ISPS - US Newsletter

United States Chapter of the
International Society for the Psychological treatments of the Schizophrenias and other psychoses

"...Innate among man's most powerful strivings toward his fellow men...is an essentially psychotherapeutic striving."
Harold F. Searles (1979)

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From the President

Ann-Louise S. Silver, MD

While I may not be posting much on the listserve, I have been far from inactive. A lot has been happening, both behind the scenes and on the stage, as ISPS-US continues to gain momentum and recognition. The ISPS meeting in Melbourne was exciting and interesting. I recommend that you go to the www.isps.org site for a report on the meeting written by Wilfried Ver Eecke. We are part of a powerful organization. The PORT Revision draft was circulated to 100 researchers and clinicians, which included myself. It did not contain the onerous Recommendations 22 and 26, which Drs. Lehman and Steinwachs said was done since negative recommendations are not given for modalities no longer in use, such as insulin coma treatment or lobotomy. The Revision should appear in the Schizophrenia Bulletin shortly. I believe ISPS-US had a huge influence in the removal of those recommendations. However, our work has just begun. The recommendations should include a positive recommendation for psychodynamic therapy. It should be clear to the mental health profession that psychodynamic and related therapeutic approaches are neither relics nor ineffective. Our Spring of 2003 ISPS issue in the *Journal of the American Academy of Psychoanalysis and Dynamic Psychiatry* sent a forceful message, and is being used in training programs currently. The *Journal's* editor has invited us to contribute an article on the Practice Guideline for the *Treatment of Patients with Schizophrenia, Second Edition*; I would appreciate your input.

Please plan to give strong support to Manuel González de Chávez Menéndez, organizer of the June 2006 ISPS meeting in Madrid. Check its website: www.ispsmadrid2006.com. We in the U.S. send Manuel our support and condolences. Manuel is head of psychiatry at the hospital nearest to the train station bombings occurring in March. I've gotten to know him through our work on the ISPS executive board. He is energetic, well organized and deeply committed to psychological approaches to the psychoses. He is planning a book on the history of ISPS, to be published after the meeting. Yrjö Alanen, Brian Koehler and I will be working with him on this project.

And it's official! On January 31, we received word from the Internal Revenue Service accepting our application for non-profit status. We now can seek research and organizational grants and begin a general fund-raising project. We can reach out to the staffs of teaching centers, the state mental hospitals and community clinics throughout the country, locating people who sense the importance of a strong therapeutic relationship for those trying to overcome psychosis. We continue aiming at providing them with support and guidance, and encouraging them to contribute to our discourse. Our membership continues to grow, and we continue dedicated to our mission of promoting the humane, comprehensive and in-depth treatment of psychotic disorders. We will hold our sixth annual meeting, "Extremes of Experience: Psychosis through many lenses" September 18 and 19 at the Chicago Institute for Psychoanalysis, to be chaired by David Garfield, M.D. Leston Havens, M.D. will be our keynoter. Each day will begin with a plenary session in which a case will be presented and then discussed by leading representatives of the major approaches to the psychological treatment of psychosis. In the afternoons we will hear from individuals. Please consult the Call for Papers, in this newsletter.

As further evidence that we are for real, we now have a staff. We welcome Karen Stern, M.A.T. who is now serving as our Executive Director, having been of invaluable assistance in making our Philadelphia meeting such a success. Karen will be sending out a new directory shortly, and then will be working on outreach. Please send her information on organizations and individuals who should learn about us. And we welcome Clara Hall as the web designer of our www.isps-us.org website. She is working with Jack Rosberg, Ph.D., editor of this website. They

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can't make this project happen on their own. They need your material. Please send Jack the text of papers you would like to have posted (by e-mail or on diskette), along with information on relevant meetings, organizations with whom we should web link, and your suggestions for developing this site.

We celebrated our fifth year in grand style, with an exciting and well-attended annual meeting in Philadelphia at the Thomas Jefferson Medical University, and are grateful to its co-chairs, Harold Stern and Brenda Byrne. We mourned the passing of Victoria Conn, who had been the co-chair of this meeting until her untimely death. Victoria had been our very talented liaison with NAMI and had often contributed her perspective on our active listserve. This meeting was our first two-track meeting. We thus had the opportunity to hear in depth from people we knew only through our listserve, or from people who are new to ISPS-US. Major authorities in our field contributed to an invigorating meeting. John Strauss, served as keynoter, speaking on "Subjectivity in psychiatry: How can we do better?" His remarks were personal, intimate, and challenging, setting a tone of rededication to our mission of inter-subjective, truly personal work with our patients. We honored, in absentia, Anni Bergman, recipient of our annual award, and watched a compelling documentary of her successful work with an autistic girl. The day closed with a lively panel discussion organized by Michael Robbins, on the future of ISPS-US. One result of this discussion will be a listserve didactic seminar focusing on particular clinical papers, with an identified faculty.

Additionally, we presented a panel at the winter meeting of the American Academy of Psychoanalysis and Dynamic Psychiatry, "Beyond medication: Remembering the spirit and mind of the psychotic patient." Presenters included Shelley Alhanati, Clare Mundell, Garry Prouty, and in absentia, Brian Koehler. There were many young people in attendance, who listened with rapt attention, and who commented that all the material was both new and inspiring. ISPS-US will organize a speakers bureau, so that our members can respond to invitations to present at grand rounds and other such events.

The David B. Feinsilver Award winner, Ishita Sanyal of Calcutta, India, gave an inspirational presentation at the ISPS meeting in Melbourne. She established a system of clinics that work with patients and their families, the project a tribute to her deceased brother. She is in the process of establishing an ISPS-India. Ishita's clinics need computers (laptops or desktops). If you have recently upgraded, and don't have a home for your old computer, please contact me and I'll help you in sending this to her.

Our listserve itself is flourishing, with a vibrant and substantive discussion of theory and techniques, including postings of clinical vignettes to which many are responding extremely thoughtfully. It reminds me of the Wednesday Conferences at Chestnut Lodge, but here the discussions are not time-limited, and treatment philosophies are unfolding. Lurking on our site is like auditing an extraordinary seminar.

