McGrath's Fiction From the Forensic Asylum

Asylum *by Patrick McGrath; New York City, Random House, 1997, 254 pages, $22*

Dr. Haggard's Disease *by Patrick McGrath; New York City, Poseidon Press, 1993, 191 pages, $20*

Spider *by Patrick McGrath; New York City, Poseidon Press, 1990, 221 pages, $18.95*

The Grotesque: A Novel *by Patrick McGrath; New York City, Poseidon Press, 1989, 186 pages, $17.95*

Harold Carmel, M.D.

Patrick McGrath's latest novel, *Asylum*, is a brilliant addition to the literature of fiction set in public psychiatric hospitals. The author's style of writing, which has been described as Gothic, is particularly suited to describing heightened emotional states, poor judgment, and behavior disconnected from external reality—in short, the experience of what we, peering in from the outside, view as psychopathology. Interestingly, McGrath's novels are always in the first person. The narrator, a subtle presence, reveals as much by indirection as by direct narration.

In *The Grotesque* (1989), his first novel, the narrator is a mute, paralyzed country squire describing his destruction at the hands of his sinister butler. "In the absence of sensory information, the imagination always tends to the grotesque," the narrator observes as he spins his convoluted tale. Before he was paralyzed, he had devoted his life to studying a dinosaur fossil; afterward, his preoccupations become increasingly bizarre.

More interesting to mental health professionals is *Spider* (1990), a brilliant portrayal of the inner world of a person suffering from schizophrenia. Spider is deinstitutionalized. He is living in a group home; he is cheeking his medications; he is sinking deeper into psychosis; and his psychiatrist has decided, during a routine medication check, not to hospitalize him.

According to Spider, his idealized mother was killed by his malicious father and replaced by a prostitute. Spider got the notion that they wanted to kill him as well. He killed his new mother and spent the next 20 years in a forensic hospital. (The years in the hospital, before chlorpromazine, are well described.)

Along the way, Spider matter-of-factly discloses a immense array of psychotic experiences, from hearing the chattering of imps in the attic to feeling his innards shrivel. By the end of the story, the reader, initially believing Spider's account, becomes aware of how Capgras' sydrome has complicated the picture.

The narrator of *Dr. Haggard's Disease* (1993) is Haggard, a surgery resident who falls in love with an enchanting older married woman. After a ecstatic interlude, the affair is discovered and ended. While Haggard is hospitalized recovering from a hip fracture inflicted by his lover's husband, he develops a morphine addiction and is fired from his residency. His lover develops an obscure ailment and dies.

Starting a new life on the south coast of England, Haggard meets his lover's son, now a Royal Air Force pilot in the Battle of Britain. Eventually Haggard believes that something is transforming the RAF pilot into a woman, who happens to resemble Haggard's dead lover.

What is this disorder, the "Dr. Haggard's disease" of the title? Haggard fancies it might be a hitherto unknown endocrinopathy that is transforming the pilot. More likely, Dr. Haggard's "disease" is his protracted grieving over the disastrous love affair, which, magnified by his morphine addiction, leads him to delusionally conclude that his dead lover is returning to him in the body of her son. In *Dr. Haggard's Disease*, McGrath's rapturous prose heightens the lush overtones of self-preoccupation and detachment from reality that saturate the tale.

Reviews of McGrath's latest novel, *Asylum*, have been favorable and, drawing on the opening line—"The catastrophic love affair characterized by sexual obsession has been a professional interest of mine for many years now"—have focused on the theme of sexual obsession. That is the story of the main character, Stella Raphael, who is the wife of the assistant medical superintendent of a forensic hospital in the English countryside and who embarks on an imprudent affair with a patient.

McGrath, the son and namesake of a former medical superintendent of Broadmoor, the venerable English

In this section . . .
Comments on the psychopathology central to Patrick McGrath's fiction—especially the author's latest work about staff and others associated with a forensic asylum—lead the section. Then several reviewers discuss books on various dimensions of psychotherapy, from supervision to cognitive therapy to relationship triangles. Also under scrutiny are an "exposé" of the plethora of unproven psychotherapies concluding that all psychotherapy is potentially dangerous and, on the other side of the fence, a "highly practical and informative" book on the "new psychiatry" written mainly for patients and families by Dr. Jack Gorman.

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forensic hospital, clearly is intimately familiar with the world of a forensic hospital. In *Asylum*, McGrath's narrator depicts all sorts of boundary violations. This theme is probably the one of most interest to the professional community. These violations multiply and later in the story are intensified by the question of how to treat a forensic patient who had been a high-status member of the staff community.

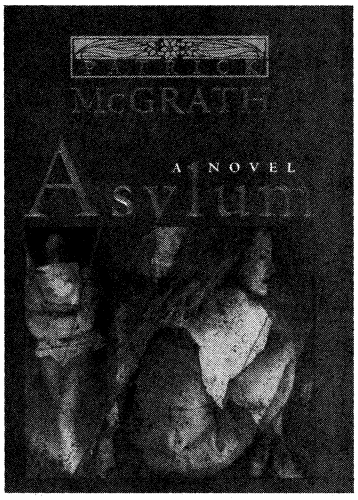
According to the psychiatrist-narrator, the hospital "is a desolate sort of a place, though God knows it's had the best years of my life. It is maximum-security, a walled city that rises from a high ridge to dominate the surrounding country. . . . It is built on the standard Victorian linear model, with wings radiating off the main blocks. . . . This is a moral architecture, it embodies regularity, discipline and organization. All doors open outward to make them impossible to barricade. All windows are barred."

Asylum's tale is played out mainly within the structure of this "moral architecture," embodied in stone, by psychiatrists and their wives, by staff, and by patients. It is against this structure that the actions of Stella—and, more interestingly, of the narrator, Dr. Peter Cleave—resonate. Cleave is an elderly, long-time hospital psychiatrist who starts as a human manifestation of the asylum's moral structure.

