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UNITED STATES CHAPTER

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Psychosis in Context: Exploring Intersections in Diverse Identities and Extreme States
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Abstracts, Learning Objectives, Target Audience & References

Joseph I. Abrahams, MD
In Search of Self and Soul
Introductory
In my three-quarters century of psychoanalytic practice, I have settled on research into Freud's concept of "Seele" as my locus of inquiry. Concomitant has been identification of phenomena of parallel disorders of the self. These inquiries have been into my extensive patient population, consisting of people who have experienced psychopathology, psychosis, depression and neuroses. Along with that, I have engaged in a lifelong self-analysis. In the last 40 years, I have done research into the enigma of Virginia Woolf.

I consider that Freud employed the word "Seele" advisedly, to include the spiritual component, but to remain strictly scientific dropped that line of inquiry. The data I have encountered have lead my to a hypothesis of messianic as a core phenomenon in the maternal infant transaction and a role reversal due to maternal depression. Melanie Klein's "Oral Guilt," to my mind, refers to the messianism of the early infant.

Alongside this inquiry, I have been accumulating evidence in what I call my "iconic cases". They were considered un-analyzable by my colleagues. However, through a messianic transference, I gained access to their intrapsychic dynamics and found them to have incorporated their parental objects in a manner which lead to an arrest at a most primitive level, arrest which was experienced as an existential impossibility. Analysis of such resulted in separation from the interjected other and deep mourning. This case material was illustrated by dream and transference manifestation of convincing nature.

My personal and professional self analysis followed an equally dramatic course. In my midlife crisis I experienced myself dead in a coffin, lid on, and were I to struggle I would die, like other men my age. I decided to analyze my way through that situation, resulting in significant alteration of my messianic narcissism. Lastly, I have been studying the Virginia Woolf story from the vantage point attained by my other two studies and found significant correlations and affirmations of my findings.

At the conclusion of this activity, participants should be able to:
1. Cite the role of the spiritual in the operation of the self in the analytic process, including the role of messianism.
2. Identify the role of mourning in the therapeutic process, centering on adherence of the introject to the object and separation therefrom.
3. Correlate Virginia Woolf's apparent madness and hypotheses to its genesis.

Abrahams, Joseph.(2016). Circles of Change: An Adventure in Therapeutic Community at Atascadero State Hospital.

Abrahams, Joseph. (2007) The Messianic Imperative: Scourge or Savior.Kindle edition.

Abrahams, Joseph. (2014) Terra Incognita: A Psychoanalyst Explores the Human Soul. UPA.

Abrahams, Joseph. (2010) This Way Out: A Narrative of Therapy with Psychotic and Sexual Offenders (Volume 2).

Fonagy, P., Kächele, H., Leuzinger-Bohleber, M., Taylor, D. (eds.) (2012) Review of The Significance of Dreams. London, UK, Karnac Books.

Tazma Ahmed-Datta, MS, LPC
Psychosis and Graves' Disease: Historical Overview and Current Standard of Care
Intermediate
What is this disease of the thyroid, as it is known to be - and is truly an autoimmune disorder that affects more than the thyroid - doing in this forum?

This paper is a question-raiser regarding psychosis in conditions related to thyroid function. It takes a historical view of treatment looks at recent research and practice regarding psychosis in the context of GD.

This paper looks at:
- How psychosis in GD, and other thyroid related conditions, has historically been treated. Instances of individuals being put away in mental asylums in the past.
- How psychosis in GD is received today. Instances of treatment with antipsychotics, unsuccessfully.
- Insidious way in psychosis or extreme states may stay unnoted or wrongly treated. How to make these discernments.
- Reception of extreme states in the healthcare industry in the context of GD, and loops back to the hand that big pharma has in the treatment protocols on offer for GD. Coming away from the pharmaceutical driven disease model of care.

This may ring a familiar bell for this forum: In GD, there is a goal of symptom reduction with no attention to underlying cause or to long term ramifications of standard interventions. Standard interventions also include mutilation of the body/ excision of the thyroid gland, a procedure considered benign, indeed, even curative. Reminiscent of lobotomy. The individual or the culture being co-opted into accepting a "standard of care" that makes one pharmaceutical-dependent for life.

This paper:
- Looks at re-articulation of illness, a narrative that articulates the prospect of a healing trajectory, not merely one of symptom reduction or containment.
- Blurs the lines in the conversation about physiological health and what is termed mental health.

At the conclusion of this activity, participants should be able to:
1. Explain how psychosis may be associated with Thyroid Disease.
2. Discuss how the lines between physiological and psychological health are not definitive.
3. Describe how healing does happen.

Aarab, C et al. 2016. Acute psychosis secondary to dysthyroidism: about 2 cases. Pan African Medical Journal. December 2016. doi: 10.11604/pamj.2016.25.216.10247

Dahale, A. B. et al. 2014. Postpartum psychosis in a woman with Graves' Disease: a case report. General Hospital Psychiatry: Psychiatry, Medicine and Primary Care, November- December 2014. Vol 36, Issue 6, 761-8.

DOI: http://dx.doi.org/10.1016/j.genhosppsych.2014.07.003

Hazen, EP et al. 2015. Case 10-2105 – A 15-Year-Old Girl with Graves' Disease and Psychotic Symptoms. New England Journal of Medicine 2015; 372:1250-1258. March 28, 2015. DOI: 10.1056/NEJMcpc1314239

Tareq, H S et al. 2013. Hallucinations as Presenting Complaint in Thyroid Storm: An Uncommon Presentation of Disease. Presentation at The Endocrine Society's 95th Annual Meeitng and Expo June 15-18, 2013 – San Francisco. Presentation Number: SAT-469. Date of Presentation: June 15, 2013.

Jessica Arenella, PhD & Trevor Temmen
The Influencing Machine is Real: Intersections of Technology and Experience
Introductory
Concerns about the erosion of privacy and invasion of the mind are increasing concerns in this highly technological era among both people diagnosed with psychiatric conditions and the general population. Mind-reading computer technology that can influence one's behavior is no longer the stuff of science-fiction and fantasy, but is already present and being developed by the military. Paranoid ideation about computers and technology is on the rise, but so are the reaches of such technology, including mind-reading or "synthetic telepathy" capabilities. Exclusionary criteria for diagnosing delusions include the caveat that beliefs that are part of a culture or subculture should not be classified as delusional. In the Internet era, there are communities that espouse and normalize ideas such as gang-stalking, voice-to-skull communications, and brain-hacking, effectively neutering the diagnostic criteria for delusions. Clinicians can no longer simply assign client communications to the realm of the delusions of an influencing machine. In this talk, Mr. Trevor Temmen reports developing ESP as a result of psychological and physical abuse and is a self-identified subject of synthetic telepathy directed by governmental forces. He will describe his experiences of intrusive telepathy and uncomfortable sensory intrusions as well as his theory of governmental hacking into his brain. Jessica Arenella will discuss her experiences with clients experiencing technological and governmental intrusions into their personal lives as well strategies to work with clients in distress regarding these issues. Additionally, a new paradigm for understanding "delusional" beliefs will be outlined.

At the conclusion of this activity, participants should be able to:
1. Define and critique current DSM definition of the term delusion.
2. Cite three examples of mind-control experiments in the United States.
3. Describe a new paradigm for understanding "delusional" beliefs.

Krishnan, A. (2016).Military Neuroscience and the Coming Age of Neurowarfare (Emerging Technologies, Ethics and International Affairs). Routledge: London & New York.

Mason, OJ, Stevenson, C. and Freedman, F (2014). Ever-present threats from information technology: the Cyber-Paranoia and Fear Scale. Frontiers in Psychology 5: 1298-1307.

Xu, L. (2014) Humans Computers And Everything in Between: Towards Synthetic Telepathy. Harvard Science Review. Published online:https://harvardsciencereview.com/2014/05/01/synthetic-telepathy/

Elahi, A., et al., Do paranoid delusions exist on a continuum with subclinical paranoia? A multi-method taxometric study, Schizophr. Res. (2016), http://dx.doi.org/10.1016/j.schres.2017.03.022

Chelsea H. Bagias, PsyD
The Heart and Soul of Human: The Protective Nature of Psychosis
Intermediate
Looking at the protective mechanisms that the body employs provides a view into the core of the so-called psychotic process. Defense mechanisns, existential threats, and blocked developmental stages all coalesce to form what is, in our culture, termed psychosis. Perspectives on these influences will be discussed, as will alternative views on extreme states.

The presentation provides a way to convey to the client an alternative view of their label of psychosis. Statistics and research findings help validate and normalize what they have gone through, highlight parallels to their life, and provide information that will be vital to their continued growth.

At the conclusion of this activity, participants should be able to:
1. Evaluate indicators of a defense mechanism in ones present symptoms.
2. Identify alternative explanations for psychosis in other cultures.
3. Cite research findings that normalize the experience of symptoms of psychosis.

Rethinking Madness: towards a paradigm shift in our understanding and treatment of psychosis. Paris Williams 2012.

Psychosis as a mechanism for coping with existential distress, Grant S. Shields, Existential Analysis, Jan 2014, Vol. 25 Issue 1, p142-158.

Experiencing Psychosis: personal and professional perspectives, Geekie, Randal, Lampshire & Read, 2013.

Claude B. Barbre, PhD, LP
Anthropecene States, Trauma, and the Subtle Body: Eco-(P)syndemic and Biosocial Contexts and Causes of Psychosis
Intermediate
The psychoanalyst Sudhir Kakar remarked that “if we look at the body through the Hindu Ayurvedic lens then the body is intimately connected with nature and the cosmos and there is nothing in nature without relevance for medicine. This body image is an unremitting interchange taking place with the environment, simultaneously accompanied by a ceaseless change within the body” (Kakar, 2016). In this view, there is no essential difference between the natural world, body, and mind (Kakar, 2016). Thus the body as matter that is intertwined with the natural world and the earth deeply affects the human psyche. Keeping in mind Kakar’s call to consider the impact the environment has on the body and psyche, this presentation will examine the influence of the Anthropocene-- the term for a new geological epoch and state named in light of human (anthropos) acts on the environment that have created catastrophic changes and crises (i.e. climate change, seasonal changes, water-land disruptions, human and animal displacement, and disease). We will explore how the earth in trauma affects our biosocial, psychological, and spiritual health. As Jeremy Davies notes, “we are living in the fissures between one epoch and another” (Davis, 2016). We will explore Freud’s notion of Enreiss and Reiss, meaning a tear or fissure in the psyche that results from trauma, to reflect on environmental tears and their effects on the human mind and spirit. We will argue that such Anthropocene states can be viewed from a syndemic orientation—syndemic meaning “a set of linked health problems involving two or more afflictions interacting synergistically,” redefining physical and psychological illness through its contact with culture and biosocial contexts. In doing so, we will explore shamanic and indigenous perspectives of soul-loss, retrieval, and the subtle body, and intercultural, eco-psychology perspectives on psychosis and the environment.

At the conclusion of this activity, participants should be able to:
1. Identify and describe the multiple meanings of Anthropocene as a new epoch, and its influence on humanity and the environment.
2. Define and apply "syndemic" and the syndemic orientation in regard to psychological and physiological illness.
3. Compare and appraise historical meanings of the subtle body in regard to psycho-spiritual and biosocial contexts.

Jeremy Davis (2016). The birth of the Anthropocene. Oakland: University of California Press.

Sudar Kakar (2013). Shamans, mystics, and doctors. New York: Knopf.

Michael O'Loughlin and Marilyn Charles (2015), Fragments of trauma and the social production of suffering. Lanham MD. Rowman and Littlefield.