I'm closing with a plea: for donations by you or by others; please do some fund-raising for us, now that these gifts are tax-deductible. And we need suggestions on foundations to whom we should apply for grants. We've been an impressive team. Let's keep up the winning streak.

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From the Editor: Phenomenology, Schizophrenia and the Self

Brian Koehler, PhD

It is with much interest and pleasure that I read a new article published by Louis Sass and Josef Parnas (2003), "Schizophrenia, Consciousness, and the Self" in *Schizophrenia Bulletin*, 29 (3), 427-444. I have been following the work of these two authors on the phenomenological foundations and aspects of the schizophrenias with great interest and I was glad to see that they are collaborating to help elucidate and shed much needed light on the enigmatic aspects of this group of illnesses. I was impressed that such a journal, which seems to shy away from phenomenologically based articles, except for their wonderful first person subjective accounts of the illness, featured this topic (although many years ago they published a special issue on qualitative subjectivity research & schizophrenia). Sass & Parnas concluded: "We have argued that schizophrenia is best understood as a particular kind of disorder of consciousness and self-experience. We described specific alterations of self-experience [ipseity, latin derived word for self, itself] and the self-world relationship that we see as fundamental to the illness, especially diminished self-affection, hyperreflexivity, and related disruptions of the field of awareness" (p.438).

Louis Sass, a member of ISPS, has a long-standing interest in psychosis. He published two well known books on this topic, including *The Paradoxes of Delusion: Wittgenstein, Schreber, and the Schizophrenic Mind*, published in 1994 by Cornell University Press, and *Madness and Modernism: Insanity in the Light of Modern Art*, published in 1994 by Harvard University Press (both, in my opinion, excellent and well worth reading). Louis Sass presented, with James Ogilvie as a discussant, at one of our ISPS-US New York Chapter meetings. His work is cogent, rich and original. He describes the self-experience of some psychotic patients very perceptively. Where I would disagree with him is in the area of his preferred epistemological model, which I see as excessively imbued with a one-body psychology. Clinically, I would prefer to relationalize his concepts. For example, solipsistic positions could usefully be understood as the patients attempts at achieving a form of self-holding (similar to Winnicott's views on where good-enough

parenting is lacking, one takes one's own mind as a holding object, therefore we see such phenomena as hyperflexivity, obsessional defenses, etc.). It is my view, that psychosis cannot be understood apart from the relationship between the self and primary, pre-reflective object. I do not believe that it is accidental that virtually all psychotic symptoms, including thought disorder, disorganization, hallucinations and delusions, as well as anhedonia, alogia and avolition, are worsened within certain social/interpersonal contexts (much of which are subtle because they are internalized as a sort of object-relational template or prototype) and are thoroughly imbued with self-world relationships. Malcolm Pines (1998), in his "Neurological models and psychoanalysis," contained in *Freud and the Neurosciences: From Brain Research to the Unconscious,* edited by Giselher Guttmann & Inge Schotz-Stresser for Verlag der Osterreichischen Akademie der Wissenschaften, noted:

"Thus my thesis is of the movement from one body to two and three-body psychology (Richman), from Freud's neurological intrapsychic one body mental apparatus [actually, as evident in various articles such as Mourning and Melancholia and in his work on group psychology and the ego, Freud had proposed a relational model of the psyche] to the position of Bakhtin, who writes, 'I am conscious of myself and become myself only by revealing myself to another, through another and with the help of another....Every internal experience ends up on the boundary. The very being of[wo/]man (both internal and external) is a profound communication. To be means to communicate....To be means to be for the other; and through [her]him for oneself. [Wo/]Man has no internal sovereign territory: [she]he is all and always on the boundary" (p. 55).Parnas and Zahavi (2002), in their "The role of phenomenology in psychiatric diagnosis and classification," published in *Psychiatric Diagnosis and Classification* edited by Maj et al for Wiley, recognize the significance of intersubjectivity in phenomenology: "...the objectivity of the world is intersubjectively constituted, and my experience of the world as objective is mediated by my experience of and interaction with other world-engaged subjects. Only insofar as I experience that others experience the same objects as myself, do I really experience these objects as objective and real" (p. 155).

It seems to me that attributing severe mental illness primarily to our genes, neurophysiology, or consciousness, can potentially be a form of dodge. Sociological, familial and individual-psychological factors are salient in the formation of self, attachment and affect regulation, and in the initiation and expression of psychiatric illness (see the work of Horacio Fabriga Jr., e.g., "Evolutionary Theory, Culture and Psychiatric Diagnosis" in "Psychiatric Diagnosis and Classification" edited in 2002 by Mario Maj et al as well as the research reviewed by John Read et al in 2003, "Sexual and physical abuse during childhood and adulthood as predictors of hallucinations, delusions and thought disorder", published in *Psychology and Psychotherapy: Theory, Research and Practice*, 1-22 and Read & Ross, "Psychological trauma and psychosis: diagnosed schizophrenics must be offered psychological therapies" published in *The Journal of the American Academy of Psychoanalysis and Dynamic Psychiatry*, 31 (1),247-268, 2003). Using this clinical and epidemiological research to blame families, individuals, and or the wider cultural zeitgeist is useless at best, and hurtful at worst. Rather, one could accept that these illnesses are biological illnesses (as long as the concept of biology is non-reductionistic and includes attachment experience, human intentionality and interactionality, etc.) initiated and expressed at various levels of system organization with multilinear modes of interaction.

I believe that clinician/researchers like Sass and Parnas are demonstrating the need for a phenomenological approach to the classification (for a good example of this see Andrew Sims *Symptoms in the Mind: An Introduction to Descriptive Psychopathology-Third Edition*, published in 2003 by Saunders) and understanding of severe mental illness. As these and other authors have pointed out, there is no reference to the self in DSM. If one's understanding of the brain is that it is a type of endocrine gland, e.g., too much dopamine in the mesolimbic pathway 'causes' productive symptomatology in schizophrenia, or too little serotonin 'causes' depression or suicide, or if the mind is viewed as epiphenomena to the brain (years ago, I used to say to students, it takes at least two brains in a social context to make a mind, or to get at the mystery of the mind/brain relationship, in the words of TH Key: "What is mind? No matter. what is matter? Never mind"), this eclipse of the self is understandable. However, if the brain is understood as an organ (earlier in his career, Gaetano Benedetti saw schizophrenia as a complex type of psychosomatic illness, with the brain as the 'target' organ) which is significantly altered by its processing of experience and human relationship (neuroplasticity), then the exclusion of phenomenology, self- and relational processes is a glaring and costly mistake.