"With the custodial staff I have always projected a sort of patrician affability," Cleave says. "They like it. They like structure and hierarchy. They know me well. I have been here longer than any of them." At the same time, he is genuinely fascinated by his patients' psychodynamics, and he believes individual psychotherapy can cure the criminally insane.

McGrath lays out the escalation of boundary indiscretions that lead to Stella's downfall—from her fairly innocent encounter with the patient Edgar Stark, through progressive secrecy and intimacy, to intercourse. At crucial points in the affair's development with Stark, an artist and sculptor convicted of killing his wife, Stella numbs her misgivings with alcohol, descending from social drinking to repeated intoxication.

In the course of their relationship, Stark is able to smuggle alcohol into his ward. This transgression is discovered, and at a staff dinner Stella learns that Stark is suspected. One passage from that occasion illustrates an essential point for administrators: "'All very tiresome,' said [the superintendent] in that slightly weary tone of voice he employed when something happened in the hospital that was annoying rather than alarming, one of the petty problems that interfered with the practice of forensic psychiatry; though one might argue that these sorts of problems were precisely the stuff of the practice of forensic psychiatric medicine, institutional forensic psychiatric medicine, that is."



The next day Stella tells Stark he is under suspicion. Stark escapes, using a set of her husband's clothes, including a set of hospital keys. Stella's role is instantly suspected, and the world of the Raphaels collapses.

Stella begins to travel to London for assignations with Stark, now in hiding. Cleave notices, and he confronts her one day with his impression that she is still seeing Stark. Stella immediately flees to London to move in with her lover. As her plight becomes increasingly desperate, she increasingly resorts to alcohol, deadening her ability to rationally consider her choices. Eventually she is arrested and returned home. Her husband is fired and finds work in an remote Welsh asylum. As her hopelessness and depression increase, Stella's alcoholism grows. Tragedy strikes, and through the intervention of her friend Cleave, now the medical superintendent, Stella is committed as insane.

And what of Dr. Cleave's role in all this? The boundary errors are not only Mrs. Raphael's. From early on, Cleave is aware of the relationship between Stella and Stark; it takes him longer to suspect the sexual component. He chooses not to intervene, to further his psychotherapy with Stark. After Stark escapes, Cleave confronts Stella with his suspicions about her affair rather than using the information to help capture the fugitive patient. This warning gives Stella the chance to run off.

And after the tragedy, Cleave says he is convinced that he is the man best qualified to treat her. "And while bringing her back to the hospital might seem unorthodox, or even, given the circumstances, positively dangerous, I was in a position now to make it happen."

They embark on a treacherous course of psychotherapy. Cleave notes that to Stella "nothing was simple anymore. I was the doctor, she the patient. We were on opposite sides. She required a strategy." Inauthenticity becomes the core of Stella's strategy.

Referring to Stella, McGrath eloquently describes what I would call the Insanity Acquitee's Predicament: "Her behavior now followed a predictable course. She began to cultivate a different attitude toward time. She had to think in terms of months, if not of years. She had to find a way to manage her impatience. With her medication reduced it became a problem tolerating boredom, and she was quite well aware that a single outburst of frustration would undo weeks of painstaking self-control.

"Nor must the effort be visible to the attendants. A calm, good-natured demeanor, amiable but not hysterical, composed but not depressed, this she knew was what we wanted to see, though what made the masquerade so difficult to sustain was not knowing how long was long enough, never be-

ing certain whether we noticed how well she was doing, and trying to cope with the idea that she was going to rot up here, grow old and die on the admissions ward. . . .

"You ceased to be mad when you began to behave as though you weren't in a madhouse, as though you weren't locked up with no real idea when you were getting out again. Once you appeared to accept these conditions as perfectly satisfactory, then you were seen to be improving and they moved you downstairs. This of course is a patient's perspective. From our point of view, the self-control involved in making these calculations and then acting on them is a necessary first step in getting better."

Cleave notes that "despite the fact—or because of it?—that I was, to Stella, far from the neutral figure generally considered appropriate to perform this sort of dynamic psychotherapy, I was becoming more convinced each time I saw her that the transference was occurring as I wanted it to, that she was shifting her dependence onto me. The thought gave me a peculiar and rather complicated satisfaction, which to my deep regret I failed properly to analyze at the time."

And then Cleave escalates his own boundary violations. They meet in his office rather than on the ward. Cleave, the superintendent, offers Stella Raphael, his patient, a gin and tonic. Over the drink, Cleave discloses his intent to retire. Then he proposes marriage, depicting it as a safe harbor, an asylum for her. Over the next few weeks, she lets him believe that she acquiesces. But tragedy strikes again, and Cleave is left with only Stark's artistic renditions of Stella.

Given his part in the development of the tragedy engulfing the Raphaels and given his ambiguous sexuality—he lives alone, he knows he is suspected of being homosexual, and at one point Stark calls him "an old queen"—what motivates Cleave? At the end, Cleave is left alone, and he reports, "I have not retired as I planned to. I still have work to do. Edgar remains on the top ward in the Refractory Block. . . . I now possess all the drawings he made of her in the studio, and also the sketch done in the vegetable garden. . . . I also have the head. I have had it fired and cast in black bronze. I keep it in a drawer in my desk. . . . It is a thin, beautiful, tiny, anguished head now, no bigger than my hand; but it is her. I often take it out, over the course of the day, and admire it. So you see, I do have my Stella after all."

And *Asylum* ends with Cleave's disconcerting remark, "And I still, of course, have him."

Patrick McGrath is an extraordinarily perceptive observer of those with psychiatric illness and of those who care for them, particularly in forensic hospitals. He uses his literary talent to tell compelling—although hardly upbeat—stories. His literature is an excellent fictional depiction of our work, its possibilities, and the effect of its failures.

