

cence. The schizophrenic fails to make the transition from childhood to adulthood. Something goes wrong.”³

During my second year of a child psychiatry fellowship, I spent part of my time at a large, general hospital that had started out as a chronic disease hospital. Family practice as a medical specialty was developed in large part at that hospital. For a number of years, in a small, self-contained, separate building, families were being provided with medical and pediatric services for many years at a time. While I was there, adolescents arrived at the hospital periodically with an acute first psychosis, usually a case of schizophrenia. Almost invariably, the youngster’s parents asserted that their child had been perfectly normal until the sudden outbreak of the psychosis. A fair number of these families had been treated for years at the Family Practice Unit. Because of this, I was able to gain access to years and years of records, and I was able to see the pediatric accounts of the repeated instances of disturbed behavior, school suspension, and learning difficulty that these “normal” children had experienced on the way to a psychotic break in adolescence! What might have happened if they had received help *before* they got to adolescence?

I have written a long review of a short book. This is because good things *can* come in small packages. I strongly recommend this book to everyone.

MARTIN A. SILVERMAN (MAPLEWOOD, NJ)

SELF PSYCHOLOGY AND PSYCHOSIS: THE DEVELOPMENT OF THE SELF DURING INTENSIVE PSYCHOTHERAPY OF SCHIZOPHRENIA AND OTHER PSYCHOSES. By David Garfield and Ira Steinman. London: Karnac, 2015. 160 pp.

As far as I am aware, there is no other book like this out there. No one else has so thoroughly described the psychological treatment of psychotic patients when concepts of self psychology are utilized to apprehend the therapist’s work and its efficacy. Of particular merit is the au-

³ Bollas, C. (2015). A conversation on the edge of human perception. *NY Times Sunday Rev.*, Oct. 18, p. 7.

thors' extensive description of clinical process, which vividly depicts how they struggled with the challenges they encountered in their work with these patients and how remarkably effective they were. The authors' extensive clinical illustrations—often including verbatim dialogue—merit close attention.

The book is organized into three parts, corresponding to each of Heinz Kohut's selfobject transferences: *Mirroring*, *Idealization*, and *Alikeness* (Kohut's designations for the latter are "Twinship" and "Alterego"). Several chapters in each part abundantly describe clinical work with psychotic patients, where attention to these selfobject transferences appears to yield beneficial results. The authors emphasize the value of attending to what Kohut referred to as the *leading edge* of these transferences—what has been elaborated as *forward edge transferences*.¹ Chapter 4, in part I, also illustrates the clinical relevance of Kohut's concept of the *vertical split* in working with these patients.

The authors' stated intent is that their book address not only the psychotherapy of schizophrenia, but also the development of the self during intensive psychotherapy of the psychoses. This is, in fact, their emphasis throughout. Their understanding is that self psychologically oriented analysis is effective with psychotic patients in essentially the same way that it is effective with any other patient—by strengthening the self through "facilitating self-esteem via effective engagement with the forward edge" (p. 11), that is, with sustained "HOPE" in hand (p. 12).

Kohut described a two-step process that he believed leads to analytic cure: prolonged empathic immersion in the patient's subjective experience, followed by interpretation (i.e., according to selfobject theory) of what the therapist has thereby gleaned. In 1985, I suggested that this second step was too narrow—that patients may variously experience all kinds of responses as optimally therapeutic, in addition to, or instead of, interpretation, depending upon the particular nature of their psychological needs.²

¹ Tolpin, M. (2002). Doing psychoanalysis of normal development: forward edge transferences. *Progress in Self Psychol.*, 18:167-190.

² Bacal, H. (1985). Optimal responsiveness and the therapeutic process. In *Optimal Responsiveness: How Therapists Heal Their Patients*. Northvale, NJ: Jason Aronson, 1998, pp. 3-34.

In further contributions,³ this view was expanded to include as a function of empathy the process of discerning the responsiveness that the patient might need from the therapist; and that therapeutic possibility depended upon the potential of the particular therapist–patient dyad in the moment and over time. I also suggested that a variety of psychoanalytic constructs might relevantly come into play within the unpredictable specificity of that analyst–patient process. In effect, Garfield and Steinman’s actual work with their patients seems to reflect such an expanded approach.

The authors’ declared position, however, is that effective treatment of psychosis is based upon the application of self psychology theory, even though their clinical work and their related discussions of many other theories indicate that they utilize much more. I also think they underplay the effects of their own personal capabilities.

Much of this is vividly illustrated in a clinical vignette in which Steinman’s patient Judith responded in a surprising way to his angry explosion when she cut herself in his waiting room. He told her that this cutting was not okay, that there was no reason to do this, that no matter what she felt, no matter what her imaginary figure told her to do, she should not act on it but rather call him right away, so that he could help her work through her feelings.