Claude B. Barbre, PhD, LP
Psychosis and Initiation: The Unfolding of Life Through the Liminal Space of the Uncanny
Intermediate
In *The Interpretation of Dreams*, Sigmund Freud talks about "ghosts" or "revenants"—revenants meaning one who returns from the dead or from a long absence. Later, speaking of the lingering horrors of war, he discusses the phenomenon of "the uncanny," (umheimlich, suggesting a "homelessness at home") as "the unexpected return of elements that should have been surmounted long ago… The uncanny is what is frightening-- what arouses dread, and horror" (Freud, 1919; 1953). As Jacques Lacan noted, the uncanny creates "an irreducible anxiety gesturing to the Real." But as Charles Taylor writes, the phenomenon may be a movement beyond the self "to a fragmentation of experience which calls our ordinary notions of identity into question." Suddenly, he says "persons, things, sense-impressions, experiences and situations which are known and long familiar arouse in us the feeling of danger, fear and even horror. Everyday objects may suddenly lose their familiar side, and become messengers." Hence, while the uncanny is an experience of unsettled liminality, uncertain locations in the world and self, it can also initiate the person beyond the self to a new identity. In this presentation we will explore the multi-layered perspectives of psychosis as an experience of umheimlich and fragmentation that can initiate a movement beyond the self to the unfolding of life. We will explore the archetypal significance of initiation that often includes suffering, creative illness, and transformation. For example, immersions into shamanic identity often include an initiation crisis such as an illness or trauma that can lead to a numinous experience of rebirth and becoming. As one Inuit shaman said of his initiation through illness: "I went crazy but not out of my mind," adding "I died a little." We will explore how the liminal space of uncanny phenomena may mirror initiation experiences of fragmentation and rebirth.

At the conclusion of this activity, participants should be able to:
1. Describe and discuss the nature of the uncanny as examined in psychoanalytic and psychosocial literature.
2. Discuss, compare and contrast diverse views of initiation in an intercultural context.
3. Examine and interpret the multiple meanings of creative illness in multicultural contexts, biographical examples, and clinical applications.

Michael O'Loughlin (2015) The Ethics of Remembering and the Consequences of Forgetting. Lanham, MD: Rowman and Littlefield.

John Kaag (2014) Thinking Through the Imagination: Aesthetics in Human Cognition. New York: Fordham University Press.

Dana Blue and Caron Harrang, Eds. (2016) From Reverie to Interpretation: Transforming Thought into the Action of Psychoanalysis.

Colleen Barron, LPC
The Interactive World of Severe Mental Illness: A Fountain of Creativity
Introductory
Underlying this presentation is the conclusion that: the social interaction of people diagnosed with severe mental illness plays a fundamental role in their mental health and treatment—ultimately facilitating their capacity to be creative human beings.

Psychotropic medication, it is true, is important in the treatment of severe mental illness. However, pills are not enough to recover from the devastation of a psychotic break. As a parallel, a person cannot recover from the death of her entire family in the Holocaust simply by taking an anti-depressant. The social interaction surrounding a person can facilitate recovery, or play a major role in maintaining her mental illness. We hope that mental health professionals and other interested parties will reflect on the

tremendous importance of growth promoting communication in the lives of the "severely mentally ill," individuals who tend to be alienated from our society. We identify specific interactions that impinge on psychological growth as well as those that enhance psychological growth and stimulate creativity. We consider the clients' overall relational worlds, including their relationships with friends, family, peers, spouses, lovers, co-workers, mental health professionals, institutions, and finally, the community as a whole.

We demonstrate how positive interaction structures contributed to the development of a play The Mind of Lincoln: Brilliance and Melancholy performed by 22 individuals diagnosed with severe mental illness and housed in a long term care facility. A fifteen minute video highlighting the performance and positive interaction structures between cast members, mental health professionals and the public shown as part of the presentation.

At the conclusion of this activity, participants should be able to:

1. Name three interaction dynamics that hinder psychological growth in severely mentally ill consumers.
2. Identify three interaction dynamics that foster psychological growth in severely mentally ill consumers.
3. Name two reasons the creative arts are a valuable venue for creative positive interaction dynamics with severely mentally ill consumers.

Semmelhack, D., Ende, L. & Hazell, C. (2013). Group Psychotherapy with Severely Mentally ill Adults: Adapting the Tavistock Method, London: Routledge.

Semmelhack, D.; Ende, L., Freeman, A., Hazell, C., Barron C, & Treft, G. (2015).

The Interactive World of Severe Mental Illness: Case Studies of the U.S. Mental Health System, (2015) New York: Routledge.

Hazell, C. (2005). Imaginary groups, Bloomington, IN: Authorhouse.

Hazell, C. & Semmelhack D. (2005). Group-as-a-whole in a county jail. In C. Hazell's, Imaginary groups (pp. 83-100). Bloomington, IN: Authorhouse.

Beatrice Birch, HAT

Deep Healing Without Meds

Introductory

Inner Fire is a unique, proactive healing community in southern Vermont, founded with the sole purpose of offering striving individuals the choice to recover from debilitating and traumatic life experiences, (which typically lead to mental (soul) health and addiction issues), without the use of mind-altering, psychotropic drugs.

My presentation will offer a view of the human being as having a body, soul and spirit and explain why and how this awareness of the human being influences our proactive, comprehensive program. The group work in the kitchen, biodynamic garden, household and forest is mindful, empowering and grounding, and helps change self-images. During the one-on-one proactive therapies: artistic, movement, music, the art of speech and massage, one focuses on one's own inner growth, creating soul balance. Biographical work and peer support via Hearing Voices and other groups, balance the therapies and outdoor work. Inner Fire's rhythmic program in our small community kindles and awakens the creative self and thereby leads toward deep and profound healing.

Inspiring examples drawn from 'seeker's' personal experiences during their year at Inner Fire will enrich my presentation. Also, examples of the challenges and joys of working in this way will be both valuable and encouraging.

At Inner Fire, we are not anti-meds, but rather pro-choice. If someone is happy on their medications, that is not our business, but too many people commit suicide because they cannot tolerate the dehumanizing and humiliating side effects of the psychotropic drugs doled out with little consciousness by too many psychiatrists and doctors.

The view of the human being has become too simplistic, with the emphasis on fixing or maintaining rather than healing. Being a human being is simply complicated. Healing is a process and takes courage and trust.

At the conclusion of this activity, participants should be able to:
1. Identify an imbalance on the deeper soul/spiritual level.
2. Explain what can help to recreate balance on the soul/spiritual level.
3. Describe the power and role of love as a force and energy which is crucial in the healing process.

Singer, Michael. (2015) The Surrender Experiment. Harmony.

Whitaker, Robert and Cosgrove, L. (2015) Psychiatry Under the Influence: Institutional Corruption, Social Injury, and Prescriptions for Reform. Palgrave Macmillan.

Brogan, Kelly. (2016) A Mind of Your Own: The Truth About Depression and How Women Can Heal Their Bodies to Reclaim Their Lives. Harper Wave.

Dunselman, Ron and Plym Peters. (1995) In Place of the Self: How Drugs Work (Social Ecology). Hawthorn.

Bento, William. (2003) Lifting the Veil of Mental Illness: An Approach to Anthroposophical Psychology. SteinerBooks.

Perry, John Weir. (1974) The Far Side of Madness. Prentice Hall.

Hornstein, Gail. (2009)Agnes's Jacket: A Psychologist's Search for the Meanings of Madness. Rodale Books.

Singer, Michael. (2007)The Untethered Soul: The Journey Beyond Yourself. New Harbinger Publications/ Noetic Books.

van den Berg, Aalt. (1990) Rock Bottom, Beyond Drug Addiction. Hawthorn Press.

Marilyn Charles, PhD, ABPP & Barri Belnap, MD
Psychosis: Two Developmental Perspectives
Intermediate
We offer two perspectives on psychosis, seen through a developmental lens. Our work at the Austen Riggs Center affords us opportunities to learn about etiology and treatment of the complex difficulties linked to trauma, neglect, and waylaid development that are often termed ‘psychotic’.

The first presenter suggests that attempts to understand human suffering have resulted in reified concepts that further marginalize the sufferer. In contrast, clinical and research experience tell us that psychosis is a function of disruptions in development, often associated with trauma and neglect, that interfere with identity development. Current medical terminology and treatment can further disrupt development by imposing labels and treatments that make it difficult to learn about oneself sufficiently to negotiate life’s challenges. Recognizing the human suffering at the core of chronic and severe symptoms of distress helps us to develop relationships that attenuate the marginalization that occurs as a function of extreme distress and also the shame invoked by marginalization.

The second presenter offers a new developmental paradigm that assumes that just-minded people trying to do the right thing end up participating in the recreation of the trouble they believe they are overcoming. She relates this phenomena to the particular loneliness of adolescence and of psychotic experience. This paradigm begins with an idea of self that includes not just who one has been - based on actions taken - but also all the potential realizations of a singular individual that are felt to be evidential traces of "myself." She links the concept of projective identification to developmental efforts to sustain a self made of 2 parts: who I am to myself and who I am to others.

We hope to invite a conversation that will enrich the communal effort of recognizing and working with the complex difficulties marked by the emergence of psychotic symptoms.

At the conclusion of this activity, participants should be able to:

1. Describe one reason why insight-oriented models might be more effective than cognitive behavioral interventions for those who struggle with psychotic symptoms.
2. Give one reason why a developmental perspective might be more useful than the medical model for those who struggle with psychosis.
3. Describe one way in which family work can be facilitative for an individual struggling with psychosis.

Bourdeau, G., Lecomte, T., & Lysaker, P.H. (2015). Stages of recovery in early psychosis: Associations with symptoms, function, and narrative development. Psychology and Psychotherapy: Theory, Research and Practice. 88:127-142.

Charles, M. (2014). Trauma, Childhood, and Emotional Resilience. In N. Tracey (Ed.). Transgenerational Trauma and the Aboriginal Preschool Child: Healing through Intervention. Lanham, MD: Rowman & Littlefield, pp. 109-131.

Charles, M. (2014). The Intergenerational Transmission of Trauma: Effects on Identity Development. In N. Tracey (Ed.). Transgenerational Trauma and the Aboriginal Preschool Child: Healing through Intervention. Lanham, MD: Rowman & Littlefield, pp. 133-152.

Charles, M. (2014). Trauma, Fragmentation, Memory and Identity. In M. O'Loughlin & M. Charles (Eds.), Fragments of Trauma and the Social Production of Suffering. Lanham, MD: Rowman & Littlefield, pp. 25-44.

Charles, M. (2016). Creativity, Identity, and Social Exclusion: Working with Traumatized Individuals. In B. Wilcock, L. C. Bohm, & R. C. Curtis (Eds.), Psychoanalytic Perspectives on Identity and Difference: Navigating the Divide. London: Routledge, pp. 144-162.

Charles, M. (2017). Working with Psychosis. In: D. L. Downing & J. Mills (Eds.), Outpatient Treatment of Psychosis: Psychodynamic Approaches to Evidence-Based Practice, pp. 55-78. London: Karnac.

Charles, M., & O'Loughlin, M. (2013). The complex subject of psychosis. Special Issue: Psychosis, M. Charles, Guest Editor. Psychoanalysis, Culture, and Society, 17(4):410-421.

Lauveng, A., Tveiten, S., Ekeland, T.-J., & Torleif, R. (2016). Treating symptoms or assisting human development: Can different environmental conditions affect personal development for patients with severe mental illness? A qualitative study. International Journal of Mental Health Systems, 10(8). DOI 10.1186/s13033-016-0041-2.

Longden, E., & Read, J. (2016). Social adversity in the etiology of psychosis: A review of the evidence. American Journal of Psychotherapy, 70:5-33.

Martin A. Cosgro, PhD
The Evolutionary Basis for some Entrenched Delusions and How to Facilitate Change (Getting Un-stuck)
Intermediate
Early trauma tends to evoke an evolutionary adaptation response that can contribute to entrenched delusions and limit the efficacy of psychotherapy of psychosis if not explored. Once the underlying trauma end evolutionary adaptation are dealt with directly, delusions tend to loosen their grip and paves the way for more flexible and adaptive thinking. Similar evolutionary responses are often experienced by clinicians in training and without knowing so hinder their clinical effectiveness. Being aware of these over learned adaptational responses tends to free up both clients and clinicians as the underlying rationale for fixed beliefs become uncovered.