Dimensions of Psychotherapy Supervision: Maps and Means

by Russell Haber, Ph.D.; New York City, W. W. Norton, 1996, 237 pages, $29

The Supervisory Encounter: A Guide for Teachers of Psychodynamic Psychotherapy and Psychoanalysis

by Daniel Jacobs, M.D., Paul David, M.D., and Donald Jay Meyer, M.D.; New Haven, Connecticut, Yale University Press, 1995, 285 pages, $28.50

Jane Thorbeck, Ed.D.

Haber leads off with the lofty proposition that "this book presents a model that integrates the relational, contextual, theoretical, and technical dimensions of supervision." However, the author provides no comprehensive model. He simply puts forward an interesting metaphor—that supervision is like a house containing "the ecosystems of both the supervisor and the supervisee." Supervisors and supervisees are advised to explore the bottom floor ("self of the therapist"), middle floor ("work context"), top floor ("ideology"), and attic ("culture"). As an exercise, such an exploration has allure. As a model or method for supervision, it is neither quite comprehensible nor particularly useful.

The author does not work from a coherent theory of the mind, and his book suffers from it. For example, within two pages early on, he refers to "systems theory," "parallel process," "transgenerational therapists," "transference problems," "the equation of the professional and clients' houses," "the *self* of the supervisor," "the isomorphism perspective," "the perpendicular intervention," and "a supervision-of-supervision group." This kind of scattered thinking keeps the book on the surface, giving the reader little to dive into.

Haber is a psychologist, an experienced clinician, and a lively and talented teacher. He is at his best when actually describing supervisory situations, innovative treatments, and supervisory techniques. His detailed descriptions about how to use the one-way mirror during psychotherapy, the telephone intervention during live supervision, videotapes with a supervisee, and the empty-chair and role-playing techniques are provocative and helpful. The section on three types of "live supervision" in which the supervisor is directly involved with the clients and the supervisee—live supervision, live consultation, and apprentice cotherapy—is the best the book has to offer. It is detailed, applicable, unpretentious, and down to earth.

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The author is also skilled in considering the contextual variables influencing the therapeutic situation. His discussion of special populations such as physically disabled people or alcoholics is informative. His review of the impact of important variables such as race, gender, age, culture, and clinical setting (in both the supervisory and the treatment situation) is thought provoking and in tune with the realities of a multicultural world.

Although Haber implies that the book will be useful to those supervising treatment of patients in any modality, the author's clinical foundations, and his heart, are in family and couples therapy. He makes frequent references to his mentors from the original family therapy movement: Whitaker, Satir, and Pesso. Yet even when he seems to be hitting his family systems stride, the reader is often astonished by what he suggests. For example, he spontaneously advised a supervisee to tell the separated parents of a 12-year-old enuretic son to "have the boy sleep in their beds in their respective homes." This suggestion may have the ring of a family therapy intervention, but it lacks a grasp of what the meaning or unconscious implication of this action is to the child.

Haber is writing for a specific, if limited, audience. This book may be useful for those who supervise, or want to learn to supervise, family and couples therapy. The vignettes on individual psychotherapy do not reflect understanding of depth psychology and the unconscious workings of the mind. Psychodynamically orientated supervisors will find this book too focused on technique and without supporting theory.

The Supervisory Encounter is a vastly different book for a vastly different audience. Jacobs, David, and Meyer, all experienced psychiatrists and teachers, have written a sophisticated yet highly readable book on supervision for clinicians who are interested in depth psychology and who supervise work primarily with individual patients. What the authors value most highly is the depth of the supervisory discourse. And so they fashion their book in every way to achieve this end. Although the authors synthesize the work of others, they are innovative in their own right. Their book is full of new ideas.

The authors assume readers have a basic understanding of the central psychoanalytic concepts of transference, countertransference, defense, and resistance. Some sections of the book are a reach for the beginning supervisor, as it is dense in places, necessitating rereading. The effort, however, is well worth making. For the experienced supervisor, the authors raise consciousness by putting into words and concepts much that is assumed or unarticulated in the supervisory experience. In so doing, they open the way for an increased supervisory repertoire and responsiveness.

Throughout the book the authors focus primarily on the supervisor-supervisee dyad. Running through the text are two vitally important and timely threads that are not stated as main topics of the book. First is the authors' emphasis on supervision as a collaborative experience—in sharp contrast to the dated psychoanalytic tradition of "received wisdom." This emphasis reflects advances in psychoanalytic theory and technique in which the therapeutic relationship is now regarded as a collaboration, coconstructed and relational.

A second and related theme is the clinical need to attend to the supervisee's potential experience of shame. The authors describe that experience as rooted in the "inescapable conflict between curiosity, exploration, and the search to deepen understanding on the one hand and the narcissistic vulnerability of the supervisee on the other."

This emphasis also parallels theoretical advances in our understanding of the importance of shame in the psychotherapeutic process. The likelihood of shame in the supervisor-supervisee relationship may be increased by the vertical nature of the relationship and the supervisee's inevitable comparison of oneself with a more advanced or idealized supervisor. Because in supervision, as in treatment, anxiety brings material into the process, and shame keeps it out, it is difficult to overestimate the importance of the supervisor's awareness of shame in the learning process.

An atmosphere of collaboration and sensitivity to narcissistic vulnerability and shame allows for differences and disagreements in the supervisor-supervisee relationship. The authors emphasize that open and debated differences are a healthy development that deepens the supervisory discourse and helps the supervisee understand and develop his or her own style. When the book fostered thinking and prompted disagreement on my part, which it did frequently, I felt it was alive, like a successful supervisory session.

The book is well organized, with innovative chapters on identifying and fostering four modes of thought that are essential to the development of the supervisee: inductive, associative, creative, and self-reflective. The chapter entitled "How Personal Should Supervision Be?" deals with the tension between the supervisor, who is "the professionally trained intruder," and trainees, who commonly feel vulnerable about opening themselves up too much. The chapter on "Supervisory Interventions" offers fine examples of confrontation and clarification, modeling, didactic instruction, Socratic questioning, encouragement and permission, and "the riskiest form of supervisory intervention," interpretation. The final chapter, "Termination," is rich with novel ideas about a topic almost unmentioned in the supervisory literature.

