrealistic to subscribe to the concept of a neurotic-psychotic continuum that might support the idea that a “cure” can be obtained from psychotherapy.

Lucas draws in particular upon the work of Henri Rey at the Maudsley Hospital to distinguish, albeit in a somewhat oversimplified manner, between borderline and schizophrenic patients, with respect to what they look for from therapy. The former, he indicates, search for a helpful container for their extremely needy and destructive inclinations, and if they find it in a therapist, they worry about losing it again. The latter, in contrast, fearfully reject the container in the external world in favor of retreating into an internal delusional world of their own making. (The catatonic young artist I worked with at Rochester State Hospital dramatically epitomized this.)

Rey believed that

The only safe position for [borderline] patients is the border between the depressive and paranoid-schizoid positions. If the demand for perfection experienced in the depressive position becomes too much, the pain is split off and projected, and the patient reverts to a paranoid-schizoid mode . . . [and] . . . the border is the only safe position where both depressive pain and persecution from the paranoid-schizoid position can be avoided. [Lucas, p. 132]

Lucas embraces Steiner's emphasis on the need to employ analyst-centered interpretations ("You experience me as . . ." or "You are afraid that I . . ."), rather than patient-centered ones, with borderline patients. This view stems from Steiner's observation that these patients "are more concerned with what is going on in the analyst's mind rather than in their own" (Lucas, p. 133). It might be said, it seems to me, that this applies as well to other classes of patients who are narcissistically extremely sensitive and vulnerable.

Lucas distinguishes clinically between what he terms *borderline states* and a *major psychotic disorder*, with respect to the kind of transferences that can develop and to the patient's ability to participate in a psychodynamic treatment process. With patients in borderline states, there are intense transferences, the ability to work psychotherapeutically (albeit with hypersensitivity and a tendency to experience narcissistic injury from the analyst's interventions), a sizable nonpsychotic self, and only brief, intermittent psychotic episodes. By contrast, in patients with what Lucas calls

major psychotic disorder; there is no transference, because splitting and projection are so intense that all that is bad is ejected, and the capacity to feel the ambivalence necessary for entering into relationships is lacking; the nonpsychotic self is miniscule; and there is constant psychosis (although it can be disguised and hidden), due to the patient being on a constant *psychotic wavelength* covered over by denial and rationalization, rather than having frank delusions and hallucinations. With the latter group of patients, the therapist must depend heavily on working with family members, on environmental manipulation, and on assistance with socialization, as well as on the major use of powerful medication.

There is probably something of a continuum between these two groups of more or less accessible psychotic patients, however. Steinman, for example, describes very difficult but ultimately quite successful work with a number of patients who would appear to fit easily into Lucas's more seriously disturbed group. Some of the patients who did well in psychodynamic outpatient therapy with him had been delusional and hallucinatory for many years, and/or had had lengthy hospitalizations before he began to work with them. Giving up too quickly, or too hastily labeling patients "untreatable," can be a very unfortunate error.

Lucas, too, describes a case in which he often felt like giving up during a lengthy treatment that eventually turned out to have a happy ending. He provides a relatively detailed account of his heroic attempt to analyze a severely manic-depressive woman who had to be repeatedly hospitalized for florid manic episodes—in which she was flagrantly psychotic—that alternated with deep depressions. He persisted doggedly, although he was frequently on the verge of despair, until she finally made a significant and lasting clinical improvement (after the death of her mother, whom she hated).

Unfortunately, Lucas provides relatively little detail about his own interventions during his work with this patient; he prefers to speak mainly about his conception, in Kleinian terms, of what seemed to him to be taking place within the patient, which included an ambivalent, hostile "identification with an all-powerful mother figure" (p. 192), "clinging to pathological object relations" (p. 198), and "manic defense and manic reparation . . . in order to defend against underlying persecutory and

depressive feelings . . . characterized by triumph, control, and contempt” (p. 199).

In connection with his work with this patient, Lucas cites Rey’s belief that:

In depression, the maternal breast, as part-object, represented the destroyed mother, and through identification, the subject felt depressed. In contrast, in manic states, the identification was with the penis as the object of reparation, with a magical ability to re-create the mother’s attacked babies and breasts, that is, through phantasy of making her pregnant and refilling her empty breasts with milk (Rey 1994). [Lucas, p. 194]

Lucas emphasizes further that:

The depressive phase is dominated by dependence on a tyrannical object, which demands total obedience and suppression of individuality Hidden resentment builds up gradually and silently These feelings of resentment gradually tighten the spring until eventually it unwinds explosively in the manic phase. [pp. 201-202]

The division of patients into groups labeled *borderline states* and *major psychotic disorder* somewhat troubles me, however. It can be heuristically useful to distinguish between the characteristics of those who are more accessible to psychotherapeutic intervention versus those who are less so, but there is a danger here. It seems to me that therapists can too easily fall prey to a tautological tendency to apply the rubric *borderline* to patients with whom their therapeutic efforts prove to be relatively successful, and apply a term like *major psychotic disorder* to those who do not respond well to treatment. This is similar to the tendency among some analysts to label patients who do not do well in analysis as *borderline* rather than *neurotic*, in order to explain inadequate results. In actuality, there is a wide range of variation among neurotic as well as psychotic patients in the ability to participate in an intensive treatment endeavor, and an individual analyst or therapist is not likely to be able to do well with every patient who lands on his or her doorstep.