At the conclusion of this activity, participants should be able to:
1. Articulate how early trauma can activate an evolutionary response.
2. Articulate how to interpret an evolutionary response which facilitates movement away from entrenched delusions.
3. List an evolutionary response from their clinical training which may be hindering their clinical effectiveness.

Pysyszynski, Solomon and Greenberg. (2015) Thirty years of Terror Management Theory: From Genesis to Revelation. Advances in Experimental Social Psychology, vol. 52, pp. 1-60.

Goldenberg, J. (2012) A Body of Terror: Denial of Death and the Creaturely Body. In: Meaning, Mortality and Choice: The Social Psychology of Existential Concerns, pp. 93-110. Washington D.C., APA.

Greenberg, J., Vaik, K., & Pyszczynski, T. (2014) Terror Management Theory and Research: How the Desire of Death Transcendence Drives our Strivings for Meaning and Significance.
Advances in Motivation Science, 1, 85-134.

Françoise Davoine, PhD
The Intersection of French Psychoanalysts with Sioux Medicine Men
Introductory
During the eighties, Jean Max Gaudillière and I spent several summers on the Rosebud reservation in South Daktoa, on the invitation of Jerry Mohatt, who lived there. His long familiarity with Sioux medicine men favored exchanges with them, as with colleagues, around clinical cases. I intend to tell what we learned from them.

At the conclusion of this activity, participants should be able to:
1. Compare French psychoanalytic and Lakota approaches to psychosis and extreme states.
2. Contrast French psychoanalytic and Lakota approaches to psychosis and extreme states.
3. Explain how cultural exchanges can benefit a clincian’s practice and understanding of trauma, psychosis and extreme states.

Gerald Mohatt and Joseph Eagle Elek, The Price of a Gift, A Lakota Healer's story. University of Nebraska Press, 2000.

Françoise Davoine and Jean Max Gaudillière: “The psychoanalysis of Psychosis at the crossroads of individual stories and of history”, in Psychoanalysis and Holocaust Testimony, unwanted memories of social trauma, edited by Dori Lub and Andreas Hamburger, Routledge, 2017.

Françoise Davoine, Fighting Melancholia, Don Quixote's Teaching, Karnak 2016. The second book on the second Don Quixote: Don Quxote's fight against perversion, will be published by Karnak in 2018.

Françoise Davoine: “Siri's Timequakes” in Zones of focused Ambiguity in Siri Hustvedt's Works. Anglia Books series, 2016.

Françoise Davoine: “Mad Witnesses”, in Listening to trauma, Conversations with the leaders in the Theory &Treatment of Catastrophic Experience, interviews and photos by Cathy Caruth, Johns Hopkins University Press, 2016.

Françoise Davoine, Mother Folly, Stanford University Press, 2014.

Anne Marie DiGiacomo, LCSW & Matt Allen, MA

Revealing Invisible Biases Within the Context of LBGTQIA/Extreme States: A Path to Mutual Recovery

Introductory

The Windhorse approach is grounded in the practice of mindfulness/awareness and the moment to moment experience of being present and open to things as they are. The experience of being present, letting in and letting be (basic attendance skills) allows for the natural flow of life to unfold without preconditioned notions of how things should be. In this way a mutual journey of healing, recovery and learning can take place between clients, family and staff. Another aspect of this sense of mutual recovery includes creating environments of sanity and well being which involve synchronizing body, mind and speech in day to day life and activity. These environments of sanity are deeply embedded in the intimacy of ongoing relationship and connection between clients, family and staff.

This kind of environmental therapy opens up the possibility for those experiencing more extreme states of mind to discover a greater sense of relaxation and workability within themselves and the world around them. As Harold Searles so movingly stated: “We shall be encouraged to enter into such work, for example, in proportion as we become convinced that even a single moment of deeply felt intrapersonal and interpersonal relatedness is subjectively timeless, eternal and ‘make up for’ several decades of living as a less-than whole person.”

It is within this context that we would like to explore the invisible biases we all have, that keep us from fully exchanging with another person’s experience. The intersection of diverse identities and extreme states is evolving within mental health. It is our intention to offer an in depth dialogue and larger group discussion to further uncover–through examining our invisible biases–the obstacles to genuinely seeing and accepting others as they are and in so doing creating relationships and environments of care and support.

At the conclusion of this activity, participants should be able to:

1. Discuss greater understanding and experience of their own invisible biases.
2. Explore greater understanding and an experience of Dialogue as a potentially dynamic platform for both teaching and learning.
3. Discuss what it is about our biases that offer unparalleled opportunities for growth and development.

Kidd, S.A., Howison, M., Pilling, M, Ross, L., & McKenzie, K. (online first, 2016). Severe mental illness in LGBT populations: A scoping review. Psychiatric Services.

Podvoll, Edward. 2003. Recovering Sanity: A Compassionate Approach to Understanding and Treating Psychosis. Shambhala Publications, Inc.

Schulman, Michael. 2013. Generation LGBTQIA. New York Times.

The National Institute of Mental Health (NIH) and Canada’s Mental Health and Addiction Network (CAMH). 2016. Reimagining Inclusion: Defining Community for LBGTQ People with Diagnoses of Schizophrenia or Bi-Polar Disorder. (This study was done in Toronto, Canada).

Keynote Address: Gogo Ekhaya Esima
Sick or Gifted? Bridging the Connection Between Mental Health Issues and Spirituality
Introductory
Gogo Ekhaya Esima is not only a Mental Health Recovery Specialist, but a traditional South African healer (Sangoma), as well. Her own experience with mental illness, and her at times frightening, at times profoundly beautiful journey through it eventually led her deeply into traditional African spirituality. This gives her the unique perspective she will be sharing. Through this expanded view, symptoms of mental illness are seen from the wider context in which they have long been perceived by many indigenous cultures. They are re-framed as evidence of a solvable problem or an indication of an individual's gifts, instead of the sentence of a more permanent diagnosis. Gogo Ekhaya Esima will explain how Sangomas determine whether a person with "psychosis" is experiencing a shamanic calling, bothersome spirits, or an ancestral dilemma, as well as what types of ceremonies, rituals, and medicine are prescribed for healing in each case. She will address the importance of ancestors, a supportive community, and other integral aspects of traditional African life and specifically the healing process, as well as how this can be applied to work in mental health in the U.S.

At the conclusion of this activity, participants should be able to:
1. Identify how characteristics of mental illness are interpreted in the Sangoma tradition in contrast to the U.S.
2. Classify solutions to symptoms of mental illness as western or African.
3. Explain how we can apply the Sangoma perspective of symptoms, diagnosis, and treatment of mental illness to the way we approach this in the U.S.

Geier, J (Executive Producer), Kaplan, J. (Executive Producer), Borges, P. (Executive Producer & Director), & Tomlinson, K. (Executive Producer & Director). (2017). CRAZYWISE [Motion Picture]. United States: Northwest Film Forum

Luhrmann, T.M., Padmavati, R., Tharoor, H. & Osei, H. (2014). Differences in voice-hearing experiences of people with psychosis in the USA, India and Ghana: interview-based study. The British Journal of Psychiatry. https://doi.org/10.1192/bjp.bp.113.139048

Mutwa, V. C. (2006). Vusamazulu Credo Mutwa: Zulu High Sanusi. Sedgwick, ME: Leet's Island Books.
Ojelade, I.I., McCray, K, Meyers, J. & Ashby, J. (2014). Use of Indigenous African Healing Practices as a Mental Health Intervention. Journal of Black Psychology, 40 (6), 491-519. http://dx.doi.org/10.1177/0095798414533345

Bret J. Fimiani, PsyD
The Experience and Treatment of Psychosis in an Urban Multidisciplinary Public Clinic Setting
Intermediate
My presentation will address the clinical concepts key to my approach to working with people who have experienced psychosis in a multidisciplinary public clinic setting in San Francisco. The clinical (neo-Lacanian) concepts will include: 1) the position required by the clinician to initiate and sustain the treatment; 2) the structure of the experience of psychosis (often called delusion) as it emerged in the 1st phase of two cases that I will discuss; and 3) the role of the dream-work in calling the 'certainty' of delusion into question. As I am working closely with medical providers who are non-psychoanalytic in orientation, I will also address the inherent challenges of integrating a psychoanalytic framework within a setting that is predominantly medical.

I begin with the premise that a person's 'system of distressing beliefs' (delusion) has a function and serves a specific purpose for people experiencing psychosis. This premise, in itself, already puts us at odds with the predominant approaches to treating psychosis within medicine and mainstream psychiatry. Furthermore, people experiencing psychosis have (or produce) a specific knowledge vis-à-vis delusion and, to begin the treatment, the clinician's position (desire) must be guided by this specific knowledge in order to allow the 'knowledge' to be elaborated. In short, the knowledge contained in delusion may correspond to events in the 'subjective history' (a singular and complex history) of the

patient. How can we help gain access to the subjective history of someone experiencing psychosis in cases where the delusion presents as impenetrable? Following the work of psychoanalyst Willy Apollon, et al., I will outline how the 'dream-work' is one path for the person experiencing psychosis to discover/produce a 'question' about their delusion. The dream in essence can lead to a symbolic treatment of delusion thus opening a space for the subject to speak in other than delusional terms. I will provide clinical examples to illustrate the treatment of delusion by the dream-work.

At the conclusion of this activity, participants should be able to:

1. Demonstrate three key elements that may predict an effective analytical treatment of psychosis.
2. Identify two psychotic clinical presentations for which an analytically informed multidisciplinary approach may be an efficacious treatment for psychosis.
3. Describe "the structure and experience of psychosis" as it is understood in contemporary Lacanian psychoanalysis.

Rogers, A. G. (2016). Incandescent Alphabets: Psychosis and the Enigma of Language. London: Karnac Books.

Jones, N., et al. (2016). "Did I push myself over the edge?": Complications of agency in psychosis onset and development. Journal of the International Society for Psychological and Social Approaches to Psychosis, pages 234-335. Published online: 16 Mar 2016.

Arnold, K. (2016). Is delusional imperviousness a backfire effect of being disbelieved? Journal of the International Society for Psychological and Social Approaches to Psychosis, pages 369-371. Published online: 16 Mar 2016.

Longden, E., et al. (2011). Voice hearing in a biographical context: A model for formulating the relationship between voices and life history. Psychosis: Psychological, Social, and Integrative Approaches, pages 224-234. Published Online: 03 Aug 2011.

Cantin, L. (2002). From delusion to dream. In R. Hughes & K.R. Malone (Eds.), After Lacan: Clinical practice and the subject of the unconscious (pp. 87-102). New York: SUNY Press.

Bergeron, D. (2002). The work of the dream and jouissance in the treatment of the psychotic. In R. Hughes & K.R. Malone (Eds.), After Lacan: Clinical practice and the subject of the unconscious (pp. 71-85). New York: SUNY Press.

Apollon, W. (2004, February). On psychotic structure. Lecture delivered in the context of the "Clinical Cases Seminar in Puerto Rico." Hosted by the Puerto Rico Psychoanalytic Circle of the Freudian School of Quebec. San Juan, Puerto Rico.

Michael D. Garrett, MD

Practical Strategies In Public Psychiatry For Fostering Psychotherapy For Psychosis

Intermediate

Research demonstrating the efficacy and need for psychological and social treatments has not led the mental health system to reset its priorities in favor of psycho-social treatments. People who believe in psychological and social treatments for psychosis would do well to look for other ways to foster such treatments in psychiatric services that are currently dominated by pharmacotherapy. I will discuss two such strategies that can be framed as questions to administrators.