The authors succeed in their stated goal of encouraging readers to better formulate their ideas on the supervisory encounter. For the psychodynamic clinician, this is the most thoughtful, engaging and useful book on supervision to come out in many years. It serves up old wisdom in a thoughtful and synthesizing manner and advances theory and technique to a new level.

The Facilitating Partnership: A Winnicottian Approach for Social Workers and Other Helping Professionals

by Jeffrey S. Applegate, D.S.W., and Jennifer M. Bonovitz, Ph.D.; Northvale, New Jersey, Jason Aronson, 1995, 290 pages, $35

Fostering Healing and Growth: A Psychoanalytic Social Work Approach

edited by Joyce Edward, C.S.W., B.C.D., and Jean B. Sanville, Ph.D., B.C.D.; Northvale, New Jersey, Jason Aronson, 1996, 484 pages, $30

Gerald Schamess, M.S.S.

Developmentally informed, psychodynamic psychotherapy is dead. Or is it? According to the official story, dynamic psychotherapy is time consuming, costly, unsuitable for patients with serious and chronic emotional disorders, insufficiently concerned with symptom alleviation, and insensitive to issues of race, class, and culture. With the widespread implementation of managed care, psychodynamic treatment has been replaced by medication supplemented by cognitive-behavioral psychotherapy.

The two volumes reviewed here challenge the official story by creatively adapting contemporary analytic theory for use with a wide range of patients and by illustrating the theory's applicability through a rich array of creative and thought-provoking case presentations. Essentially, both books advocate for therapeutic relationships that help patients knit past and present together in a growth-promoting, mutually constructed narrative.

In *The Facilitating Partnership*, Applegate and Bonovitz review D. W. Winnicott's developmental insights, applying them systematically to therapeutic practice in mental health settings and in private practice. The authors particularly value Winnicott's ideas about the interaction between individuals and their social (caregiving) environments, the "holding" function of the therapeutic relationship, transitional phenomena, and the "true" and "false" selves. Special attention is paid to patients whose early development has been significantly compromised, who carry a diagnosis of borderline or narcissistic personality disorder, and who experience significant levels of environmental stress.

Reflecting current social norms, most contemporary psychotherapists view regression and dependency as antitherapeutic because they impair functional adequacy, undermine self-sufficiency, and thereby loot the public purse. Ubiquitous though these views are, they ignore what child development researchers and therapists know about the ways early emotional development influences adult functioning.

Applegate and Bonovitz follow Winnicott in arguing that regression to dependence reflects "an unconscious effort to return to the true self, to repair gaps in ego development, and, thus, to remobilize psychosocial growth. By welcoming and accepting the client's dependency, he [Winnicott] offered himself as a new object—someone who was reliable, consistent, and able to withstand and survive the intensity of the client's frightening impulses and feelings."

The authors are also guided by Winnicott's view that antisocial behavior both in children and in adults is a signal of distress reflecting care that was not adequately provided during childhood. Accordingly, antisocial acts represent "an urge toward cure," a hope that caregivers will repair childhood deprivations through meaningful, need-gratifying relationships and firm, nonpunitive limits. Case reports document that such patients modify antisocial behavior after projecting their destructive feelings onto a symbolic caregiver, the therapist, without destroying the therapist or being destroyed by retaliatory aggression.

Fostering Healing and Growth approaches psychotherapy from a related but somewhat broader psychodynamic perspective. Expertly edited by Joyce Edward and Jean Sanville, this book features case reports by distinguished, analytically trained social workers. The case reports are framed by five chapters that provide an overarching theoretical framework and by a concluding "postlude" that summarizes the book's major themes.

Books that feature psychotherapeutic case reports are rare, even though such reports offer exceptional opportunities to study the relationship between theory, practice technique, process, and outcome. In this volume each contributor presents a significant segment of therapeutic interaction or dream work in the context of a particular theoretical framework. Most patients have experienced significant trauma and demonstrate serious difficulties in ego integration and self-organization. In the past most would have been "deemed unreachable by a psychoanalytically informed perspective." For this reason the contributors focus on promoting progressive emotional development—that is, "growth" rather than insight. Interpretations are mutually arrived at rather than presented authoritatively by the therapist.

In comparing this approach with practice approaches that emphasize premature cognitive understanding and behavioral change, it is instructive to listen to patients freely describe their life experiences. Among others, we hear a paranoid schizophrenic man describe his father's threat to kill him, and a woman who is terrified because she dreams of cutting off the top of her baby's head. The therapists represented here do not interrupt these narratives, or discourage patients from becoming dependent, or insist on discussing functional impairments. They struggle to understand what patients communicate when they evoke frightening, painful, angry, and hopeless feelings,

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and they work toward metabolizing such feelings to promote healing.

Most remarkable, perhaps, is the creativity contributors exercise in treating clients whose life experiences make it difficult for them to consider or "use" a human relationship. For six years Aronson used telephone interviews to maintain therapeutic contact with a repeatedly hospitalized, severely anorexic, often autistic young woman until the woman could tolerate a face-to-face relationship and begin addressing overwhelming feelings of hopelessness and despair. Another contributor, Graziano, approached the "trust-fragmentation-mistrust cycle" that characterizes "catastrophically traumatized" sexual abuse survivors by modifying the frame of treatment. She extended therapeutic sessions to two hours, read the patient's writings aloud during sessions, sat next to the patient at moments of terror, and, when asked, held the patient's hand. She "linked affects with words," bore witness to the reality of unspeakable events, and helped the client "move from isolation inside the events toward a fuller life in the external world." In the finest tradition of clinical social work practice, Aronson, Graziano, and others "started where their patients were" and creatively modified accepted treatment procedures to address the most pressing developmental needs.