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A human being is a part of the whole, called by us Universe, a part limited in time and space. He experiences himself, his thoughts and feelings as something separated from the rest--a kind of optical delusion of his consciousness. This delusion is a kind of prison, restricting us to our personal desires and to affection for a few persons nearest to us. Our task must be to free from this prison by widening our circle of compassion to embrace all living creatures and the whole nature in its beauty.

-- *Albert Einstein*

(Sent to us by Ann-Louise Silver, MD)

From the Secretary

Julie Kipp, CSW

I want to echo Ann-Louise Silver's comments in her President's Column in this issue of the Newsletter in welcoming Karen Stern, our new Executive Director. This is a significant step forward in our organization becoming more viable. In my column in the last Newsletter I was still noting that all work in our organization was done by volunteer effort, with the exception of the nominally paid clients of Bronx REAL Continuing Day Treatment Program who intermittently stuffed envelopes.

We continue to hold monthly organizational conference calls to plan for our development. Conference calls are at 11 am EST on the first Sunday of the month, and the minutes are usually posted on the listserve. Recent discussions have included planning for the annual conference to be held in Chicago in September, organizing the Newsletter and the new ISPS-US website (www.isps-us.org), reports from the Research Committee, which is planning a survey of our members' work with people with schizophrenia, and discussions of how to increase our membership and expand our influence in the prevailing zeitgeist.

Even with Karen on board, there is still opportunity for getting involved in the development of this organization. If you're interested in seeing whether there is an ISPS-US initiative with your name on it, join us in one of our conference calls and hear what is going on. Just contact Ann ahead of time (asilver@psychoanalysis.net) and tell her you are interested in joining in on the call.

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From the Treasurer

Julie Wolter, PsyD

As I begin my duties as Treasurer of ISPS-US, I want to thank Barbara Cristy for her dedication and hard work during the years she held this position and to also thank Ann Silver for handling these duties during my transition from Illinois to New Hampshire.

Some exciting news now that we officially are a 501(c)(3) non-profit: we have received a generous donation of $10,000 from Theodore and Shera Silver, for use in strengthening our organization. On behalf of ISPS-US, I would like to thank them for the very generous financial assistance this provides us.

Additionally, as of June 1, ISPS-US has received 23 donations totaling $905, evidencing the importance of non-profit status for our financial growth. We currently have 167 members, consisting of 5 institutional members and 162 individual members. We look forward to hosting a grand meeting in Chicago, and hope that the revenues from this meeting will allow a more aggressive outreach for new members.

I look forward to serving ISPS-US as treasurer, and thank all those who have supported me during my transition to the East Coast.

Julie Wolter
jwolter@safeplace.net

From the Executive Director

Karen Stern, MAT

As the new Executive Director of ISPS-US, I am very pleased to be working for this fine organization. I see as my main purpose helping to grow ISPS-US into a larger and more effective organization. So far I have focused on recruiting new members and encouraging current members to renew, publishing a new ISPS-US directory (coming soon!), assisting with the Annual Meeting, the web site and the list serve, doing the newsletter layout, and seeking grants and donors to enable ISPS-US to further its mission.

A little bit about my background: I taught English as a Second Language for 11 years, until I had my son 2 years ago. I am now at home with him and I really value the chance to spend time with him and work from home part time. I also enjoy the opportunity to play with the ISPS-US membership database and to develop new skills.

I'd like to thank all of our new and renewing members for being a part of ISPS-US; a special thanks goes to those who have contributed to ISPS-US in addition their dues (see donor list elsewhere in this issue). I'd like to thank Ann Silver, the Executive Board and the members for making me feel so welcome in ISPS-US. I have enjoyed meeting and working with you: you are very caring, brilliant and fascinating people, and you do important work for people with psychoses.

Please contact me if you have any questions regarding your membership, if you haven't renewed your membership yet, or if you know individuals or institutions who might be interested in joining or making a contribution. The best way to reach me is by e-mail, but you can leave a message at the number below if you prefer.

ISPS-US has a new address!

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ISPS-US Listserve: WWW Wanderings

Joel Kanter, LCSW-C

The ISPS-US listserve continues to be active with more than half our members participating. Recent postings have discussed an array of clinical and theoretical issues, as well as more prosaic requests for referral information. In all of these discussions, the collective wealth of information and experience among our members is truly impressive.

For those interested in joining the listserve, just send a request to myself (joelssmd@aol.com) or Karen Stern (karen.s.stern@earthlink.net), the listserve moderators.

I also want to call attention to several interesting websites. ISPS International has an interesting website (www.isps.org) with reports and papers from around the world. From England, the Association for Psychoanalytic Psychotherapy in the National Health Service (www.app-nhs.org.uk) has an array of information from mental health clinicians in the public sector in England. The organization's journal is quite interesting and a sample issue is available online without charge (and articles can be easily downloaded). But the real treat here is their audio/video archive where you can listen and/or view brief clips of talks by Freud, Melanie Klein, Winnicott and Jung. And members with a historical bent might also be interested in the online version of the Freud exhibit that was at the Library of Congress in 1999 (www.loc.gov/exhibits/freud); virtually the whole exhibit is available on this website.

ISPS-US Web Site: www.isps-us.org

Jack Rosberg, Ph.D.

I just returned from the Baltic Countries and spent some time in Estonia and the majority of time in Lithuania. I lectured and trained students and professionals in both countries and found that they were hungry for information and training. However, they are unable to pay what most professionals who are qualified to give that training want for their services in terms of payment.

I want to inform the membership of ISPS-US that we have a website that has been in existence for the past several months. We are in a position to continue the process of educating ourselves and others, a process which should never end, and also provide information to professionals who are not members of the organization and other individuals who need help and direction.

The ISPS-US website has important features to it. There is room for many more Articles, Announcements and Recommended Books. If you look at the Home Page, you will find a list of categories that are very important to assist you in presenting your information.

I believe that there are many members who have papers that can be posted and other important information that can be put on our website. I encourage the membership to become more active in this important part of the ISPS-US organization.