He then took her to the emergency room to have her cuts sutured and to arrange for a short hospital admission. The medical doctor who attended the patient there called Steinman to let him know that he had

. . . never seen a happier patient She was almost bragging about how you swore at her and told her she could never cut herself again. She told all the nurses and me how worked up you got. She’s been positively beaming about it. [p. 21]

Steinman was initially astonished to hear this. And he could not know at the time that Judith would never cut herself again. He had identified his response to Judith as a spontaneous countertransference reaction whose positive effect, he writes, was due to its evoking a “mirroring selfobject experience”—that Judith felt “noticed, affirmed, and

³ For example: Bacal, H. & Carlton, L. (2010). Kohut’s last words on analytic cure and how we hear them now—a view from specificity theory. *Int. J. Psychoanal. Self Psychol.*, 5:132–143.

important" (p. 21). His first comment about it, though, was a feeling that "[my] outburst showed her that [I] really cared about her" (p. 21).

Let us take a closer look at this. From the point of view of self psychology theory, the evocation of Judith's apparently significant therapeutic experience is not wholly encompassed by the concept of a mirroring selfobject. Her therapeutic experience is also due—and, arguably, is primarily due—to a vitalizing idealization when she discovered that her doctor was really an authentically caring figure. These experiences were specific to what she deeply needed, which she had never believed she could have—rather, we might surmise, quite the opposite.

We might also note that the effectiveness of Steinman's response was not only unpredictable; it was also not an interpretation. Yet his reaction appears to have been therapeutically optimal. In this regard, we could view the positive effect of Steinman's intervention over time—that the patient never cut herself again—as an instance of the operation of a construct offered by Sampson and Weiss: that the disconfirmation of a pathological expectation is significantly therapeutic.⁴

In retrospect, Steinman could see how he may have contributed to Judith's earlier view of him. He recalls that in his prior explorations of her suicidality, he maintained what he calls a psychiatric detachment, and he considers that perhaps the patient's action was an unconsciously organized test about whether he cared about her; and that her view of his uncaring nature was authentically disconfirmed in the moment of his angry outbursts, which she experienced as so caring.

In effect, then, to reduce the theoretical understanding of this therapeutic effect to a mirroring selfobject experience triggered by a countertransference reaction may give insufficient substance to other ways of understanding how it happened. This perspective also does not take into account the therapeutic specificity of emergent process between that therapist and that patient, which offers a new conceptualization of transference and countertransference.⁵ In this regard, what may be at

⁴ Sampson, H. & Weiss, J. (1986). *The Psychoanalytic Process*. New York: Guilford.

⁵ See the following two sources: (1) Bacal, H. (2011). *The Power of Specificity in Psychotherapy: When Therapy Works—and When It Doesn't*. Lanham, MD: Rowman & Littlefield; and (2) Bacal, H. (2015). Beyond transference and countertransference: the dyadic specificity of psychoanalytic process. Paper presented at the 38th annual conference of the International Association of Psychoanalytic Self Psychology, Los Angeles, October 17.

least as therapeutically significant as the application of self psychology and other constructs to the treatment of patients described in this book is Steinman's ability to be with these particular patients empathically and to respond to them optimally. I will say more about this in a moment.

In contrast to the book's unique assertion that psychosis can be effectively treated by applying self psychology concepts, it is generally known—although the authors do not mention it—that Kohut regarded borderline patients as untreatable. Kohut was implying that, with such patients, one cannot carry out the necessary first step—that is, adequately empathizing with the patient's subjective experience—because borderline patients are too fragmented. Psychotic patients, by implication, would be even less accessible due to their severely fragmented states.

From the evidence presented in this book, Kohut would seem to have been wrong. When he asserted that such patients could not be treated with his approach, he was likely thinking of himself as the treating clinician and perhaps of his sense of his colleagues' limitations. But he had presumably not yet met anyone as intuitively empathic as Steinman.⁶

Interestingly, Garfield and Steinman quote Kohut's declaration that: "If you really can achieve empathic access to psychosis, psychosis in one sense has ceased to exist" (p. xxiv). Is it possible that Steinman is not only an unusually empathic therapist, but also someone who can respond therapeutically to such patients? I suggest that the latter ability constitutes a separate skill. The two—empathic attunement and optimal responsiveness—are not necessarily identical, as I shall describe and as Steinman's clinical examples illustrate.

A central—and remarkable—message that Garfield and Steinman seem to be conveying to psychotherapists who would treat psychotic patients is that, if the clinical approach is based on self psychological concepts, not only could all such patients be cured, but also that all therapists could effect such cures. The authors tell us, for example, that the skill required to speak schizophrenese and to make sense of psychotic productions (such as through the ability to understand the patient's sym-

⁶ While both authors of this book offer illustrations of their clinical work, Steinman's appear much more prominently; my comments on clinical work described in this book are based upon his illustrative examples.

bolism in hallucinations and delusions⁷)—which Steinman illustrates—is essential in treating these patients effectively, and that it is an easily acquired skill.