If we now reconsider the litany of criticism that introduced this review, it is fair to acknowledge that analytically informed psychotherapy is long, and sometimes expensive. It does not yet effectively address the complexities of interracial treatment, and it is often slow in alleviating symptoms. However, the analytic practitioners represented here do thoughtfully consider issues related to social class, culture, and gender. Moreover, they treat patients who have serious and persistent emotional disorders with impressive efficacy. If we then consider the bottom line, we are justified in emphasizing how many health care dollars are saved by, for example, reducing or eliminating rehospitalization for Aronson's anorexic patient, or by eliminating the need for protective services on behalf of a patient's infant daughter.

As social workers provide well over half the psychotherapy offered in this country, it is fitting that these books are written by social workers for a social work audience. Nonetheless, they have much wider value. Because they thoughtfully consider how psychological growth takes place within the context of a developmentally attuned relationship, as well as the effect environmental impingement has on individual functioning, they make a vital contribution to psychotherapy theory and practice. They should be required reading in every graduate program for mental health practitioners, and they will be of compelling interest to experienced therapists who study therapeutic process.

Reaching Across Boundaries of Culture and Class: Widening the Scope of Psychotherapy

edited by RoseMarie Pérez Foster, Ph.D., Michael Moskowitz, Ph.D., and Rafael Art. Javier, Ph.D.; Northvale, New Jersey, Jason Aronson, 1996, 275 pages, $35

Andrew J. Lagomasino, Psy.D.

In a sense, the authors of *Reaching Across Boundaries of Culture and Class* put psychoanalysis itself on the couch. In the first section of the book, the authors diagnose psychoanalysis, the patient, as suffering from various forms of pathology, such as ethnocentrism, elitism, and classism. Pérez Foster argues that analysis has made itself irrelevant to the poor and to people from other cultures because of the tendency of many analysts to idealize their own values and the patients who share them and to reject the values of poor non-Westerners.

In each of the chapters they provide, Moskowitz and Mario Rendon bring to light the many forces that have shaped psychoanalysis, regarded as the patient. The authors paint a portrait of the "patient" in infancy as a radical critic of and rebel against society, an identity borrowed from the patient's outsider father. They examine how significant events in the patient's life, such as emigration to the United States and collisions with other powerful entities, such as the American medical establishment and the managed care movement, changed psychoanalysis. Good analysts that they are, the authors see the metamorphosis of psychoanalysis from rebel to reactionary as being overdetermined—the result of many causes.

In the second section of the book, the authors give the patient a prescription for a cure. The chapters deal with the treatment of poor patients, African Americans, and blue-collar workers from psychoanalytically informed perspectives free of ethnocentrism, classism, and elitism. The final part of the book deals with other interesting and important issues, such as the significance skin color has for some patients and considerations for treating bilingual patients.

This book will not be all things to all people. Readers searching for the firm theoretical underpinnings of this type of therapy will probably be disappointed and should instead consult a work like Neil Altman's *The Analyst in the Inner City* (1). This flaw aside, however, the editors are to be lauded for putting together an important collection of papers on the treatment of poor and minority patients. Clinicians who work with these populations in public clinics and other settings may find its message—that it is possible, desirable, and honorable to conduct psychodynamic psychotherapy with these populations—especially heartening.

The editors should also be complimented for advocating honesty by analysts both in their clinical work and about their participation in the psy-

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choanalytic movement. The book argues for a fuller recognition of the impact that the analyst's own motivations, values, and history have on the therapeutic interaction. According to the authors, psychoanalysis has suffered from various forms of pathology, but the treatment is at hand, and the prognosis is good.

Reference

1. Altman N: The Analyst in the Inner City: Race, Class, and Culture Through a Psychoanalytic Lens. Hillsdale, NJ, Analytic, 1995

Cognitive-Behavioral Therapy for Bipolar Disorder

Monica Ramirez Basco and A. John Rush; New York City, Guilford Press, 1996, 291 pages, $35

Cognitive Therapy: Basics and Beyond

Judith S. Beck, Ph.D.; New York City, Guilford Press, 1995, 338 pages, $33

Peter W. Moran, Ph.D.

These two books on cognitive therapy are right on schedule in the era of managed mental health care.

In *Cognitive-Behavioral Therapy for Bipolar Disorder,* Drs. Basco and Rush tackle a major intra- and interpersonally damaging mental health disorder and demonstrate how it can be treated with a combination of cognitive-behavioral and psychopharmacological approaches. The managed care field favors treatment protocols that are empirically based, able to be applied consistently across disciplines, focused on the present, and symptom specific. This text describes a treatment that meets these requirements and that is easily understood by professionals across the mental health disciplines.

This text also meets the need for a conduit between psychopharmacological and psychotherapeutic interventions. For medical practitioners it is an fine resource for understanding the cognitive-behavioral interventions of their mental health colleagues. The book's excellent end-of-chapter summaries are especially useful. Similarly, the chapter on psychopharmacological treatments for bipolar disorder, a succinct summary of the psychiatrist's choices, is invaluable for non-medically-trained mental health treaters. The several chapters on cognitive and behavioral symptoms in mania and depression not only specify techniques for treating the symptoms but delineate what the patient is experiencing, which is likely to increase empathy.

Patient involvement is key to increasing the impact of treatment between sessions, and the text provides excellent ideas for homework assignments. Patients' self-monitoring of symptoms is fully addressed, as is the ever-important issue of adherence to treatment. On the whole, Drs. Rush and Basco successfully bring together their combined clinical experience of three decades to produce a timely, pragmatic cognitive-behavioral treatment approach for bipolar disorder.

The second book, *Cognitive Therapy: Basics and Beyond,* is an invaluable text for mental health professionals who want a theoretical and pragmatic reference in their attempts to deal effectively with managed care. The author, Dr. Judith Beck, is the daughter of Aaron Beck, M.D., the father of cognitive therapy. She successfully describes cognitive therapy's theoretical essentials and adds excellent present-focused, symptom-specific strategies. This product is complemented by contemporary clinical examples, giving the reader a sense of empowerment about his or her own clinical potential as a cognitive therapist.