Editor's note: Contributions to the ISPS-US website should be sent as Word attachments to Jack Rosberg, PhD, JARosberg@aol.com.

Internet Drop-Ins

Michael Eigen, PhD
New York University Postdoctoral Program in Psychotherapy and Psychoanalysis

Over the past few years, the number of people contacting me for help on the internet has increased dramatically. I'm aware there are intricate ethical issues, but where I feel I can respond in possibly helpful ways, I do -- or try to. All of these individuals have faced major suffering and some struggle with psychosis.

What I have learned is that brief contacts can be helpful, as part of long term work. The long term work can take many forms, including ongoing or intermittent therapy, church groups, day treatment centers, community support networks, peer groups and recovery groups. I've come to believe that long term commitment to work on oneself is necessary, whatever form it takes. What has taken me longer to learn is the value of consultations and short term contacts.

There are many stories to tell, but I must confine myself to a bit of one in this brief communication, perhaps more in future issues. It is about one person, but carries weight beyond itself. She is a twenty-three year old woman who suffered her first breakdown at eighteen and has been hospitalized four times since. This young woman began hearing voices and having visual hallucinations in college. She felt people were talking about her, saying bad things, sometimes words of great praise. Cosmic visual hallucinations offered ordeals, challenges, tests of courage, hardship, messianic strivings, dreadful and impossible choices. She has had no psychotherapy. All her treatment has been medical. She came from a hard-working family with meager means. Out of her own initiative, driven by a wish to escape a suffocating life, she won scholarships to a competitive boarding school and then college. She hated boarding school, taxed to her limits, felt unwanted by privileged others, did not fit in. In college, she felt she could breathe, made friends for the first time, looked forward to studies. The world, finally, was opening.

It was then she began feeling numb, losing her feelings, not feeling herself. The sense of self-loss was so great she went to the university clinic, where she was put on an anti-depressant. Her mood improved, but loss of I-sensation continued. After a few months, she felt the medication made her jittery, kept her up nights, agitated. They gave her a higher dose of another anti-depressant and in weeks she was hospitalized, the first of a series, with regimes of anti-psychotic meds. Why did she seek me? She stumbled on *The Psychotic Core* in the university library and felt a simpatico resonance. "I recognized what I was going through in your descriptions. While I was reading, I felt myself again. I saw me, felt me." She began to wonder if there was another way, another treatment she was missing. She looked up writings of mine on the internet, where my e-mail address is posted, and screwed up courage to get in touch. Her approach to me was a bit messianic, convinced I could help her. It was a good prognosis that she was able to settle for what contact we could have and see what that might do. After e-mail and phone contacts, she came to New York City for several meetings. She looked stronger and clearer than I expected, although her face was stiff, mouth semi-frozen, with semi-constricted affect. It was clear we could not work together, that only sporadic consultations were possible. I have no time and she lives elsewhere. The meetings were for their own sake and anything they generated.

For its own sake -- a very important experience. Like finding her self-feeling when she read my book. A kind of gratuitous grace, a happening. Not a manipulation, not figuring cause-effect. More a spontaneous psychospiritual opening. Not something one can plan or predict or make happen.

Finding her self-feeling did not cure her psychosis and did not last. It came and went. But she now knew that what she was going through was not irreversible. She got a taste of affective resonance, having experience validated, and an orientation that valued subjectivity. Previously, the best she could do was hear that she had a biological disease that medication should control, a chemical imbalance that pharmacology might correct. Sometimes she felt better, sometimes worse with medication. But the threat was always there, that she would go under without it. On her first e-mail contacts and the first minutes I saw her, she insisted there was nothing in her background to explain her breakdowns. She had a happy childhood, loved by parents, many activities. By the end of our second meeting, she spoke about constant fights between parents, wrenching separations, how much they put her and life down. A bitter attitude drenched her home. Pain of childhood transferred to boarding school: she feared she was always about to be criticized and whipped herself to perform. The trail of trauma began early and was covered over as long as possible. Medication enabled her to continue the cover. When I saw her, I realized she waited a long time to tell a different story. No one had spent this kind of time, speaking in a slow, respectful, thoughtful way about her feelings and the states she underwent. At first she asked -- many times -- if this would go away, if she would ever be as whole as she was before. I gave her a long term orientation, not knowing what would happen. Some people do get better completely. Some people are transformed and reach creative dimensions of living. Some learn to make do with varying states, taking the bad with the good in a larger life. Some must manage longer on the edge. There was no way to know how far she would go or what form getting better might take. But, I assured her there was more to go.

By the end of two meetings, she no longer insisted that her early life and "pre-breakdown" personality were unproblematic, that she had to be problem free in order to be OK. She understood that she could keep growing no matter what she went through and that the work ahead would take a long time. She felt much better.

We scanned the Internet for programs and contacts in her area that might be useful. Within a few months she

was part of a spiritual healing group and a peer self-help group set up by a social worker who offered therapeutic contacts. She entertained the idea of going into weekly or bi-weekly therapy with her. So, at least, a new process had begun. At last she had a chance to speak her truth and share herself with people.

Learnings and affirmations: (1) Any contact one has may be an opening for a person. One doesn't know, positively or negatively, what leads to what. Simple things one takes for granted, may open worlds for another individual. Don't put down or minimize what you have to offer just because it isn't everything or something else. Feeling inadequate in face of immense processes is no excuse for not sensing your way into whatever you can sense.

(2) One never knows where life will come from. Nina recognized her shattering and dying in my book. For her the latter was a mirror that awakened her sense of self. Just coming into contact with a living sense of what one goes through can be enlivening and seed hope. Nothing in her condition changed by reading or seeing me. But she became more ready to undergo and transcend it.

Editor's note: Mike Eigen's *The Psychotic Core* is now being reprinted by Karnac Books and will no longer be with Jason Aronson. This is also so for *Psychic Deadness* and *The Electrified Tightrope*. *Rage* and *The Sensitive Self* are published by Wesleyan University Press.