1) "Can psychotherapy for persons with psychosis help you to achieve the goals by which your performance as an administrator will be judged?" The efforts of the mental health system to reduce re-admission rates, lower inpatient length of stay, reduce violence, and discharge people who have been hospitalized for years, are measured and quantified to assess administrative performance. In many cases the reason patients do poorly, and therefore the reason the system struggles to meet its goals, is a failure to provide patients the psychological care they need. I will argue, in a way that one might with

administrators, that a program of ambitious psychotherapy will likely aide administrators in achieving their goals.

2) “Doesn’t the current standard of care in psychiatric practice, defined by the bio-psycho-social model, require you to provide ambitious psychotherapy for persons with psychosis?” The so-called “bio-psycho-social” model is the gold standard for clinical formulation in psychiatry. The current model in practice is more often a bio-bio-bio model. I will report on a research project designed to determine the relative proportion of biological and psychological information recorded in the medical record, and how this information is used or not used in formulating a treatment plan. The working hypothesis of the study is that psychological information is collected less often than biological information, and when it is recorded, it is rarely put to meaningful use.

At the conclusion of this activity, participants should be able to:

1. List at least 2 administrative goals that will be fostered by psychotherapy for psychosis.
2. Describe the relative proportion of biological and psychological information in the typical medical record.
3. Say how information about goals and the medical record can be used to argue in favor of psychotherapy.

Read, J., & Dillon, J. (Eds.). (2013). Models of Madness. Second Edition. London New York: Routledge.

Riggs, S. E., Garrett, M., Arnold, K., Colon, E., Feldman, E. N., Huangthaisong, P., Lee, E. (2016). Can Frontline Clinicians in Public Psychiatry Settings Provide Effective Psychotherapy For Psychosis? Am J Psychother, 70(3), 301-328.

Lotterman, A. (2015). Psychotherapy for People Diagnosed with Schizophrenia SPECIFIC TECHNIQUES. London New York: Routledge.

James E. Gorney, PhD & Marilyn Charles, PhD

History Beyond Trauma*: The Enduring Legacy of Davoine and Gaudillière*
Intermediate

The purpose of this panel is to explicate the profound and original illumination of trauma and the field of madness contained within *History Beyond Trauma* by Francoise Davoine and Jean-Max Gaudillière. Over the course of this ambitious volume, these psychoanalysts integrate thirty years of clinical and theoretical research in working with individuals who have had psychotic experience.

Drawing upon their early studies in philosophy and classics, the authors approach an individual's experience of madness not as a symptom, pathology, or structure in the DSM, but rather as a Place. This is the Place where the symbolic order, which guarantees a subject's connection to language, history and social relations has ruptured, exploded or disappeared. Consequently, one of the most important insights found in this work is that the person experiencing psychosis is engaged in a research investigation into the nature and history of this Place; he or she is a seeker.

The authors radically locate psychosis within a social and historical field. Within psychotherapy, the therapist is second in command to the patient–the Principal Investigator–who desperately attempts to articulate an unspeakable dimension of trauma and catastrophe, which has come to be foreclosed in the individual's personal or social history. Drawing upon their own histories, as well as their French identities, the author's develop a model of trauma rooted in the paradigm of war; the individual traumatized patient thus brings a war zone into the consulting room. Ultimately, principles derived from war psychiatry are employed as salient tools in approaching trauma and madness.

Each of Davoine and Gaudillière’s major theoretical concepts will here be illustrated via vivid clinical examples. It will be the intention of this panel to communicate the propositions of *History Beyond Trauma* with great clarity and to demonstrate their broad relevance in a manner that can be

immediately useful both to clinicians and to those who have had a personal encounter with psychotic experience.

At the conclusion of this activity, participants should be able to:
1. Describe the key concepts developed by Davoine and Gaudillière in explicating the multi-generational transmission of trauma.
2. Describe how to implement the clinical approaches of Davoine and Gaudillière in an ongoing practical way while engaging in psychotherapy with patients inhabiting an immediate zone of trauma, and/or with traumatic family history.
3. Describe the pivotal role of intergenerational and individual trauma in the eventuation of psychotic experience.

Davoine, F. and J-M Gaudillière (2012). Wittgenstein's Folly (Trans. W.J. Hurst). New York: YBK Publishers.

Davoine, F. (2014). Mother Folly (Trans. J. Miller). Stanford, CA: Stanford University Press.

Fromm, M.J. (Ed.) (2012). Lost in Transmission. London: Karnac.

Elahe Hessamfar, PhD
"Why I believe my psychosis is the result of demonic influences!"
Introductory
Decades of research have demonstrated how significant a person's personal, cultural, and religious beliefs are in shaping the substance of their psychosis. Behavior that would be regarded as psychotic by reductionist psychiatry may be highly valued and have a useful social role through other lenses.

This paper argues why it is rational for those of a religious faith, particularly Christians, to interpret their psychotic experiences as demonically influenced. It will maintain why we are doing a huge disservice to those suffering, by rejecting the validity of their religious interpretations, because of our own naturalistic doctrines. We are ignoring the valuable knowledge hidden in their understanding of their illness at our own peril. What one experiences internally cannot always be talked about without making oneself the subject of mockery, as it is immediately considered "insanity" to express one's inner experiences in a manner that is foreign to most of us.

Forging links between contemporary psychiatric disorders and demon-induced maladies portrayed in the New Testament is fraught with difficulty. This discontinuity is emphasized by many psychiatrists who are disposed to relate religious beliefs with those things that contribute to mental illness than with its therapeutic treatment. And their objections are valid in many regards. But that does not explain the whole story.

The twentieth century saw an astronomical rise in the popularity of sciences as explanatory frameworks for everything. Science has served humanity in remarkable ways, yet one should beware of dangers of scientism–the view that science is the supreme authority over all human questions and the solution to all human problems. If knowledge can be obtained only by scientific method through empirical evidence, then a whole dimension of knowledge gained in the course of centuries is ignored and that is spiritual knowledge.

The seductive simplicity of a materialistic argument has led to an entrapment in a medical epistemology for understanding madness, which limits our exploration of spiritual dimensions of the phenomenon. The paper provides a basis for reflection and interdisciplinary discourse between theology and mental healthcare.

At the conclusion of this activity, participants should be able to:
1. Identify the religious nature of psychosis.
2. Interpret the meaning of psychosis.

3. Employ effective treatment based on the substance of psychosis.

Hessamfar, Elahe. In the Fellowship of His Suffering: A Theological Interpretation of Mental Illness—A Focus on "Schizophrenia." Eugene, Oregon: CASCADE Books, 2014.

Cook, Christopher C. H. editor. Spirituality, Theology & Mental Health: Multidisciplinary Perspectives. London: SCM Press, 2013.

Jones, Nev, and Timothy Kelly, and Mona Shattell. "God in the brain: Experiencing psychosis in the postsecular United States." Transcultural Psychiatry 53, 4 (2016): 488-505. DOI: 10.1177/1363461516660902 tps.sagepub.com

McClay, Wilfred M. "The Strange Persistence of Guilt." The Hedgehog Review: Critical Reflections on Contemporary Culture. Vol. 19. No. 1 (Spring 2017).

Woods A. "On shame and voice-hearing." Medical Humanities (07 April 2017). Doi: 10.1136/medhum-2016-011167.

Larchet, Jean-Claude. Mental Disorders and Spiritual Healing. Hillsdale, NY: SOPHIA PERENNIS, 2005.

Ruth Israeli LCSW
Psychosis Goes High Tech: Navigating Alternative Treatment Approaches in the Age of Millennials
Intermediate
A lot has changed in the age of millennials, and that includes psychosis. What's real and what's not has never been more difficult to decipher than in the digital age. The world of the internet and social media has given birth to both helpful and harmful resources in the recovery process.

This presentation will address how the digital age has both helped and hindered the recovery process. Starting with the ways in which individuals are "coming out" about their Psychosis by means of Facebook, youtube or other social media outlets to the impact it has one's self and family. The plethora of information available on the web can seem puzzling not only to the individual, and family, but at times can even leave clinicians feeling mystified. This presentation will address these issues and more by taking in an in depth look into how mental illness is perceived in our popular culture while also exploring the impact it has had on individuals living with psychosis. In addition this lecture will provide participants with alternative treatment approaches that have a specific recovery oriented approach. These approaches include systems theory, and the Ackerman Relational Approach, as well as Need Adaptive Treatment Model (NATM) a modality adopted from Finland, which gave rise to what is now known as Open Dialogue. Additionally, participants will get an inside look into the cutting edge of practice happening at Glassleaf Inc., and will learn ways to incorporate new approaches into their practice.

At the conclusion of this activity, participants should be able to:
1. Explain what problems are facing young individuals with psychosis.
2. Distinguish the difference between NATM and OD.
3. Analyze their own way of practice and utilize 1-2 basic dialogical practice techniques.

Anderson. H (2012) Collaborative Relationships and Dialogic Conversations: Ideas for a Relationally Responsive Practice.

Seikkula. J (2014) Dialogue Is the Change: Understanding Psychotherapy as a Semiotic Process of Bakhtin, Voloshinov, and Vyg.

Seikkula. J (2012) Becoming Dialogical: Psychotherapy or a Way of Life?

Shienberg. M, & Brewster, K (2014) Thinking and Working Relationally: Interviewing and Constructing Hypotheses to Create Compassionate Understanding.

Wilson. J (2015) Family Therapy as a Process of Humanisation: The Contribution and Creativity of Dialogism.

Nev Jones, PhD & Sascha DuBrul, MSW

Developing and Implementing Radical Peer Support in Specialized Early Psychosis Programs

Introductory

In this panel, the two presenters will describe their work developing radical/progressive peer support programs, trainings and outreach in early intervention in psychosis/coordinated specialty care settings. This work builds on a foundation developed within the Icarus Project (T-MAPs) and the Hearing Voices Movement, with a strong focus on encouraging the exploration of the meaning and holistic impact of "psychosis", including alternative conceptualizations of the nature of experience and distress with ties to the punk culture, philosophy and the arts, the history of unusual experiences, and cross-cultural religious and spiritual practices. All discussion points acknowledge and will explicitly frame implementation in terms of the tremendous heterogeneity of experiences of psychosis, and diversity of healing journeys. Participants will be provided with free, open access materials to encourage broader implementation (and creative experimentation).

At the conclusion of this activity, participants should be able to:

1. Describe diverse ways of explaining/framing psychosis.
2. Discuss the importance of open-ended processes of exploration and meaning making.
3. Delineate concrete ways in which strategies and materials included in the presentation could be implemented in their own programs.

DuBrul, Sascha Altman. "The Icarus project: A counter narrative for psychic diversity." Journal of Medical Humanities 35.3 (2014): 257-271.

Larøi, F., Luhrmann, T. M., Bell, V., Christian, W. A., Deshpande, S., Fernyhough, C., ... & Woods, A. (2014). Culture and hallucinations: overview and future directions. Schizophrenia bulletin, 40 (Suppl 4), S213-S220.

Luhrmann, T. M. (2013). Making God real and making God good: Some mechanisms through which prayer may contribute to healing. Transcultural Psychiatry, 50(5), 707-725.

Islam, Z., Rabiee, F., & Singh, S. P. (2015). Black and minority ethnic groups' perception and experience of early intervention in psychosis services in the United Kingdom. Journal of Cross-Cultural Psychology, 46(5), 737-753.

Randal, P., Geekie, J., Lambrecht, I., & Taitimu, M. (2009). Dissociation, psychosis and spirituality: Whose voices are we hearing?. Psychosis, Trauma and Dissociation: Emerging Perspectives on Severe Psychopathology, 333-345.