The text has many strong points. Early presentation of the principles of cognitive therapy teaches the reader to apply cognitive theory in a managed-care-savvy, solution-focused approach to treatment. The descriptions of how thoughts, emotions, and behaviors influence one another help the reader understand and formulate a strong theoretical basis for cognitive-behavioral therapy. Inclusion of dialogues between therapist and patient provides a smooth transition from theory to practice.

The chapter on core beliefs demonstrates how the patient's cognitive etiology leads to dysfunctional thinking, feeling, and behaving. Work sheets facilitate the application of cognitive-behavioral principles within therapy sessions as well as in homework assignments. Information about modifying cognitive treatment for specific disorders highlights the importance of targeted intervention, a real state-of-the-art essential for managed care.

Dr. Judith Beck's decade-long involvement in cognitive training shows readily in this book. Whether readers are graduate students getting their first exposure to cognitive therapy or seasoned professionals wanting a refresher on cognitive theory, Dr. Beck's book will satisfy most all professional training needs.

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Working With Relationship Triangles: The One-Two-Three of Psychotherapy

by Philip J. Guerin, Jr., Thomas F. Fogarty, Leo F. Fay, and Judith Gilbert Kautto; New York City, Guilford Press, 1996, 251 pages, $27.95

Nancy Glimm, M.S.W.

This invaluable new addition to the treatment literature will be appreciated by the student, the novice or experienced psychotherapist, and the educator. In *Working*

Ms. Glimm is a psychiatric social worker with the child and adolescent team at the Bronx Mental Health Center of the Health Insurance Plan of New York.

With Relationship Triangles, the well-regarded team of Guerin, Fogarty, Fay, and Kautto have set out to advance clinical knowledge of the relationship triangle.

Although triangles are frequently referred to in the family therapy and psychodynamic literature, the authors believe they are less than fully conceptualized and translated into workable treatment approaches. They make their readers aware of the omnipresence of relationship triangles, and they hope the psychotherapy community will become more comfortable with thinking about them in individual, dyadic, and family treatment. They also hope to provide new ideas to sharpen conceptualization and intervention skills.

The authors first review the evolution of the concept of the relationship triangle. The basic instability of the dyad produces the relationship triangle; the authors explain how emotional reactivity is the key to seeing the emergence of triangles from unstable dyads. They discuss Bowen's work as it enlarges on Freud's view of the oedipal triangle–dilemma as well as the evolution of their own work.

The book swiftly moves into the clinical context. We are reminded that although triangles are everywhere, we tend to think in linear and dyadic ways—especially harried clinicians in busy clinics attempting to provide service in a time-sensitive manner. The authors believe their treatment methods are applicable to short-term care, and they provide varied clinical examples. All the while they emphasize patients' complexity and the influences that individuals in relationships have on each other.

Three types of primary triangles are introduced: those seen in individual therapy, child- or adolescent-centered triangles, and marital triangles. The authors explain that clinical work should be focused on the process in the relationships between the individuals in any triangle. The problems emerge as those in treatment try to rework their relationship triangles.

The therapist is much more a coach, and interpretation is usually not employed. The emphasis is on helping those in treatment to see their individual lives, dyadic personal relationships, and relationship triangles in such a way as to become self-focused, rather than being directed by underlying emotional forces. Self-focus is the ability to see a relationship problem as a result not only of the other person's limitation but of one's own.

The authors go on to clearly and thoroughly describe the structure, process, and function of relationship triangles. The structure will determine the movement, or lack thereof, within the triangle and the reactive process. Function or dysfunction will follow for the individual. The interaction between structure, process, and function is described.

The second half of the book is devoted to treatment. Coaching and direct interventions are applied to individual, marital, child and adolescent, and family treatment. These treatment chapters reveal the authors' clinical expertise as well as their compassion and creativity.

The authors provide a richly conceptualized treatment that is patient centered and process oriented, with self-focused awareness as the goal. As a clinician, one feels renewed optimism for providing care after reading this book.

Mind Games: Are We Obsessed With Therapy?

by Robert A. Baker, Ph.D.; Amherst, New York, Prometheus Books, 1996, 477 pages, $29.95

Robert Racusin, M.D.

The exposé, in its various literary and journalistic forms, has long been a feature of American culture. Tenacious investigative reporting and careful attention to uncovering the truth by reformers from Upton Sinclair to Ralph Nader have had a profound and positive impact on social policy. Another niche occupied by this same genre is the entertainment offered by the supermarket tabloid, whose "revelations" appeal mostly to our wish to be titillated but rarely run the risk of being taken seriously by more than a few.

However, another, more problematic, type of exposé has superficial similarities to the work of serious social reformers but bears more resemblance to tabloid journalism in its use of hyperbole and exaggeration. *Mind Games*, unfortunately, is such a book.

This outcome is particularly disappointing because the author has focused on an area that deserves to be discussed critically, the plethora of unproved psychotherapies that have become the domain of incompetent and unethical practitioners. Rather than confining his topic to the abuses and misuses of psychotherapy, however, Dr. Baker has decided that all psychotherapy is potentially dangerous because it is used primarily as a tool of the "Psychotherapeutic State," a conspiracy that, under the leadership of psychiatry, seeks to "manage every aspect of our social lives" by creating "a nation of whining, self-pitying, irresponsible 'psychiatric-drug' and 'psychotherapy' addicts totally incapable of living free, independent and spontaneous lives."

What follows are 400 pages of sweeping and largely unsupported statements that become the "facts" used to prove that this conspiracy exists and that physicians in general, and psychiatrists in particular, are arrogant, greedy, and interested primarily in imposing their "god-complex" on their patients. To make mat-

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ters worse, according to Dr. Baker, the illnesses that psychiatrists and most other therapists treat are not illnesses at all. He dismisses schizophrenia, depression, and anxiety disorders, among others, as "emotional problems not *biological* or medical problems." Cartesian dualism is apparently alive and well.