Culture-Bound: The Transgenerational Transmission of Trauma

Eve Huynh

Two weeks ago Mrs. X asked me to help her solve a personal problem. Mrs. X had refused to visit her father even when he had been hospitalized for cancer. She said, "I hate him, but I know if I don't go, sooner or later I'll become screwed-up." She attempted to solve the problem by writing him a seven-page letter. The letter catalogued his many sins against her. She insisted that unless he confessed his sins, there would be no possibility of reconciliation. Her father was seventy-five years old.

Reading Mrs. X's letter, I saw a little girl walk down a dark alley with both sleeves soaking in tears. She called out her brother's name but wished that he would not answer. For at home her father was loading a gun and was ready to put the bullets through her brother's head. I saw a mother who sat there like a statue. She watched the gun rise to her son's head. I was seven years old.

There is a Vietnamese saying that goes like this: Shirts are not to be worn over the heads. Children (shirts) are to obey and parents (heads) are always right. Had we still lived in Vietnam, this issue of child abuse would have been dismissed. It would have been disgraceful just to bring it up. But we were now in the United States with liberty and justice for all. Should we demand "justice?" The answer for me was no, because that would not serve the purpose of reconciliation.

To ask my parents to admit that they were wrong would be asking them to spit on their ancestors' graves. When they grew up, rods were their daily rice. Rods filled their bodies with wisdom and so rods became love. Love broke bones and left scars. Such was the love that passed from generation to generation and built the foundation of my culture and family. Instill fear and you shall have obedient children. Obedient children produce a harmonious society. I believe that my father was convinced that he did the right thing when he hung his five-year-old child on a tree and left it overnight in the mountain. It was his deep conviction that if it survived the night with ghosts and snakes and tigers, then she would never fear neither darkness nor death again.

Growing up in America, having studied great science and advanced technology, it was easy for me to believe that my Americanized love was far more superior than that primitive love of my parents. I standardized, legalized, and labeled love like products on a shelf. I let my desire for justice -- an eye for an eye -- hinder my compassion. I followed quickly and failed to recognize my own culture-bound voice.

I can choose to abandon my parents now, for I no longer need them. Quite the reverse, they are old and weak and they need me. I can hold the rods but that won't heal the wound in my heart. Harboring revenge has long prevented me from seeing the hands that had dug up the dirt to plant the maniocs that I ate. True, putting food on the table does not give my parents the right to abuse their children. But being grateful and understanding my heritage will enable me to forgive and bring me closer to reconciliation. Reconciliation may give my parents a chance to see the scars which they had inherited and passed on to their children.

Now and then, when I take my children to visit my father in New Jersey, I would bring some barbecued squids. He would shred the squid for my five-year-old daughter, and as we eat, he would tell her about the first time he had helped me catch a shark twice my size. My father's eyes would glow and I could see that he has felt love without rods. The vicious circle of abuse ends with me. Hate and hurt will not have the chance to wound my children -- that's more important to me than his admittance of guilt.

Comments on the Keynote: John Strauss' "Subjectivity in Psychiatry: How Can We Do Better?"

Grace E. Jackson, MD

The keynote lecture at the 5th annual meeting of ISPS-US was delivered by Dr. John Strauss. Entitled "Subjectivity in Psychiatry: How Can We Do Better?" the presentation featured the personal insights of one of the world's leading investigators of the schizophrenias.

I first met Dr. Strauss in the winter of 2000, when I was still mired in a Navy practice setting which demanded my allegiance to a medication-check surreality. For a variety of reasons, my military existence became unbearably corrosive to my soul. In the depths of my misery, Brian Koehler reached out to me: do you know the work of John Strauss?

Several serendipitous connections later, as I was seated in my Bethesda work place one day, a Connecticut area code flashed across my pager. I was shocked to discover the voice of John Strauss on the receiving end of my return phone call. He graciously invited me north for a visit, and I immediately accepted. During a subsequent sojourn to New England, I enjoyed unfettered access to the gentle wisdom of his mind and soul (meanwhile, he endured the unbridled fury and confusion of my own). In that first contact, we dialogued like college roommates for many hours, conversing and sparring about the many mysteries of the human condition. The day was capped by the perfections of French-pressed coffee and cheese fondue.

Three years later, I have had the privilege of a second contact (sans coffee and fondue). John Strauss was recently introduced at the ISPS-US conference as a preeminent American psychiatrist, but this is only partly true. For much of his life, he has lived a split existence -- spending many weeks each year since adolescence as an expatriate (inpatriate?) to France. I cannot help but feel that these twin personae have considerably shaped John's capacity to understand alienation (alien nations). Indeed, it was the feeling state that emerged from reading two of his French papers that expanded my appreciation of the psychological impact of context (e.g., language and culture). As the Post-Structuralists and psycholinguists have long realized, our way of being in the world powerfully determines the kind of world we ultimately perceive. This perspective necessarily leads to an appreciation of subjectivity, and to uncertainty about the existence of universal, fixed, external realities.

It has taken me time (and more serendipitous connections) to discover the work of phenomenologists (such as Brentano, Husserl, Bergson, Merleau-Ponty, Prouty). Despite the limitations of my own training and experience, I feel justified in associating the work of John Strauss with the reflections of the most creative thinkers. The keynote lecture's title -- Emphasizing Subjectivity -- captures the inner spirit of a man passionately devoted to healing through understanding. Such a form of healing places an absolute priority on understanding others, as if we could step for a moment into their skin.

Reflecting on discoveries which he has made through years of psychiatric practice and academic research, John's lecture featured a variety of lessons culled from a number of professional and personal vignettes.

Lesson #1: Abandon the medicocentric.

John opened his discussion with an anecdote from his research experience. He revealed his confusion about how to react to an interviewee who had stopped participating in mental health after care. Expecting the worst, and needing to record the status of this individual for research posterity (stable, improved, or deteriorating), John divulged his private reflections: "schizophrenic, staying home in apartment, limited contact with others, socially withdrawing, illness is worse..." Several moments into the interview, the patient revealed that he had grown too busy to attend therapy. He had become an active assistant to his landlord, helping with gardening and assisting less able tenants with their maintenance problems or other needs. Far from having deteriorated, the patient had demonstrated something which few providers dare to contemplate: he had had the audacity to improve without them. This particular experience impressed John with the lunacy of a *medicocentric* approach to healing. Patients often know what they need in order to improve, and the provider's treatment plan may not be the only part of it. The experience taught John to ask his patients: is there anything you do to help yourself?