Nev Jones, PhD, Janis Hunter Jenkins, PhD, Sarah Kamens, PhD & Neely Anne Laurenzo Myers, PhD

Cultural and Structural Contexts of Early Psychosis: Lived Experiences and their Relevance for Program Change

Intermediate

Conventional psychiatric practice, particularly in the United States, has tended to privilege clinical conceptualizations over those derived from lived experience, and quantitative program evaluation metrics over deep engagement with the diverse experiences of clients and their families. However, failing to engage with subjective experiences of psychosis–including their rich cultural, social, and political contents–can foreclose deeper healing and drive a wedge between providers and service users.

In this panel, the four presenters synthesize a substantial body of their own original phenomenological and ethnographic research as well as the larger qualitative literature, arguing for much greater attention to the nuances and contexts of clients' lived experiences of psychosis, including voices, visions, and unusual beliefs, their social and cultural embeddedness, the perceived roles and meanings of mental health systems, and implications for improving and/or rethinking psychosis services, including specialized early intervention programs.

Specifically, the presenters will challenge long-standing stereotypes regarding the nature and form(s) of psychosis, exploring cross-cultural variations (drawing on interviews conducted in the U.S., Israel-Palestine, India, Tanzania, and Ghana) as well as the rich social and political content of these experiences, and the relationships between external contexts–including disadvantaged neighborhoods and neighborhoods riven by both physical and structural violence–and the meaning and content of psychotic experiences. The panelists will also argue for the importance of careful consideration of social context and meaning for engaging youth, with particular focus on the erosion of autobiographical power (Myers), or the ability to tell one's own story. In doing so, this presentation will emphasize the possibility of innovation and change within existing service models. Presenters will also weigh in on the twin problems of essentialism and depoliticization in both phenomenological research and conventional clinical practice.

The presentation will conclude with overview of concrete and tractable suggestions for programmatic and systems change.

At the conclusion of this activity, participants should be able to:

1. Describe key themes concerning the phenomenological diversity of early psychotic experiences.
2. Discuss the implications of diverse phenomenology for working with clients from minority racial/ethnic and cultural backgrounds.
3. Discuss some of the ways in which trauma impacts on the onset and content of psychosis and experiences of early intervention services.

Boydell, K., Gladstone, B., & Stasiulis, E. (2014). Using arts-based methods to explore pathways to care for young people experiencing psychosis. Early Intervention in Psychiatry, 8, 115.

Haug, E., Øie, M., Andreassen, O. A., Bratlien, U., Raballo, A., Nelson, B., ... & Melle, I. (2014). Anomalous self-experiences contribute independently to social dysfunction in the early phases of schizophrenia and psychotic bipolar disorder. Comprehensive psychiatry, 55(3), 475-482.

Jansen, J. E., Wøldike, P. M., Haahr, U. H., & Simonsen, E. (2015). Service user perspectives on the experience of illness and pathway to care in first-episode psychosis: A qualitative study within the TOP project. The Psychiatric Quarterly, 86, 83-94.

Jones, N., Shattell, M., Kelly, T., Brown, R., Robinson, L., Renfro, R., ... & Luhrmann, T. M. (2016). "Did I push myself over the edge?": Complications of agency in psychosis onset and development. Psychosis, 8(4), 324-335.

Kamens, S. R., Wertz, F. J., & Scanlon, R. (2016, October). A transcultural, phenomenological approach to reconceptualizing the "schizophrenia" diagnosis. Paper presentation at the International Society for the Psychological and Social Approaches to Psychosis conference, Boston, MA.

Schalkwyk, G. I. v., Davidson, L., & Srihari, V. (2015). Too late and too little: Narratives of treatment disconnect in early psychosis. The Psychiatric Quarterly, 86, 521-532.

Škodlar, B., Henriksen, M. G., Sass, L. A., Nelson, B., & Parnas, J. (2013). Cognitive-behavioral therapy for schizophrenia: a critical evaluation of its theoretical framework from a clinical-phenomenological perspective. Psychopathology, 46(4), 249-265.

Woods, A., Jones, N., Bernini, M., Callard, F., Alderson-Day, B., Badcock, J. C., ... & Krueger, J. (2014). Interdisciplinary approaches to the phenomenology of auditory verbal hallucinations. Schizophrenia Bulletin, 40(Suppl 4), S246-S254.

Bert Karon, PhD, ABPP

Who am I to Treat This Seriously Disturbed Person?

Introductory

Who am I to treat this person? That's what came to mind every time I treated a seriously disturbed person. I don't know enough and I have hangups. But no one knows enough, and every therapist has hangups, although our own analysis helps. We may feel confused, frightened, angry, or hopeless because these are the patient's feelings. Discussed are creating rational hope, dealing with feelings (including terror), depression, delusions, hallucinations, and suicidal and homicidal dangers. Theory is helpful, but it is not enough. Tolerating not knowing often leads to effective improvisations. Best results were obtained with psychoanalysis, or psychoanalytic therapy, without medication. Next best was psychoanalytic therapy with initial medication withdrawn as rapidly as the patient can tolerate. Electroconvulsive therapy is discouraged.

At the conclusion of this activity, participants should be able to:

1. Explain that schizophrenia is treatable.
2. Discuss how to form a relationship with the schizophrenic patient.
3. Reflect how to endure the unpleasant feelings when working with schizophrenic patients.

Karon, B.P.(2014) How do you talk to a patient about medication? ISEPP Bulletin, 1, 15-16.

Karon, B.P. (2014) Suicide. ISEPP bulletin, 2, 10-11.

Karon, B.P.,& Widener, A.J. (2013) Cognitive Fears And Psychoanalytic Phobias. Ethical Human Psychology and Psychiatry, 14, 192-198.

Brian Koehler, PhD

The History of ISPS: From Benedetti to Persons with Lived Experience

Introductory

A selective review of the history of ISPS from its beginnings as a psychoanalytic group started in 1956 by Gaetano Benedetti and Christian Müller through its inclusion of other psychotherapeutic approaches including family and milieu therapies to CBTp, Open Dialogue, Compassion Mind Training, Acceptance and Commitment Therapy, etc., to the recent and vital deeper inclusion of peer support and dialogue with persons with lived experience will be discussed. This presentation will be a both a selective historical review of ISPS as an international organization devoted to psychosocial approaches to distressing experiences of psychosis as well as an organization which can (and should) address the human rights issues and adverse social processes encountered by persons with lived experiences.

At the conclusion of this activity, participants should be able to:

1. Discuss the historical roots of ISPS.
2. Describe how ISPS incorporated various psychosocial approaches to psychosis.
3. Explain the importance and necessity to ISPS of the inclusion of persons with lived experience at all levels of organization.

Koehler, B. (2015). Speaking One's Dissociated Mind: So Should My Thoughts Be Severed From My Griefs and Woes. In E. Howell & S. Itzkowitz (Eds.), The Dissociative Mind in Psychoanalysis. NY: Taylor & Francis.

Koehler, B., Silver, A.-L. & Karon, B. (2012). Psychodynamic psychotherapy in psychotic disorders. In J. Read, L. R. Mosher & R. P. Bentall (Eds.) Models of Madness: Psychological, Social and Biological Approaches to Schizophrenia : Second Edition, 209-222.NY: Brunner-Routledge.

Koehler, B. (2017). ISPS and Psychosis Relational Psychosis Psychotherapy. Paper being submitted to the journal "Psychosis:Psychological, Social and Integrative Approaches."

Koehler, B. (2006). Gaetano Benedetti MD. In Y. O. Alanen, A.-L. S. Silver & M. Gonzalez de Chavez (Eds.) Fifty Years of Humanistic Treatment of Psychoses, 371-373.Madrid: Fundacion para la Investigacion y Tratamiento de la Esquizofrenia y otras Psicosis.

Koehler, B. (2006). Commentary on “Breaking the covenant: International schizophrenia research and the concept of patient-centredness 1988-2004” by TimothyCalton et al. In Y. O. Alanen, A.-L. S. Silver & M. Gonzalez de Chavez (Eds.) Fifty Years of Humanistic Treatment of Psychoses, 321-324. Madrid: Fundacion para la Investigacion y Tratamiento de la Esquizofrenia y otras Psicosis.

Dorin Levy

Making Meaning of Psychosis Through Relational Psychoanalysis and Art Therapy

Introductory

“Every man’s condition is a solution in hieroglyphic to those inquiries he would put. He acts it as life, before he apprehends it as truth.” (Emerson, 2009, p. 31) The essayist and poet Ralph Waldo Emerson understood something very vital to the process of making meaning. He saw in it a crystallization of individual truth. Psychotic states are often perceived as so far removed from truth that their fragmentations become weightless and not of this world. In the clinical setting, the psychotic patient is, more often than not, rendered unable to distinguish reality in any of its forms, an outcast, and an impingement on society.

Many patients, on the neurotic end of the spectrum, seek out art therapy and a relational approach out of a sense of meaninglessness to life. It is then, through therapy, that meaning has the potential to emerge. Why not apply that frame of thought to the psychotic end of the spectrum, as well? As humans, we are all in constant search for meaning. Thoughts come into being and have consequences only through the lens with which each individual processes them. It is impossible to draw a sharp line between when thoughts are normal and when pathological. Both relational psychoanalysis and art therapy bear a similar desire to create meaning from within a disorganized inner world. Art therapy addresses the clinical setting in a more tactile and material sense using tools, colors, and a physical, emotive creation of an object, while relational therapy uses language and, most of all, the other (in this case the therapist) to create meaning from within the interpersonal field. The merging of object relations and interpersonal theory allows for a dynamic and an individually attuned therapeutic process. The role of the therapeutic alliance, in both relational therapy and art therapy, is of the utmost importance. It is when the therapist and patient are able to locate each other in their own individual inner world that therapy is able to ignite and help make sense of deep emotions that attribute meaning to life.

At the conclusion of this activity, participants should be able to:

1. Assess the effectiveness of art therapy and relational therapy for psychosis.
2. Locate where the patient has more or less access to the meaning behind their disorganized state, and assess which could be more conducive to putting the psychosis in context.
3. Formulate new avenues for making meaning to empower both therapist and patient.

Suri, R. (2011). Making sense of voices: An exploration of meaningfulness in auditory hallucinations in schizophrenia. Journal of Humanistic Psychology.

Stern, D. B. (2015). Relational freedom: Emergent properties of the interpersonal field. New York, NY: Routledge.

Atwood, G. E. (2012). The Abyss of Madness (Vol. 37). Routledge.

Goldsmith, L. P., Lewis, S. W., Dunn, G., & Bentall, R. P. (2015). Psychological treatments for early psychosis can be beneficial or harmful, depending on the therapeutic alliance: an instrumental variable analysis. Psychological medicine, 45(11), 2365-2373.

Montag, C., Haase, L., Seidel, D., Bayerl, M., Gallinat, J., Herrmann, U., & Dannecker, K. (2014). A pilot RCT of psychodynamic group art therapy for patients in acute psychotic episodes: feasibility, impact on symptoms and mentalising capacity. PloS one, 9(11), e112348.

Casadi "Khaki" Marino, PhD, LCSW & Jennifer Hanley, DNP
Experts by Experience Plenary
Intermediate
A wide range of social disparities and traumatic experiences have been found to exert adverse influence over mental well-being. Extreme states of consciousness or madness are bound up with other aspects of identity and madness cannot be considered as the only salient aspect of an individual's experience or position. To be fully explored, madness cannot be examined in isolation. Intersectionality considers the relevance of multiple identities and the ways in which identities are defined and experienced through one another or how they are mutually constitutive. No one person who has experienced madness can represent mad people as a whole as there are significant variations in the ways we are privileged and disadvantaged. Accordingly, there are multiple perspectives outside the dominant medical model of madness. Those with lived experience of mental or emotional distress can offer alternative constructions to the mainstream narrative of "mental illness." Communicating Mad knowledge through stories or testimonies has been foundational to the Mad communities as a means of asserting that such perspectives are representative of real knowledge. Such testimonies can contribute to the social imagination and social change. We must begin to regard everyone's self-narrative as central and assert that there can be no knowledge about us without us. The Experts by Experience plenary will focus on how the presenters' experiences and identities impacted both their mental distress and their recovery journeys. The presenters will discuss how oppression and privilege impacted both disability and healing and why certain recovery approaches appealed to them. There will be time for audience questions and dialogue.