With all these points, I must respectfully disagree—at least with regard to my own experience, as well as the experiences of many bright colleagues and of many capable students whose work I have supervised over the years. I worked with Kohut in the late 1970s and studied with a number of his first-generation self psychology colleagues for several years. Self psychology has continued to usefully inform my treatment of a wide range of psychological disorders, and I have never been dissuaded by Heinz's pessimism that his new self concepts were ineffective with seriously fragmented patients. On the contrary, I have applied them with some success in working with these patients.⁸ Yet not infrequently, I have found myself struggling to attend affectively, and/or to respond effectively, to psychotic patients. I suspect that more than a few well-trained—even self psychologically well-trained—analysts (besides Kohut himself) cannot do this work at all.

I will not invoke the extreme caveat offered by those who, after demonstrating amazingly impressive accomplishments, may caution, “Do not try this at home!” On the contrary, there is ostensibly no reason for any of us not to try applying Garfield and Steinman's promising ideas in our own clinical work. Nevertheless, it may be that Steinman has a special ability for this that is not only remarkable, I suspect, but also relatively uncommon—and possibly essential—in order to treat these patients effectively, although he identifies a number of other clinicians who are, famously, skilled in similar ways.

There are multiple explicit indicators about how and with whom Steinman's skills in working with these patients were nourished and honed, and about what may have strengthened his professional self⁹

⁷ The authors regard delusion from the perspective of self psychology—that is, as an attempt to repair a narcissistic deficit.

⁸ Bacal, H. (1981). Notes on some therapeutic challenges in the analysis of severely regressed patients. *Psychoanal. Inquiry*, 1:29-56.

⁹ In the following source, see the description of the strengthening of the therapist's *professional ego* through significant interpersonal contact: Balint, E. (1967). Training as an impetus to ego development. *Psychoanal. Forum*, 2:255-270.

to enable him to persist in responding to situations that many, perhaps most, psychodynamically oriented therapists would experience as beyond what they are able to tolerate and/or too disruptive to address therapeutically. In addition to having extensive, wide-ranging clinical experience with psychotic people, Steinman has worked and studied with some of the most prominent clinicians and theoreticians in the field in the United States and Great Britain, over many decades.

Furthermore, Steinman is not only especially talented, trained, and tolerant when it comes to interacting with psychotic people and helping them reclaim their wholeness; he was also a virtual self psychologist even before he encountered and assimilated Kohut's selfobject theory. "[I learned] that there was a whole person who needed to be treated To me, the self was suprapordinate" (p. xix), he writes. His grasp of self psychology concepts would seem to have effectively expanded and to some extent structured his understanding and responsiveness to these patients.

Although self psychology concepts usefully inform my own work, as mentioned, they are not the only ones that emerge with central relevance. Let me provide some clinical material to illustrate this. I have been seeing a paranoid schizophrenic woman several times a week for a number of years.¹⁰ She attends her sessions regularly and clearly values our relationship, which both of us experience as warm, respectful, friendly, and carefully close. Dina is interested and curious about me and my family, some of whom she sees from time to time, since my office is next to my home. I have had no difficulty answering questions Dina has about them, and she clearly appreciates my responses.

During most of her time in treatment with me, Dina has not been overtly psychotic. To all appearances, she is an eccentric, clever, nice, middle-aged lady who is a bit reclusive, somewhat sensitive, and a little "paranoid." A few years ago, however, when Dina was refusing to take medication, she became suicidal and acutely psychotic, with the most florid persecutory delusions and hallucinations—in every sensory modality—that I have ever witnessed, including during the years I worked on locked psychiatric wards.

¹⁰ For a more detailed account of this treatment, see pp. 94-100 of the first source in footnote 5.

Now Dina's demons stay mostly in the background, but they are not gone; and I believe she would be right back in hospital if she were not now regularly taking a fairly high dose of Clozaril. While she is somewhat plagued by the possibility of impending calamity, and must sometimes take Klonopin at night, she feels much safer than before. What has emerged as pivotal for Dina in her experience of my helping her is not the relevance of selfobject transferences, but rather her sense that I understand her struggle to allow the relational intimacy she longs for with people, and the particular dangers she faces in attaining this. I touch on this in our sessions as it manifests in the transference, but only lightly, because keeping the optimal psychic distance/closeness in relation to Dina feels to me to be crucial. It is centrally important to Dina that I apprehend how a deep-going "self-sensitivity" to certain behaviors of others—the ways in which she is affected by certain kinds of people—makes life hard for her.