It is also clear that Bion's heuristic division between the psychotic self and the nonpsychotic self is not to be taken literally. *Everyone* is developmentally uneven, full of contradictions, different from day to day and from circumstance to circumstance, and unique in the details of the balance between rational and irrational. I am reminded in this regard of Bishop Berkeley's rejoinder, in response to John Locke's assertion that "beasts abstract not," that—as Carl Sagan quotes him in *The Dragons of Eden* (1977)—"if the fact that beasts abstract not be made the distinguishing property of that sort of animal, I fear a great many of those that pass for men must be reckoned into their number" (p. 113).

Greenspan (1997) wrote an interesting book on the topic of building ego structure in developmentally stunted, emotionally and intellectually primitive, but nonpsychotic individuals in order to enable them to participate in psychotherapy—just as Fonagy and his co-workers (2002) emphasized the necessity of assisting borderline and developmentally stunted but nonpsychotic patients in developing a capacity for mentalization before they can be expected to make use of traditional modes of psychodynamic psychotherapy.

Lucas's tendency to focus almost entirely on his conceptualization of what is going on within his patient psychologically, without providing as much detail of his own participation in the therapeutic work as I would have liked to have seen or of the interchange between them, can convey the impression that he is applying theoretical concepts to what is emanating from the patient rather than extrapolating understanding from it, although I am aware that this might be an artifact of shorthand expression. Examples include such statements as:

When she was severely depressed, Mrs. L would also report a sensation that she had swallowed two tablets of stone that lay heavily on her stomach, i.e., the unresponsive stone breasts of her mother. The image also evoked [an image of] the Ten Commandments, not to be disobeyed. [p. 213]

Another such example involves a man in a withdrawn, psychotic state who suddenly threw bleach into the face of a woman who was waiting to pick up her child from school.

He said at the time that his aim had been to scar her. His action could be understood in terms of the wish of the psychotic part of his personality to avoid any reflection on his current mental state. Mr. R envied the child, who seemingly had no problems, as he was totally looked after by his mother. The psychotic part of his personality wished to ensure that any current self-criticisms were projected and disowned into the mother, so that he could remain in an omnipotent state of mind. [p. 257]

Lucas provides a longish account of supervision of a therapist working with an extremely depressed, frequently suicidal woman, in which the central point seems to be that the therapist needed help recognizing that her patient required something specific: that is, assistance in realizing that her (the patient's) guilt about seeking care and attention by being ill was only the surface manifestation of her problem. The patient's self-deprecation actually stemmed from the attacks of a brutal superego that had developed out of an internalization of intensely hypercritical parental figures who could never be pleased, and who had convinced her that she was incorrigibly bad and sinful.

In psychotic depression, Lucas emphasizes, the patient is

. . . totally identified with an idealized ego-destructive superego, which remains tyrannically in control There is a pull to remain in identification with the absolute in order to avoid all the confusing mixed feelings towards the ideal that result from starting to experience separateness. [p. 278]

Lucas, following Rosenfeld (1987), stresses the need to speak both to the (sadistic) psychotic and the (timidly tortured) nonpsychotic parts of the patient's personality, in the interest of "furthering the move in the sessions from a monologue to a dialogue . . . thereby moving them away from a total domination by a relationship with an ego-destructive superego" (Lucas, p. 277). This is quite consistent with Steinman's approach to such patients.

In the last section of the book, Lucas addresses a number of practical issues concerning the treatment of psychotic patients, including those that arise during hospitalization. These include risk assessment, the management of violent outbursts and (especially) of suicidal incli-

nations, working with family members, and the need for education of mental health professionals and auxiliary personnel about psychosis and about the challenges presented by psychotic patients.

* * * * *

These two books by Ira Steinman and Richard Lucas dovetail and complement one another in very useful ways. They convey the joint message that psychotic people are not necessarily untreatable, so long as psychotherapists understand what is taking place within them, are able to tune in to what Lucas terms the *psychotic wavelength* within them, and are able to speak to and establish a constructive alliance with the non-psychotic dimension of the personality. If these therapeutic aims can be successfully carried out, it is possible to engage many patients with a psychotic condition in such a way that they can collaborate effectively in psychodynamic psychotherapy, which in turn can lead to extremely welcome clinical results.

These two books inspire and inform. They deserve a place in all mental health training programs.

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