At the conclusion of this activity, participants should be able to:
1. Contextualize mental distress and madness experience in personal and social experience.
2. Discuss ways identity, marginalization, and privilege intersect.
3. Develop knowledge needed to engage in anti-oppressive practice.

Harding, S., Read, U. M., Molaodi, O. R., Cassidy, A., Maynard, M. J., Lenguerrand, E., ... & Enayat, Z. E. (2015). The Determinants of young Adult Social well-being and Health (DASH) study: diversity, psychosocial determinants and health. Social psychiatry and psychiatric epidemiology, 50(8), 1173-1188.

Holley, L. C., Stromwall, L. K., & Tavassoli, K. Y. (2015). Teaching Note—Oppression of People With Mental Illnesses: Incorporating Content Into Multiple-Issue Diversity Courses. Journal of Social Work Education, 51(2), 398-406.

LeBlanc, S., & Kinsella, E. A. (2016). Toward Epistemic Justice: A Critically Reflexive Examination of 'Sanism' and Implications for Knowledge Generation. Studies in Social Justice, 10(1).

Pilling, M. D. (2012). Invisible identity in the workplace: Intersectional madness and processes of disclosure at work. Disability Studies Quarterly, 33(1).

Ratts, M. J. (2017). Charting the Center and the Margins: Addressing Identity, Marginalization, and Privilege in Counseling. Journal of Mental Health Counseling, 39(2), 87-103.

Wolframe, P. M. (2012). The madwoman in the academy, or, revealing the invisible straightjacket: Theorizing and teaching saneism and sane privilege. Disability Studies Quarterly, 33(1).

Erin McIntyre, OTR/L, OTD

Exploring the Occupational Needs of Individuals with Psychosis who Experience Hoarding

Introductory

A growing body of research highlights the complexities involved in hoarding disorder (DSM-V, 2013) and its impact on an individual's occupational, social, and vocational functioning (Bratiotis et al 2011). Research regarding hoarding disorder is limited, particularly addressing co-morbidities such as psychosis, and there is little evidence describing the role of occupational therapy. The session will present a study conducted in London, United Kingdom at the South London and Maudsley NHS Foundation Trust. The aims of the study were to understand the clinician and service user experience with hoarding disorder in a community mental health team setting, focusing primarily on psychosis related disorders, and to gain their respective views about how they think occupational therapists could contribute to the treatment and management of hoarding disorder. Describe hoarding disorder and current best practice.

At the conclusion of this activity, participants should be able to:

1. Identify current evidence for occupational therapy best practice in the context of hoarding disorder.
2. Identify clinician and service user experiences with hoarding in mental health service contexts.
3. Identify clinician and service user views about occupational therapy's future role in the management of hoarding disorder.
4. Reflect on the implications for developing occupational therapy approaches for the management of hoarding disorder in the future.

American Psychiatric Association (2013). Diagnostic and Statistical Manual of Mental Disorders 5th Ed. Arlington, VA: American Psychiatric Publishing.

Bratiotis, C., Schmalisch, C.S., & Steketee, G. (2011). The Hoarding Handbook: A Guide for Human Service Professionals. New York: Oxford University Press.

Frost, R.O., Ruby, D., & Shuer, L.J.. (2012). The Buried in Treasures Workshop: Waitlist Control Trial of Facilitated Support Groups for Hoarding. Behaviour Research and Therapy, 50: 661-667.

Frost, R.O., Steketee, G., & Tolin, D. F. (2012). Diagnosis and Assessment of Hoarding Disorder. Annual Review of Clinical Psychology, 8: 219-242.

Frost, R.O. & Steketee, G. (2014). Treatment for hoarding disorder: Therapist Guide. 2nd Edition. New York: Oxford University Press.

Frost, R.O. & Steketee, G. (2014). Treatment for hoarding disorder: Workbook. 2nd Edition. New York: Oxford University Press.

Krupa, T., Kirsh, B., Pitts, D. & Fossey, E. (2016). Bruce & Borg's Psychosocial frames of reference: Theories, models, and approaches for occupation-based practice. 4th Edition. New Jersey: SLACK Incorporated.

Muroff, J., Underwood, P., Steketee, G. (2014). Group Treatment for Hoarding Disorder: Therapist Guide. New York: Oxford University Press.

Nordsletten, A.E., Fernandez de la Cruz, L., Pertusa, A., Reichenberg, A., Hatch, S.L., & Mataix-Cols, D. (2013). The Structured Interview for Hoarding Disorder (SIHD): Development, usage and further validation. Journal of Obsessive Compulsive and Related Disorders, 2(3), 346-350.

Ong, C., Pang, S., Sagayadevan, V., Chong, S.A. & Subramaniam, M. (2015). Functioning and quality of life in hoarding: A systematic review. Journal of Anxiety Disorders, 32: 17-30.

Tolin, D.F., Frost, R.O., Steketee, G., Muroff, J. (2015). Cognitive behavioural therapy for hoarding disorder: a meta-analysis. Depression and Anxiety, 32: 158-166.

Tompkins, M.A. (2011). Working With Families of People Who Hoard: A Harm Reduction Approach. Journal of Clinical Psychology, 67(5): 497-506.

Ryan Melton PhD, LPC, ACS, Nybelle Caruso, Michael Haines, Michelle Roberts & Emily Soule
The EASA model of Coordinated Specialty Care for Early Psychosis: Shared Experience Informing Recovery
Introductory
This panel will consist of individuals who all have a shared experience of being part of Oregon's Early Assessment and Support Alliance (EASA). EASA is the only state-wide early psychosis coordinated specialty care model in the United States and one of the few that has developed a deliberate practice of integrating the voices of those with lived experience into the treatment model. Members of this panel will include; individuals with lived experience of psychosis who participated in EASA, family members of individuals with psychosis and members of the EASA clinical team.

The panel will be facilitated by a member of EASA's Young Adult Leadership Council (YALC). YALC is made up of individuals with lived experience of psychosis who have participated in EASA and is a fully recognized by the State of Oregon as an Advisory Committee for EASA and other young adult treatment models. All members of the panel will share their experience of EASA and early psychosis from their own unique cultural perspective. Those experiences will include; how psychosis is experienced, the EASA treatment model including medications, psychosocial interventions, vocational/ educational support, sensory integration, family interventions and peer support and transition from EASA.

In addition to a general discussion from the panel members, cartoons and art created by EASA participants will be used to demonstrate the shared experience.

At the conclusion of this activity, participants should be able to:
1. Describe the basic goals of the EASA model.
2. Identity how lived experience of psychosis influences and guides the EASA model.
3. Discuss how the various roles in EASA are integrated deliberately with the intention of culturally informed shared decision making.

Drake, R.E., Xie, H., Bond, G.R., McHugo, G.J., & Caton, C.L.M. (2013). Early psychosis and employment. Schizophrenia Research, 146, (1-3), 111-117.

Ichii, M., Okumura, Y., Sugiyama, N., Hasegawa, H., Noda, T., Hirayasu, Y., & Ito, H. (2014). Efficacy of shared decision-making on treatment satisfaction for patients with first-admission schizophrenia: a study protocol for a randomised controlled trial. BMC Psychiatry, 14 (111). doi: 10.1186/1471-244X-14-111

Melton, R.P., Penkin, A., Hayden-Lewis, K., Blea, P., Sisko, S., & Sale, T. (2013) The early assessment and support alliance practice guidelines and fidelity manual. Retrieved November 14, from http://www.eastcommunity.org/shop/images/EASA_guidelines_final_Jun12_with_contrib_list.pdf

Miller, S., & Bargmann, S. (2012). The Outcome Rating Scale and the Session Rating Scale. Integrating Science and Practice, 2 (2), 28-31.

Welsh, P., & Tiffin, P.A. (2014). Assessing adolescent preference in the treatment of first-episode psychosis and psychosis risk. Early Intervention in Psychiatry, 8, 281-285. doi: 10.1111/eip.12077

Wendy O'Leary-Mair
Rude Awakenings: New Perspectives on Helping
Introductory
Based on my personal experience as a parent of an adult son who has had many diagnostic labels, including schizophrenia, and from my work in the field of family advocacy, I have witnessed far too many desperate and anguished parents and helpers do more harm than good despite their very best intentions and sincerest efforts to help. Myself included. Sometimes, after many years of sacrificing time, energy, money, health, jobs and even relationships, desperate parents and helpers realize that nothing has "helped" and they find themselves standing in the middle of the wreckage, usually worse for the wear.

Rude awakenings refer to a series of not so pleasant experiences that I've had over the years with my own son and the poignant lessons I've learned in my advocacy work with other families which have finally awakened me to some critical realizations that I had always known but had somehow ignored for far too long. These paradigm-shifting perspectives have led me to adopt a new belief system that inspires hope and possibility instead of a belief system that increases fear and confusion. I am committed to sharing a different way of seeing and helping those who experience extreme states. I share techniques and tools that have helped me create positive energy flow and allow my heart to remain open despite distressing situations.

I believe that anyone who is a parent/caregiver or works in helping field is ready to awaken to the deeper meaning of the experience that we are sharing together when we care about and try to help someone who experiences extreme psychological states and/or who has disturbing behaviors and unusual perceptions. There is a gift of awakening here for all of us if we know where and how to look.

At the conclusion of this activity, participants should be able to:
1. Identify their own helping style and underlying energetic patterns.
2. Discuss how their belief system makes a difference in their ability to be helpful.
3. Be able to obtain information and tools to help them shift their beliefs and underlying energy patterns, if they desire to do so.

Nurtured Heart Approach www.childrenssuccessfoundation.org

Conversations with and research from Gail Hornstein. See her book, Agnes' Jacket: A Psychologists Search for the Meaning of Madness (to be re-released in 2017)

Conversations with and articles about Nev Jones and her work with Early Psychosis and Hearing Voices Network 2016 (see articles about her work: http://www.stigmaandempowerment.org/dr-corrigans-lab/74 and http://www.psychiatrictimes.com/authors/nev-jones-phd)

Honoree Address: Narsimha R. Pinninti, MD
Trauma, Psychosis and TIMBER Model to Treat Traumatic Psychosis
Introductory
There is evidence to show that childhood adversity and trauma lead to psychosis. When trauma is not addressed and psychotic experiences are not processed in the most helpful way, it can turn into psychotic disorders. However the role of trauma in causing psychosis is not adequately recognized or addressed by mainstream psychiatric practice. The author in this presentation would present data to show the role of trauma causing psychosis and the rationale for separating traumatic psychosis from rest of psychotic disorders. Also a particular protocol of Cognitive Behavior Therapy and Mindfulness called TIMBER (Trauma Interventions using Mindfulness Based Extinction and Reconsolidation of trauma memories) will be presented. The pilot data from the use of this protocol for five individuals with psychosis will be presented.

At the conclusion of this activity, participants should be able to:
1. Cite the evidence for childhood adversity and trauma in causing psychosis.

2. Differentiate traumatic psychosis from other psychotic disorders.
3. Explain TIMBER model for dealing with traumatic psychosis.

Pinninti, N. R., Schmidt L, & Snyder R. Case Manager as Therapy Extender for Cognitive Behavior Therapy of Serious Mental Illness: A Case Report." Community Ment Health J 2014;50 : 4: 422-426.

Rathod, S., Kingdon, D., Pinninti, Narsimha, Turkington, D., Pheri, Peter (2015). Cultural Adaptation f CBT for Serious Mental Illness: A Guide for training and practice.West Sussex, Wiley Blackwell.

Brief Interventions for Psychosis: A Clinical Compendium. Editors: Pradhan Basant, Pinninti Narsima, Rathod Shanaya (2016). Springer. Switzerland.