Lesson #2: Patients reveal themselves differently to different providers.

Drawing again from his work as an academic researcher who performed longitudinal assessment interviews with persons suffering from schizophrenia, John shared his perception that many patients seemed to feel free to reveal elements of their experience with him, which they would not share with their regular providers. In his lecture, John appeared to attribute this phenomenon to the different obligations or responsibilities assumed by the research interviewer, versus the regular clinician. Deeply disturbed by the implications of this notion -- namely, that an uninvolved interloper might have access to "truths" which the patient would not communicate to the deeply entrenched provider -- I asked John to explain this tension after the lecture. I wondered if the additional, or different, information that he felt he acquired as an intermittent observer might be equivalent to the privileged status experienced by grandparents relative to parents. John had no clear answers to my question, but conceded that it was possible that as a research clinician, he may have enjoyed the privileges of functioning as a "super grandparent." It seems probable to me now that John's

experience demonstrates the effects of interviews conducted in the presence of transferential (and countertransferential) processes of varying intensity and duration.

Lesson #3: Follow the patient's agenda and priorities.

John disclosed some discoveries which emerged from role playing. He discussed several interview portrayals shared with a close friend and colleague, in which he (John) had assumed the role of paranoid schizophrenic. John emphasized his personal feelings of rage and withdrawal during the process of being on the receiving end of a scheduled interview that reduced his experience to a checklist of permitted symptoms. In one role play, John had fabricated an entire personal history, complete with the acquisition of a new job (he had recently been "hired" by a local McDonald's). When the interviewer displayed no interest in his real life experiences, John shut down completely. The role play painfully illuminated the advisability of following the patient's agenda, rather than one's own.

John next mentioned the histories of several patients, who had made significant progress once their first children were born. When asked in assessment interviews what had happened to trigger recovery, these patients had emphasized the fact that their conditions had changed because they had "needed to be well" for their infants. While such recoveries and motivations are surely not universal or common, I believe that John offered them to underscore the importance of not forgetting that our patients have lives, too. Simply stated, our clients need not be defined by our ideas about how their conditions must limit them. Perhaps as an outgrowth of these perceptions, John has found it helpful to ask each patient how the illness experience has affected his or her life. (Another way of "hearing" this might prompt us to inquire about how the illness experience has affected each person's life.)

Lesson #4: Context determines reality.

John proceeded to tell a story from his clinical practice. He described the problems of a patient, troubled with the symptoms of a borderline psychosis. Due to the severity of this individual's condition, she had been confined to the hospital and placed on ward restrictions. One day during treatment, the patient approached John with a special request: could she leave the hospital each day, to participate in a drama production at a church across the street? Every staff member told John that this was neither advisable, nor allowed. Despite their negative reactions, John arranged to have the patient chaperoned and consented to her wish.

Some weeks later, John sat in the audience. Amazingly, his problem patient was the star of the show. At the end of the performance, the director appeared on stage with the cast members, praising John's patient as the "glue" that had had held the ensemble together. The experience epitomized the contextuality of illness. Moreover, it demonstrated the curative potential of certain kinds of rule breaking. If the provider cared about the patient so much that he was willing to accept the consequences of breaking certain rules [borderlines are not supposed to leave the hospital], then the patient may have received the message that she was worthy of a higher level of self-care.

John shared a second vignette which communicated a similar insight. Whenever possible, he has found it helpful to vary the therapeutic setting (e.g., walking, eating together, shopping). He recalled a visit to an IKEA furniture store, accompanying a patient who had conveyed an interest in making a purchase there. Despite his linguistic prowess (the event transpired in France, I believe), John remembers feeling overwhelmed by the store's gargantuan proportions. When he asked for staff assistance (an overt concession of his own limitations), he recalls that his patient's symptoms seemed to fade. This was another lesson into the contextuality of psychotic experience, and the fact that patients are not always as ill as we imagine or intend them to be.

Lesson #5: Listening lies at the center of healing.

If it is true that attunement lies at the core of healing, then John Strauss offered several approaches to expanding this essential capacity. One technique he described was based upon his experience of "listening to voices." He commented upon the discoveries which emerged from wearing a walkman for a day, while a tape cassette played pre-recorded voices (auditory hallucinations). John spoke of the impossibility of attending to anything other than the voices (such as locating a good movie in the local newspaper) -- even though he could reach down and stop the tape at any time. The experience strongly reinforced how hard it is for psychotic clients to concentrate or function, when they under the distracting and seductive influence of internal stimuli.

In closing his address, John spoke admiringly of the interviewing skill of James Lipton -- the host of the TV program "Inside the Actor's Studio." He emphasized Lipton's capacity to listen. John moved on to relate the story of his personal struggle as an artistically-challenged human. He referred to his childhood attempts at illustrating the perfect tree. At age 5, his art work was considered fairly capable. By age 12, he drew the tree the same way. His art work was considered acceptable. In his early 20s, he still drew the same tree. Now, his art work had become an embarrassment. John eventually summoned the courage to pursue art instruction. He enrolled for a beginning course in drawing, where his teacher encouraged him to stop drawing pre-conceived notions of any ideal (stereotypical) tree. Instead, John was instructed to focus on the spaces in and around the limbs and leaves. For the first time in his life, his hand captured the essence of what his eyes could see, and he reproduced his first real tree.

John closed his lecture with this metaphor, in order to demonstrate an approach to receiving others more authentically. If we listen only for the pre-conceived notions to which we expect others to conform, we may never hear anything real. If we learn to listen through the spaces, though, we may allow our ears and souls to become more fully opened. In that process, we might evolve as John did -- assuming the role of mature artist, who finally captures the authentic images of each client's subjective reality.