Harry Guntrip (arguably, a self psychologist in the way that Steinman was, early on¹¹) would have framed Dina's plight as a kind of *schizoid dilemma*. She lives alone and for the most part stays alone, except for coming to her sessions, visiting her sister occasionally, driving to the market once a week, and getting her hair done. Her hairdresser has become a long-standing "nonfriend friend"—that is, someone with whom she especially experiences her central conflict.

When Dina feels the wish to reach out for close relatedness, she experiences a serious threat to her sense of self due to the conviction that she would either be ignored or overwhelmingly invaded by the other's needs, or materially robbed by them (when she was psychotic, perceived invasion of her was by poisonous toxins that were destroying her flesh via bizarre conduits). An intense conflict has been constituted by the usurping threat to the integrity of her self in allowing others to come close—especially certain people to whom she is particularly drawn—and by the terrible aloneness consequent upon her need to self-protectively withdraw from interpersonal connection. One might say that Dina lives a "manageably" lonely life.

¹¹ Bacal, H. & Newman, K. (1990). *Theories of Object Relations: Bridges to Self Psychology*. New York: Columbia Univ. Press.

In retrospect, I saw that when Dina fled into suicidal psychosis, she was unable to manage—without medication—the painfully disruptive intensity of a deep but completely unacceptable longing for intimacy with me, nor could she handle her despair that I could neither fully validate the concrete reality of her delusions nor adequately apprehend the pain inflicted by her persecutors. Furthermore, I would not help her escape in the only way possible—by doing away with herself.

Because of her severe suicidality and her refusal to take medication, Dina's outpatient therapy was interrupted and she was hospitalized. She returned to me some time later, in remission after having received ECT and now taking Clozaril.

There are indications, from our conversations and from Dina's feelings and mine in various contexts, that mirroring, idealization, and twinship selfobject experiences continue to come therapeutically into play—that they are helping Dina develop a more coherent, enhanced sense of self. Yet I also believe that maintaining the stability of our relationship is of equal importance. This depends both upon her continuing to take Clozaril and upon our tacit recognition that we need to proceed wisely and judiciously, considering very seriously the limitations we may have to accept regarding her wish to establish close relationships that are safe as well as self-enhancing.

It is not only so very important that we, as psychoanalytic therapists, are able to *empathize* with the subjectivity of our patients—even sometimes to the point that they can feel we feel what they feel, as Garfield and Steinman recognize¹²—in order to be truly therapeutic, but also that we can *respond optimally* to the patient's therapeutic needs. Our ability to do both, in the moment and over time, will be specific to the capacity of the particular patient-therapist couple. My sense is that the authors of *Self Psychology and Psychosis* may be optimistically generalizing the capacities of their colleagues both to empathize and to respond optimally to psychotic patients.

I am certain that I have not fully empathized with or responded to the complexities of this fascinating book. And I have not been able to

¹² Herzog, B. (2016). Establishing the therapeutic impact of empathy through "affect sharing." *Int. J. Psychoanal. Self Psychol.*, 11:152-168.

answer adequately one of the cardinal questions required of a reviewer: do the authors convincingly demonstrate their apparent intent with this book—in this case, that a self psychologically based treatment is the most effective way of working with psychotic patients?

The richness of the book's clinical examples suggest to me that much more is going on therapeutically that cannot be completely conceptualized in terms of selfobject transferences. In order to validate their thesis, we need to find out, as psychoanalytic therapists, whether we can repeat—or even come close to—the authors' impressive accomplishments by utilizing self psychology concepts in our own work. My central questions remain: how much of their success is due to the application of self theory and other constructs (which they do utilize), and how much to the talent and tolerance of a particular therapist (such as Steinman) and to the therapeutic possibilities of the particular patient–therapist pair?

This book is relatively short in its page count: 146, plus additional pages that make up the preface, introduction, prelude, and entre. Nevertheless, it is so abundant in theory and clinical data that it feels like a big book that demands close study if its precepts are to be adequately tested, even by clinicians who have experience doing psychotherapy with psychotic people. Those who would like to apply the approaches utilized by Garfield and Steinman might wish to consider consulting directly with the authors around their own patients. We then need to hear from these therapists, too, in order to get a sense of how much Garfield and Steinman's remarkable work with such patients is usable, and whether other clinicians can achieve such positive results by applying self psychology constructs in treating their own psychotic patients. Systematic outcome research, of course, would also be welcome.

HOWARD BACAL (LOS ANGELES, CA)

CONTEMPORARY PSYCHOANALYSIS AND THE LEGACY OF THE
THIRD REICH: HISTORY, MEMORY, AND TRADITION. By Emily
A. Kuriloff. New York: Routledge, 2013. 200 pp.

The human race, throughout the course of its history, has suffered periods of unspeakable savagery and abomination. This book is about the