Judy Schermer, MPH
Our Stories Matter, Too: Writing as a Parallel Healing Journey for Families
Introductory
Former US Representative Patrick Kennedy has said, "In speaking out, we find each other." And as Karen Wolk Feinstein, PhD, president of the Jewish Healthcare Foundation expressed, "we are all living inside narratives about ourselves, of which we are the main author." Those of us living with or alongside of those living with a severe mental illness each have a powerful narrative to express and share. The experience of writing words on paper, and then sharing them with an increasingly wider audience, can be both personally and societally transformative. According to a recent New York Times "Well" column, "studies have shown that writing about personal experiences can improve mood disorders, help reduce symptoms among cancer patients, ... reduce doctor visits and even boost memory."

At the conclusion of this activity, participants should be able to:
1. Define the terms creative non-fiction and memoir.
2. Explain the personal benefits and contribution to stigma reduction that telling our stories can provide.
3. Apply the ideas shared in the presentation by responding to writing prompts and optional sharing and discussion of responses.

Gutkind, L. (Ed.). (2016). Show Me All Your Scars: True Stories of Living with Mental Illness. Pittsburgh, PA: In Fact Books.

Gutkind, L. (2012). You Can't Make This Stuff Up. Boston, MA: Da Capo Press.

Karr, M. (2016). The Art of Memoir. New York: Harper Perennial.

Alexander W. Smith, MA & Alberto Fergusson, MD
An International Perspective on Community Interconnectedness and Recovery from Psychosis: Accompanied Self-Rehabilitation and Open Dialogue
Introductory
This presentation will explore the central role of personal networks and community interconnectedness in the course of coping with emerging psychotic episodes and long term experiences of life impacting mental health challenges, and will be based on the premise that these factors are under-researched and undervalued in service planning and yet are key variables in determining the trajectory and degree of suffering associated with psychosis related conditions. The presentation will discuss the experiences from Sopó, Colombia which decided to become a “therapeutic town” in collaboration with Dr. Alberto Fergusson and others involved in the “Accompanied Self Rehabilitation” project where unique efforts were made to establish meaningful community roles, including mutual support pairings with isolated elders as well as with guerillas who were in the process of repatriation. We will also discuss experiences from pilot applications of Open Dialogue at a community mental health program in Vermont.

The presentation will describe how Open Dialogue can help improve the trajectory of "psychotic" experiences at the point of emergence, and in the course of long term multimodal community supports, with an emphasis on cultivation of shared understanding with family and support networks, and how Accompanied Self Rehabilitation's emphasis on cultivating meaningful community roles can lead to better outcomes for people coping with long term experiences of mental health challenges. The helping relationship stance of "accompaniment" will be described as a framework of co-presence that prioritizes the personal agency and meaning framework of the person at the center of concern.

Discussion will include an exploration of how more emphasis can be given to factors of social interconnectedness, personal and social constructs of meaning, and meaningful roles in both studying outcomes and in envisioning community service systems that prioritize these factors.

At the conclusion of this activity, participants should be able to:

1. State the main principles of Accompanied Self Rehabilitation and Open Dialogue.
2. Explain the role of relationship and community connection in the trajectory of life impacting psychotic experiences
3. Discuss innovative frameworks for protecting and restoring personal network and community interconnectedness in the context of life impacting psychotic experiences.

Fergusson, A. (2015) Accompanied Selfrehabilitation. Bogota, Colombia Universidad del Rosario.

Harding, C. M., Brooks, G. W., Ashikaga, T., Strauss, J. S., & Breier, A. (1987). The Vermont longitudinal study of persons with severe mental illness, II: Long-term outcome of subjects who retrospectively met DSM-III criteria for schizophrenia. The American journal of psychiatry, 144(6), 727-735.

Hopper, K., & Wanderling, J. (2000). Revisiting the developed versus developing country distinction in course and outcome in schizophrenia: results from ISoS, the WHO collaborative follow up project. Schizophrenia Bulletin, 26(4), 835-846.

Marrow, J., & Luhrmann, T. M. (2012). The zone of social abandonment in cultural geography: on the street in the United States, inside the family in India. Culture, Medicine, and Psychiatry, 36(3), 493-513.

Mezzina, R., Borg, M., Marin, I., Sells, D., Topor, A., & Davidson, L. (2006). From participation to citizenship: How to regain a role, a status, and a life in the process of recovery. Archives of Andrology, 9(1), 39-61.

Seikkula, J.; Arnkil T. (2014) Open Dialogues and Anticipations – Respecting Otherness in the Present Moment. University of Jyvaskyla Press.

Steve Spiegel

Do No Harm: The DSM and the Medical Model (video & discussion)

Introductory

I will present a video lecture that is intended as a template for a documentary about the "medical model" and "social welfare model" of psychosis; I plan on editing it after feedback. *Do No Harm: The DSM and the Medical Model* advocates for our humanity; it contends that distressful experiences naturally cause emotional suffering for the disenfranchised. The video challenges the dominant "medical model" of mental distress and the pseudoscience and elitism that support it. The medical model pathologizes "problems with living"- natural expressions of emotional suffering, natural responses to emotional suffering deemed "anti-social" by psychiatry, and expressions of physical health problems. The medical model is a classical paradigm- a complete, homogeneous world view (as per Thomas Kuhn); the dominant "mental health" paradigm makes it difficult to imagine emotional suffering greater than is personally experienced. After introducing the medical model, the video introduces the "social welfare model" that describes "life circumstances" and "lived experiences" as producing varying degrees of emotional well-being- "mental health." Emotional suffering varies in direct proportion to the

degree of the distressfulness of personal experiences; the aversion of extreme emotional suffering is emotionally painful- sensed similar to physical pain. After introducing the two divergent narratives of mental distress, the video summarizes the pseudoscience of psychiatry's medical model and its DSM. The medical model: 1) gaslights emotional sufferers, 2) falsely stigmatizes emotional sufferers, 3) promotes drug abuse, and 4) promotes counterproductive "coercive 'therapies.'" Promoting a false, medical narrative and denying basic human rights to emotional sufferers worsens outcomes (that includes suicide). *Do No Harm: The DSM and the Medical Model* concludes with an emotional appeal for rejection of the medical model of mental distress and "coercive 'treatments.'"

At the conclusion of this activity, participants should be able to:

1. Describe the "social welfare model" of psychosis that has only been alluded to previously.
2. List criticisms of the medical model and its DSM.
3. Explain the harm of treating a social welfare problem as a medical problem (utilizing academic references).

British Psychological Association (June, 2012), Response to the American Psychiatric Association: DSM-5 Development, http://apps.bps.org.uk/_publicationfiles/consultation-responses/DSM-5.

Frances, A. (2013). Saving Normal: An Insider's Revolt Against Out-of-Control Psychiatric Diagnosis, DSM-5,Big Pharma, and the Medicalization of Ordinary Life, William Morrow.

Insel, T. (2015). A Different Way of Thinking. New Scientist, 227(3035), 5.

Kirk, S., T. Gomory & D. Cohen (2013). Mad Science: Psychiatric Coercion, and Drugs, Transaction Publishers.

Moncrieff, J. (2013). A Straight Talking Introduction to Psychiatric Drugs, PCCS Books.

Whitaker, R. & L. Cosgrove (April, 2015). Psychiatry Under the Influence: Institutional Corruption, Social Injury, and Prescriptions for Reform, Palgrave Macmillan.

Ira Steinman, MD

Catatonic Schizophrenia or a Beatific State: Curing Psychosis with an Intensive Psychotherapy

Introductory

Intensive Psychodynamic Psychotherapy of Psychosis has become a nearly lost art. Yet, a dynamic psychotherapy using concepts of transference, unconscious motivation and symbolization, as well as counter transference and resistance to understanding these phenomena, is well known to be helpful in the treatment of better put together people, as previously unconscious phenomena are interpreted and made clear.

It also can be healing and, at times, curative in the exploration and psychotherapeutic treatment of psychosis. Here delusions and hallucinations are dealt with as what they are: unrecognized creations of the psychotic patient.

In my Karnac books, *TREATING the 'UNTREATABLE'* and *SELF PSYCHOLOGY and PSYCHOSIS: the Development of the Self during the Intensive Psychotherapy of Schizophrenia and the other Psychoses*, such a clinical improvement and cure are clearly demonstrated. I will highlight the efficacy of such a therapeutic approach in the following clinical presentation.

This is a case of a spiritual seeker, a Baba lover, who hungered for union with the cosmos. He had been psychotic for more than 20 years, refusing to see psychiatrists who only medicated him to no avail. He came to my office, a seer with an extremely long beard; pulled and pushed into the office by his family would be more correct.

His previous diagnosis was catatonic schizophrenia. Yet, in the course of our uncovering work, it became clear that he was lucid and well versed in Hindu theology and cosmology. He appeared psychotic to family and previous treaters; to me he was highly intelligent and bent on achieving union with the godhead.

This is the tale of such a quest and how Intensive Psychotherapy aided and cured this seeker, and protected him from the hospital and other psychiatrists who wanted to treat his “catatonic” schizophrenia with shock therapy.

Such an Intensive Psychotherapeutic approach brought this seemingly psychotic man, who I saw as an inquiring saddhu, through his many years of psychosis and silence to a place where he can now talk, be with friends, go to conferences and enjoy his daily life, no longer beset by hallucinations and delusions.

Once again, Intensive Psychotherapy can be shown to be curative in the treatment of psychosis.

At the conclusion of this activity, participants should be able to:
1. Discuss how Catatonic Schizophrenia can be cured by an Intensive Psychotherapy.
2. Explain how Intensive Psychotherapy can help heal psychosis during a spiritual crisis.
3. Explain why ECT, shock treatment, is not the treatment of choice for catatonic schizophrenia.

Garfield, D. and Steinman, I., Self psychology and Psychosis: the Development of the Self during the Intensive Psychotherapy of Schizophrenia, Karnac Books, London, 2015.

Bacal, H, Psychoanalytic Quarterly: Book review of Self psychology and psychosis, Volume 85, issue 4, Nov 2016, pp 1008-1017.

Barrera, A, "Self Psychology and Psychosis: The Development of the Self During Intensive Psychotherapy of Schizophrenia and Other Psychoses." American Journal of Psychiatry, 173(11), pp. 1152-1153, November 01, 2016.

Ron Unger, LCSW
Distinguishing Between Effective Help for Psychosis, and the Oppression of Individual and Cultural Differences
Introductory
While simplistic approaches contrast an imagined “normality” with “psychopathology,” more realistic approaches acknowledge that different cultures have different ways of being healthy, and individuals within those cultures commonly find even more diverse ways to interpret experience and to live successfully. And when major problems do occur, it may be unclear whether the person truly needs to become more “normal” to be healthy, or whether the person may simply need access to people who can affirm their differences and help them discover ways to live successfully with them.

The Hearing Voices Network has been a pioneer in suggesting an “emancipatory approach,” proposing that hearing voices may be understood as a human difference like being gay, one that people may struggle with but also something people can accept and integrate into a successful life, especially if given appropriate assistance in overcoming any difficulties. Other apparently “psychotic” experiences may also be understood as, to some extent at least, just human differences that can be accepted and integrated rather than suppressed.

The process of becoming “psychotic” may itself be understood as one of breaking away from what is “normal” within a given culture, but it does not follow that whatever then emerges is pathology. Rather, new states of mind may be a mix of unhelpful “mistakes” in being organized that exist alongside possible individual, family, and even cultural innovations, the stuff of prophecy and shamanism.

What would it look like to have a less arrogant “treatment” approach for psychosis, one that appreciated cultural nuance and the wide range of individual variation that can be part of a successful lives, rather than attempting to “colonize” divergent individuals by imposing on them dogmatic paradigms about “mental health”? What would it look like to instead collaborate with people in discovering unique possibilities that might work for them?