Almost lost in the polemics about the evils of psychiatry are two important points. First, there have always been, and probably always will be, charlatans eager to take advantage of human misery by offering magical cures, instant relief, and the secret to living happily forever. Many of these swindles have been promoted as "psychotherapy," which leads to the author's second valid observation. As consumers of mental health services, we must be vigilant and demand information about efficacy, safety, and alternative treatments. He is also correct that mentally ill people can do a great deal for themselves, including avoiding self-destructive lifestyles, becoming involved with helping others, and developing their own support networks.

However, these sensible ideas, which could have been the basis of a very useful book for patients and families, are overridden by another message that reappears throughout, namely that those who do seek professional help are probably themselves to blame for not trying hard enough. It seems that one of the "freedoms" that the author is inadvertently insisting on for the victims of the "Psychotherapeutic State" is the freedom to continue to suffer from the symptoms of untreated mental illness.

The New Psychiatry: The Essential Guide to State-of-the-Art Therapy, Medication, and Emotional Health

by Jack M. Gorman, M.D.; New York City, St. Martin's Press, 1996, 388 pages, $27.50

Richard W. Roukema, M.D.

This is a highly practical and informative book written primarily for the patient and his or her family. It is an up-to-date view of what is new in psychiatry in today's world of health maintenance organizations, which has forced fiscal and therapeutic pragmatism on all those who work with the emotionally and mentally ill.

Dr. Gorman begins with a list of eight principles. Among them is the idea that mental health treatments must be result oriented in terms of the patient's needs and not dictated by the therapist's favorite theories. Only treatments with demonstrated effectiveness should be used. If they are not useful, they should be "abandoned or changed." Also, a patient has a right to know his diagnosis, the available treatments, and the reasonable expectations for help with the various disorders. Psychiatric care should be regarded as similar to care for medical illnesses such as cancer, high blood pressure, or diabetes.

Practical considerations such as when to ask for help, where to seek it, the importance of a psychiatric diagnosis, and the involvement of family members in determining treatment plans are stressed. The author speaks with a refreshing frankness. For example, he suggests that if a psychiatrist, especially during the first session, follows the patient's straightforward query with the old saw "Now what do you mean by that question?" maybe it is time to look for another psychiatrist.

Patients are advised on how to pick a psychiatrist, on what should happen in the first meeting, and on other topics such as fees, cancellations, and self-help groups. *The New Psychiatry* suggests using the simpler, shorter therapies first—cognitive-behavioral and biological therapies. If success is not attained, then longer dynamically oriented psychotherapy is recommended. Psychoanalysis is considered useful only in very specific situations, such as personality disorders. Group therapy and family therapy are also considered. The pros and cons of the various therapies are clearly spelled out. Dr. Gorman includes a very detailed but clear discussion of how psychiatric medications work and how they are used effectively for each disorder.

The author provides clinical examples of the various psychiatric disorders that are helped by treatment, including the anxiety and depressive disorders, schizophrenia, substance abuse, eating disorders, and personality disorders. The treatment plans outlined for each are so specific that psychiatric residents, nurses, psychologists, social workers, family practitioners, and other mental health workers could benefit from reading and following them.

Several topics are missing in the discussion of adult psychiatric disorders, such as sexual dysfunction, paraphilia, and dementia. The author doubts that avoidant and dependent personalities are valid diagnostic entities and regards paranoid, schizotypal, and schizoid personalities as variations of schizophrenia.

Dr. Gorman has successfully written a well-rounded book that is reader friendly and extremely useful. It is time to take psychiatry out of its theoretical mumbo-jumbo and put it into plain language. Dr. Gorman has succeeded remarkably in accomplishing this long overdue task.

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Mental Health Services: A Public Health Perspective

edited by Bruce Lubotsky Levin, Dr.P.H., and John Petrila, J.D., LL.M.; New York, Oxford University Press, 1996, 430 pages, $49.95

Phyllis Solomon, Ph.D.

This edited volume represents the first attempt to provide an integrated text of the critical elements and issues of mental health policy, management, and service delivery within a public health framework. This approach requires the integration of knowledge derived from mental health epidemiology, treatment, and service system research.

The editors are well suited to this challenge. Both are from Florida Mental Health Institute, a multidisciplinary research and training institute whose efforts are focused on the public mental health system. Dr. Levin is trained in public health and is noted for his writings on mental health administration and policy. Mr. Petrila is trained as a lawyer and known for his critical assessments of the impact of legislation and regulation on service delivery.

The first, and strongest, of the volume's four sections covers core mental health service delivery issues including organization, legislation and regulations, economics, financial management, quality improvement, consumer and family advocacy, evaluation, and multicultural perspectives. All the contributors to this section are nationally recognized experts on their respective topics.

The chapters in this section generally are good comprehensive overviews of the substantive issues covered, such as the chapters on mental health services by Elpers and Levin, on economics of mental health by Frank and McGuire, and on the impact of consumer and family advocacy on service delivery by Lefley. However, for readers well versed in mental health service delivery issues, they offer little new information. The chapters on evaluation written by Orwin and Goldman and on the impact of disability law on mental health policy and services by Petrila and Levin are strikingly innovative and do provide new insights.

The following three sections are devoted to three specialized populations—children and adolescents, the elderly, and adults with substance abuse problems—with each containing three chapters on the relevant epidemiological, treatment, and policy issues. These sections are uneven in quality and comprehensiveness. For example, the chapter on epidemiology of psychiatric disorders among the elderly is too detailed, and the reader becomes impatient. On the other hand, the treatment chapters in these three sections provide rather limited coverage; in addition, they have an extremely clinical orientation, not well balanced with a service perspective. The selection of these three populations results in the omission of relevant treatment, service, and policy issues related to adults with severe mental illness, such as those who are homeless, those who are in jails and prisons, and those who need psychiatric rehabilitation.