Panic: Have We Lost Our Minds? (Letter to *The New York Times*)

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New York University

In a recent article "Panic Spells Are Traced to Chemical in the Brain" by Anahad O'Connor published in the science section of the *NY Times* on 1/27/04 the error of not adequately differentiating cause from correlation was made. In particular, the author espoused a Cartesian perspective of brain separate from mind and experience. There was a striking neglect of a robust research literature on developmental psychobiology demonstrating the massive effects of experience (e.g., separation distress, trauma, etc.) on CNS structure and function. The author noted reductions in 5HT1A (serotonin) receptors in three neural regions. Yet, it is widely known by neuroscientists that downregulation of receptors occur during excessive neurotransmission of a host of neurotransmitters, including 5HT (see Stephen Stahl's *Essential Psychopharmacology: Neuroscientific Basis and Practical Applications: Second Edition* published in 2000 by Cambridge University Press) which takes place during stress/anxiety. This has been capitalized on by pharmaceutical companies in drug development, e.g., the SSRI's. Dennis Charney, chief of the mood and anxiety disorders research program at NIH, was quoted as saying: "Panic disorder is due to a specific abnormality in the brain, not a weakness of character." Unfortunately, opposing neural causation with "weakness of character" is a loaded, forced choice option. What about other explanations, e.g., anticipatory separation distress? Research, that Charney himself participated in, demonstrated that perceived, threatened, or actual separation may precede the onset of panic (Charney & Heninger, 1986; Breier, Charney & Heninger, 1986). Gorman, Papp and Coplan (1995) suggested: "...that very early traumatic events, especially insecure infant-parent attachment, may produce neurobiological changes that ultimately lead to panic susceptibility" (p. 52). Non-reductionistic perspectives on panic and anxiety can be found in many psychoanalytically oriented sources, including Steven Roose and Robert Glick's *Anxiety as Symptom and Signal* published in 1995 by The Analytic Press

Panksepp and colleagues (1988) demonstrated that stimulation of neural areas that produce the "separation distress call" also produces symptoms of panic, e.g., hyperventilation. It is widely known in molecular biology that a number of environmental inputs, including sensory inputs, medications, psychological stress, learning (including psychotherapy), can lead to a biological cascade leading to the synthesis of various proteins (including neuroreceptors) as a result of transcriptional and translational processes involved in the trans-synaptic regulation of gene expression (see Hyman & Nestler *The Molecular Foundation of Psychiatry* published by American Psychiatric Press).

To the author's credit there was a suggestion that the depletion of 5HT receptors could be the result of the disorder rather than the cause. However, the emphasis is on a primary neural causation of panic disorder. The average, uniformed reader, would certainly be led to interpret their symptoms of panic, anxiety, sadness, etc. as being "caused" by a brain disorder. This reductionistic trend in our 'mindless' psychiatry, to my way of thinking, is ethically as well as scientifically suspect., in that it can potentially lead patients away from effective forms of treatment, e.g., psychoanalytic therapy, CBT, etc., for anxiety disorders. For an excellent summary of the effects of anxiety/stress on the brain see *New Frontiers in Stress Research: Modulation of Brain Function* edited by Aharon Levy et al in 1998 for Harwood Academic Publishers.

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Medication and Psychotherapy: Part 2*

[Editor's Note: This is part 2 in a 2-part series.]

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*This paper is extracted from *Phenomenology and Lacan on Schizophrenia, after the Decade of the Brain* by Alphonse De Waelhens and Wilfried Ver Eecke. Leuven. Leuven University Press, 2001.

The Michigan State project developed a research design that was free of the major defects of the California project. 1/ In the Michigan project there were no reluctant therapists. The two supervisors were therapists, experienced in the treatment of schizophrenic patients, knowledgeable of the subculture of the patient group (inner-city of Detroit), and known to their colleagues to be clinically efficient (Ibid., 396) . They trained and closely supervised their trainees. The study also differentiated the impact of the experienced therapists from that of the trainees (Ibid., 448, 455). 2/ The Michigan project included a test (the Feldman-Drasgow Visual-Verbal Test, abbreviated as VVT) specifically designed to measure schizophrenic thought disorder, which according to Bleuler is the primary symptom of schizophrenia. The Michigan project used the VVT test both as a major index of imputed deep-structure improvement of the patient and as a predictor of long term condition as defined by other measures such as hospitalization days (Ibid., 431). 3/ Improvement was measured at preset times (6, 12 and 20 months) not at time of discharge which is presumed to bias against measurement of improvement caused by psychotherapy.

The findings of the Michigan study after 6 months were that in comparing the hospital group, called Group C (treated with medication), with the combined psychotherapy groups (Group A was treated psychoanalytically without medication; Group B used ego-analytic therapy with adjunctive medication progressively decreased; both groups used about 70 sessions over a 20-month period) (Ibid., 391, 399), psychotherapy contributed little (Ibid., 425). However, if the psychotherapy group is subdivided between experienced and inexperienced therapists, then the patients of the experienced therapists did significantly better than the patients of both the inexperienced therapists and those of the hospital group treated by medication (Ibid., 425) as measured by both thought disorder tests and days of hospitalization (Ibid., 423, 425).

The findings after a twelve month period were: the pooled psychotherapy patients were hospitalized less, exhibited less thought disorder (VVT test), and are judged to be functioning healthier (Clinical Status Interviews abbreviated as CSI) than the hospital patients treated by medication. Looking specifically at the patients treated by inexperienced psychotherapists (trainees), the authors noted imbalanced improvement of these patients as a group. Indeed, patients of A's trainees had longer hospitalization and much improvement in thought disorder; whereas patients of B's trainees had much less hospitalization but their thought disorder remained similar to that of the control group C treated by medication (Ibid., 428).

The findings at 20 months were that the patients of the psychotherapy group had 31 to 51% less hospitalization days, and had less thought disorder than the control group using medication only and the patients of the experienced therapists had improved more than the patients of the trainees (Ibid., 430-3).

Karon and VandenBos confirm their conclusion that psychotherapy is more helpful than medication alone by quoting the results of a Wisconsin and a Massachusetts study that reported more hospital days for patients on medication than psychotherapy patients the year after termination of therapy (Ibid., 440). They reconcile the apparent contradiction between their findings and those of the California study as follows: "The California project has little to say about the effectiveness of psychotherapy, with or without medication. It does answer the question: 'Is psychotherapy provided by inappropriately trained but medically qualified residents of much use?' The answer is 'no.' The Michigan State Project asks the question: 'Is psychotherapy provided by appropriately trained professionals (psychiatrists and psychologists) useful?' The answer is 'yes.' The fact that the trainees in the Michigan State Psychotherapy Project really did learn to do psychotherapy effectively, as evidenced by the actual progress of their patients during the project, clearly indicates that psychotherapy with schizophrenic patients is a skill that is both teachable and learnable" (Ibid., 460).