At the conclusion of this activity, participants should be able to:

1. Differentiate an emancipatory approach to “abnormal” experiences from traditional approaches, and identify possible advantages to the emancipatory approach.
2. Formulate a psychotic break as possibly resulting from efforts at innovation that may have some value as well as serious problems.
3. Employ a collaborative approach to helping people find ways to change that possibly build on, rather than suppress, their individual and cultural uniqueness.

Corstens, D., Longden, E., McCarthy-Jones, S., Waddingham, R., & Thomas, N. (2014). Emerging perspectives from the hearing voices movement: implications for research and practice. Schizophr Bull, 40 Suppl 4, S285-294. doi:10.1093/schbul/sbu007

Fielding-Smith, S. F., Hayward, M., Strauss, C., Fowler, D., Paulik, G., & Thomas, N. (2015). Bringing the “Self” into focus: conceptualising the role of self-experience for understanding and working with distressing voices. Frontiers in Psychology, 6. doi:10.3389/fpsyg.2015.01129

Simon McCarthy-Jones, A. W. J. W. (2013). Spirituality and hearing voices: considering the relation. Psychosis: Psychological, Social and Integrative Approaches, 5(3), 247-258. doi:10.1080/17522439.2013.831945

Elizabeth A. Waiess, PsyD

Into Psychosis and Back Again: Is It Or Isn't It (Psychotic)?

Intermediate

In clinical practice, patients often report or display behavior and/or beliefs that the therapist considers to be breaks with reality, that is psychotic. It is easy to be caught up in the attempt to diagnose rather than maintain emotional connection with the patient at such times, at least for this clinician. Rarely does the patient state with conviction, "I am crazy". Perhaps this might be said in a self-deprecating or joking manner. More likely the patient says "I don't know what you'll think of this," or "You probably think I'm crazy", or other phrases of that nature. In these statements it is possible to hear the patient's continuing realistic connection with the therapist. Those who are unquestionably overwhelmed with managing their emotions, or seem to have lost track of the reality of the therapist, seem especially to trigger the desire for leaping to the illusory lifeboat of diagnosis. While an accurate diagnosis has some practical use in communicating with other clinicians, it is practically useless in the therapeutic relationship. A diagnosis conveyed with hopelessness brings real work to an end: why bother. One is reduced to being a case manager at best. If a clinician can use the diagnosis and maintain hope at the same time, then the work is truly just that, not just managing. Learning to tolerate empathy in chaotic moments requires hard work on the part of the therapist. This can be illuminated in professional writing, but is best learned through supervisory experience and one's own therapy. Ultimately, the learning becomes authentic when actually with the chaotic, aka psychotic, patient.

At the conclusion of this activity, participants should be able to:

1. Discuss the importance of re-considering the clinical use of diagnosis.
2. Explain the importance of having other clinicians or a consultant.
3. Describe the multiple meanings and infinite complexity of symptoms which are labelled "psychotic".

Cornwall, M. W. (2015) "If madness isn't what psychiatry says it is, then what is it? That's been my koan for almost fifty years!” In PSYCHOSIS, 7 (3),279-285.

Prot-Klinger, K. (2016) "Difficulties in diagnosing psychotic patients with traumatic experiences. Why don't we hear what our patients say?" in PSYCHOSIS, 8(3), 260-269.

Hinshelwood, R. D. (2014) "Whose suffering? - Carers and curers." in PSYCHOSIS 6(4), 278-287.

Melissa D. Weise, MSW, LICSW & Julie R. Bermant, RN, MSN, APRN

Intentional Intersectionality in Early Psychosis Program Development

Introductory

In 2013, Caplan wrote about a program treating early psychosis in young adults in Boston, MA called PREP (Prevention and recovery in early psychosis). He spoke about the need for expansion of this program, which lead to the Massachusetts Department of Mental Health funding a second such program in Western Massachusetts with SAMHSA backing. PREP West through Servicenet was formed in Holyoke MA in 2015 and has been working to define itself and its work in the early psychosis field. This talk will outline the second year development of the program with the hiring of a new director and full team in the fall of 2016. This new team worked to intentionally develop a program for up to 50 young adults aged 16-30, treating those in the prodrome stage of psychosis up through three years past an initial psychotic episode. The program uses an inclusive and intersectional model, realizing the diverse need of not only the Western Massachusetts population but the clinically significant identities that tend to be held by young adults and those who experience psychosis. These include varying gender and sexual orientation presentation and exploration, racial cultural and class diversity, co-morbidity and the meaning of diagnosis on an emerging young adult identity. The PREP West team is also a multi-disciplinary team consisting of social workers, bachelors level counselors, a nurse practitioner, a wellness nurse, a clinical psychologist, a peer specialist , and master's level social work clinical interns. As a rural and less resourced area of Massachusetts, our program, like many in Western Massachusetts and other similar areas, must serve a diverse population in a variety of ways to make up for a lack of services. The PREP West program offers many services including outpatient therapy, family therapy, psychological testing, psychiatry, wellness, substance treatment, peer supports, case management and, our core service, a milieu program. Within the milieu, we work to build community, recovery and skills of daily living through groups, recreational activities and a daily hot lunch prepared and served by the participants alongside the staff. Our program is clinically framed using Needs Adaptive Dialogism which stresses a non-hierarchical and community-centered approach to psychosis. In this frame and with our program, we work and continue to work intentionally to create-cross identity interventions, acknowledging the staff and participant's identities and finding meaning as a way toward recovery.

At the conclusion of this activity, participants should be able to:

1. Describe and discuss the development of the Prevention and Recovery in Early Psychosis (PREP) Program model.
2. Examine the relevance of cultural humility concepts with young adults experiencing early psychosis.
3. Recognize and integrate ways in which early intervention mental health programs can intentionally incorporate intersectionality in clinical practices.

Ajnakina, O., Trotta, A., Oakley-Hannibal, E., Di Forti, M., Stilo, S. a, Kolliakou, A., … Fisher, H. L. (2015). Impact of childhood adversities on specific symptom dimensions in first-episode psychosis. Psychological Medicine, (September), 1–10.

Caplan, P. et al (2013). Prevention and recovery in early psychosis (PREP): Building a public – academic partnership program in Massachusetts, United States. Asian Journal of Psychiatry.http://dx.doi.org/10.10.1016/j.ajp.2012.10.0009.

Carey, B. B. (2016). New Plan to Treat Schizophrenia Is Worth Added Cost , Study Says, 2–4. http://doi.org/10.1017/S0033291715001816.

Health, M., Nimh, S. U., October, O., Services, M., Directors, S. M., Program, H. I., … Psychosis, E. (2016). Federal Agencies Partner to Promote Coordinated Services for Patients with First Episode

Psychosis Contact (s) More Science News about Contact the Press Office NIMH-Funded Science on EurekAlert, 2015–2016.

Health, M., Release, P., New, T., Kane, J. M., Early, R., Program, T., … Heinssen, R. (2016). Team-based Treatment is Better for First Episode Psychosis Contact (s) More Science News about Contact the Press Office, 2015–2017.

Longden, E., Madill, A., & Waterman, M. G. (2012). Dissociation, trauma, and the role of lived experience: toward a new conceptualization of voice hearing. Psychological Bulletin, 138(1), 28–76. http://doi.org/10.1037/a0025995.

Olson, M., Seikkula, J. & Ziedonis, D. (2014). the Key Elements of Dialogic Practice in Open Dialogue : Fidelity Criteria. University of Massachusetts Medical School, 1–33. Retrieved from http://umassmed.edu/psychiatry/globalinitiatives/opendialogue/.

Podvoll, E.M. (2003). Recovering sanity. Shambhala. London, England.

Seidman, L. (April 2017) From High Risk State to First Episode Psychosis: Scientific and Clinical Developments. From a talk presented at Early Psychosis Professional Education Event hosted by The University of Massachusetts Department of Psychiatry at the University of Massachusetts Medical School in Worcester, MA.

Seikkula, J. & Arnil, T.E. (2006) Dialogic meeting in social networks. Karnac Books Ltd. London, England.

Tervalon, M., & Murray-Garcia, J. (1998). Cultural humility versus cultural competence: A critical distinction in defining physician training outcomes in multicultural education. Journal of Health Care for the Poor and Underserved, 9, 117-125.

Ashley Weiss, DO, MPH & Serena Chaudhry, LCSW, MPH

C.A.L.M. - Clear Answers to Louisiana Mental Health: Dismantling Psychosis & Stigma in the South

Intermediate

Psychosis is a symptom experienced as a loss of contact with reality, and often signifies the emergence of a severe mental illness. The first episode of psychosis often occurs in late teens and early twenties. Typically, one experiences psychotic symptoms for more than a year before seeking help, reasons including experience of stigma surrounding psychosis. The longer the duration of untreated psychosis (DUP) the poorer the outcomes. RAISE, a 2015 NIMH funded randomized controlled trial of first episode services, found that 75% of first episode psychosis (FEP) patients who had access to coordinated specialty care, during a one-year period compared with just over 50% of those allocated to usual care. Public education campaigns have also proven to be pivotal strategy in the efforts to reduce DUP. Two exemplary programs, Treatment and Prevention in Psychosis (TIPS) in Norway and the MindMap at the Specialized Treatment Early in Psychosis (STEP) Clinic at Yale University, have both demonstrated success at shortening DUP.

The Early Psychosis Intervention Clinic-NOLA (EPIC-NOLA) is a coordinated specialty care clinic for first-episode psychosis. EPIC-NOLA, following in the footsteps of TIPS and MindMap, saw the value in working with a marketing firm to strategically craft a message about psychosis, especially that early treatment improves outcomes: Clear Answers to Louisiana Mental Health (CALM) was developed through collaboration with Red Rock Branding to create and brand a community movement towards improving psychosis awareness. The campaign works side by side with the clinic, and the community at local cultural festivals, disseminating educational materials and engaging families in conversation about how different people experience psychosis. In order to reach our unique community with our specific messaging about psychosis, we as clinicians need to engage with marketing specialists who have a necessary skill set to communicate with mass audiences.

At the conclusion of this activity, participants should be able to:
1. Define psychosis.
2. Identify truths and myths surrounding psychosis.
3. Discuss the value in collaboration between clinicians and other fields in order to improve public health campaigns, especially surrounding stigmatized conditions such as psychosis.

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Pat Wright, MEd, Cynthia Rubin Brown, PsyD, MFT, Georgia Case, Anne Marie DiGiacomo, LCSW & Jason Jones
Plenary: Families: A Vital Link to Recovery
Introductory
Historically, family members of those diagnosed with extreme states have been separated, consciously or not, while professionals take over the care and treatment of a loved one, leaving family members isolated from the treatment and recovery process. Often overwhelmed and uncertain of what needs to happen, when and how, families, treatment providers as well as those involved in a crisis, are often unaware of the curative practices and the adjunct role that families can play to support their loved one's care and recovery.

Evidence and first-hand experience now points to how empathetic attunement and other informed emotional and relational ways of engagement and interactions are essential organizing and curative factors for those who experience disorganized, extreme states of mind and mood.

In this informative and interactive plenary, providers and families will demonstrate how the family can be an integral component of their loved one's treatment and recovery.

Two model programs, a unique home-based setting in Colorado and a criminal justice department in Portland, as well as a psychotherapist in Los Angeles, will demonstrate innovative approaches within their communities to strengthen the family's role in recovery. Family members will guide the discussion on the benefits and challenges of interacting with family members in crisis and treatment, and will encourage audience input and participation.

At the conclusion of this activity, participants should be able to:
1. Explain how families can use "empathic attunement", meditative attitudes, and other skills to contribute to the equilibrium of the family system.
2. Discuss how a model criminal justice program works in their community especially with families of loved ones with extreme states.
3. Describe how a home-based approach to people experiencing psychosis (who also use medication judiciously) work with family members within a healing philosophy.

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