This book suffers from the typical problems of edited volumes, variable quality and redundancy of information. Given the book's significant gaps, it falls somewhat short of being a comprehensive introduction to mental health services from a public health perspective. However, many practice disciplines, such as social work, nursing, and psychiatry, need a single source that offers an overview of mental health services and related policy issues. With the use of some supplemental material, this book can serve as such an introduction, for there is no text that currently competes with it.

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Corporate Therapy and Consulting

by Len Sperry, M.D., Ph.D.; New York City, Brunner/Mazel Publishers, 1996, 241 pages, $27.95

Eric D. Lister, M.D.

Len Sperry has written a particularly useful book. It is designed, and organized, as a primer for clinicians that addresses the issues involved in organizational consultation. In this sense, it reminds me of Colby's classic *Primer for Psychotherapists* (1).

Dr. Sperry goes to particular lengths to describe consulting interventions along a continuum from those that most closely resemble psychotherapy, simply relocated into the workplace, to interventions that have primarily systemic and nonpsychological underpinnings. This frame of reference should be quite helpful for clinicians without formal business training or experience, and it offers some protection against the common but dangerous assumption that consultation work involves simply "doing the same thing, just a little bit differently."

Dr. Sperry sequentially reviews organizational dynamics, the concept of organizational diagnosis, and a menu of possible organizational interventions. He guides the reader to extending the perspective of an experienced clinician, who uses a basic-science understanding of relevant phenomena to clarify a sense of the problem and then tailors an intervention appropriately. In three chapters dealing with the clinical-organizational interface—called "Clinical-Organizational Interventions," "Executive Dynamics," and "Executive Consulting, Psychotherapy, and Coaching"—the text frames a wide variety of consultative interventions that draw specifically on the psychological skills of clinicians who have become consultants. Dr. Sperry shows how our understanding of personality, adult devel-

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opment, stress, change, aggression, and group process, all of them basic skill sets for the dynamically trained psychiatrist, can be transmuted and applied in organizational settings. By providing tables and outlines—for instance, an outline for interviews aimed at creating an organizational diagnosis—along with annotated references, this book positions itself to be a platform for further learning and skill development.

Despite its clarity and profound utility for clinicians interested in understanding the world of organizational consultation, there are some weaknesses worth at least brief note. First, this volume, which is part of Brunner/Mazel's series on Mental Health Practice Under Managed Care, risks implying that the transition to consultation work is an easy or a natural way to escape the impact of managed care. Such a suggestion belies the multiple hurdles awaiting any clinician who attempts such a professional transition. These hurdles include the need to ascertain "fit" between personal style and the demands of consultation work, the need to embark on a significant and sometimes challenging learning curve, the need to dramatically expand one's comfort range for professional interactions, and the daunting challenge of "marketing" oneself successfully as a consultant.

Second, Dr. Sperry's volume does not do justice to the topic covered in its seventh chapter, consultation to health care organizations, which perhaps deserves its own volume. He also might have said more about the role of psychiatric expertise in leadership training, an area where many in our field have established visible and impressive careers.

Finally, *Corporate Therapy and Consulting* does not provide a primer on how business organizations function. The clinician who has not had significant exposure to the world of business may lack the context necessary to appreciate some of the subtleties of Dr. Sperry's work. Again, perhaps this topic warrants its own companion volume.

All things considered, this is a clear and extremely useful book for psychiatrists interested in understanding organizational consultation and those who are beginning to take on consulting assignments outside of the traditional clinical encounter.

Reference

1. Colby KM: A Primer for Psychotherapists. New York, Ronald Press, 1951

International Review of Psychiatry, Volume 2

edited by Felice Lieh Mak, M.D., and Carol C. Nadelson, M.D.; Washington, D.C., American Psychiatric Press, 1996, 476 pages, $35

Helen Herrman, M.D., B.S.

Effective advocacy for resources and effective administration of mental health services are important capacities. They require at least as much wisdom and cooperation as the humane and well-informed practice of psychiatry. The appearance of this volume is welcome in that it emphasizes the interdependence of these areas of work and addresses many broad issues affecting and affected by the practice of psychiatry.

The book is a collaboration between American Psychiatric Press and the World Psychiatric Association and is published in conjunction with the tenth World Congress of Psychiatry. The publishing history suggests much energy and distillation of thought. The editors' stated aim is to move from the relatively narrow confines of psychiatry, as covered in the first volume of the series, to address broader issues. They are well aware of the dangers of loss of focus.

For me, much of the interest and stimulation of the book comes from reading the justifications from the distinguished group of editors and section editors for their choices and themes. For instance, Dr. Mak writes in the foreword that "the exploding cost of health care has led governments to focus on cost containment and cost reduction without effectively dealing with the problems engendered by misallocation, waste, and inequitable distribution of resources."

The section on the economic aspects of mental health then invites us to go beyond bemoaning the impoverished state of most mental health services to embrace the critical issue of economic analyses of the problem of mental illness. Section editors Harold M. Visotsky and Norman Sartorius point out that "indicators of cost of illness and cost of treatment, as well as indicators of direct and indirect gain in terms of money (and quality of life), are poorly developed, rarely used, and differently interpreted." Clinicians unsure about how this thinking fits with responsibility to each patient are likely to find the section a useful discussion, although they will need to look to some of the citations to find more on the basics of health economics.

The section on violence is beautifully crafted to discuss the epidemiology of extreme violence, posttraumatic stress disorder among victims, and the treatment of violent patients. While supporters of the gun lobby will find no joy, the contributions remain relevant to psychiatry.

The sections on traumatic stress and on childhood and adolescence each constitute one-third of the volume. Although they lack the coherence of the previous sections, they tackle major areas such as torture and refugee trauma, stress disorder and medicolegal issues, child abuse and neglect, and adolescent suicide. The emphasis is on the continuing need to examine practice and definitions as experience is shared across cultures and across emerging and difficult areas of practice.

I recommend this volume to those working in mental health services. It is not a primer, but rather a stimulus to think more broadly.

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