Having argued that medication only is not the treatment that produces the best results for schizophrenics, do the authors of the Michigan Project advocate psychoanalysis or psychotherapy only? They do not. Rather they provide arguments for a dualist approach by writing: "It would be a mistake to cite our position as objecting to all uses of medication. Medication is better than no treatment at all, and it may even be better than treatment provided by inappropriately trained and unmotivated therapists. As an adjunct to psychotherapy, it may be helpful to some psychotherapists in the beginning of treatment, or as an adjunct to weather a particularly upsetting crisis" (Ibid., 436; also 209-10).

C. Importance of psychoanalysis or psychodynamic approach to severe mental illness.

One statistical result in the Michigan study not pointed out by the authors is that the VVT statistic (measuring thought disorder) and days of hospitalization (corrected for male/female difference) indicated a greater efficiency of the approach by Supervisor A (psychoanalytic therapy) than the approach by Supervisor B (ego-analytic

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Medication and Psychotherapy, continued

approach) after twelve and twenty months of treatment and in the two year follow-up study.

Notwithstanding the success in the Michigan study of psychoanalytic oriented psychotherapy in Group A, many remain still skeptical about psychoanalysis because it is difficult to create valid empirical studies about psychoanalytic treatments. Fisher and Greenberg write in their book *Freud Scientifically Reappraised*: "In fact, there is no study of psychoanalysis as a treatment that cannot be dismissed because of seriously contaminated or compromised data" (Fisher & Greenberg, 201). Rolf Sandell and his co-authors of the Stockholm Outcome of Psychoanalysis and Psychotherapy Project, however, write: The requirements of this [Fisher and Greenberg's] gold standard is that patients be randomized to treatment groups, either comparative therapy groups or to a therapy group and a non-treated group, and that the ensuing treatment should be strictly controlled and monitored, so that one may be sure that the treatment in question was really delivered the way it was intended to. This in turn requires a thorough standardizing training of therapists in adhering closely to a therapy manual. Unfortunately, it will never be possible for an outcome study on psychoanalysis to be conducted so as to satisfy these requirements. This is not only a matter of the fact that psychoanalysis could not ever be manualized without ceasing to be psychoanalysis or that psychoanalysts in general could never be expected to accept being manualized, in any case. It is also a matter of the fact that such degrees of control are inevitably impossible for such long durations as are typical of psychoanalysis. Not only would we have to control the practices of analysts for years; if we had a non-treatment control group, we would also have to control the adherence of the non-treated patients to this condition. Or, if we had a comparative treatment group, we would have to enforce that the patients stayed in their respective therapies during the whole trial, let alone that we would have had to enforce their compliance with the randomized treatment assignments to begin with. That is not a realistic plan. Patients actively seek out their therapies, interrupt those they are not satisfied with and seek other, new ones. So, as some scholars argue...self-selection is part and parcel of psychotherapy and psychoanalysis, not only to begin with but all the way through, that is, in choosing to stay in treatment, to go to today's session, day after day (Sandell et al. 1998, 1-2).

If one cannot provide empirical proofs, that meet the "gold standard" of empirical research for the usefulness of psychoanalysis, it does not mean, however, that there are no empirical proofs at all. Studies by Blatt and his co-workers provide evidence, first, of the therapeutic efficacy of psychodynamic treatment of severely disturbed young adults and, second, of the greater efficacy of psychoanalysis in the treatment of one group of patients. In a first publication, 90 patients at the Austen Riggs Center, Stockbridge, Massachusetts, were studied at admission and some 15 months later, having received during the interim period "psychodynamically informed treatment, including psychotherapy at least four times a week" (Blatt & Ford 1994, 197). According to DSM-IIIR diagnostic "approximately 20% (n=29) of the sample were considered psychotic, 70% (n=50) as severe personality disorders (including borderline and narcissitic disorders), and 10% (n=11) as primarily depressed" (Ibid., 32). Blatt and Ford conclude that evidence for significant progress in these patients was observed in systematic and reliable ratings made on clinical records...and on variables independently derived from several different types of psychological assessment procedures (i.e., Rorschach, Thematic Apperception Test [TAT], human figure drawings, and Wechsler intelligence tests)" (Ibid., 197; 149-57 for the statistics).

The progress took different forms for two different categories of patients--anaclytic versus introjective ones (Ibid., 201).1

In a second article, surveying a wealth of research, Blatt distinguishes between anaclytic forms of psychopathology (nonparanoid schizophrenia, borderline personality disorder, infantile--or dependent--character disorder, anaclitic depression, and hysterical disorders) and introjective pathologies (paranoid schizophrenia, overideational--or guilt-ridden, self-critical--borderline personality disorder, paranoid and schizoid personality disorders, obsessive-compulsive disorders, introjective--guilt-ridden--depression, and phallic narcissism) (Blatt 1995, 1013). The anaclytic disorders involve exaggerated concern with interpersonal relations and use "avoidant defenses ranging from withdrawal and denial to repression to cope with psychological conflict and stress" (Ibid.). The introjective pathologies are overly concerned with autonomy and control and "primarily use counteractive defenses (e.g., projection, rationalization, intellectualization, doing and undoing, reaction formation, and overcompensation)" (Ibid.). Blatt argues that a dialectic between those two strategies is necessary in human development. This remark hints at a profound reason for dealing with the psychic side of the treatment of mentally ill people: developmental balancing acts that were not performed or were performed badly need to be allowed to occur for the first time or need to be allowed to be redone and corrected.

Blatt further reports that introjective pathologies do not respond as well to brief pharmacological and psychological outpatient treatment for depression [the specific illness upon which the article is focused, using however generalizable arguments] as other patients do. They do better than other patients in long-term, intensive, psychodynamically oriented therapy. Furthermore, a reanalysis of the data of the Menninger Psychotherapy Project (MPRP) indicated that introjective outpatients made significant greater therapeutic gain in intensive (5 times weekly) psychoanalysis than in long-term, twice weekly) psychotherapy. .... Their therapeutic gain in psychoanalysis was also significantly greater than was that of anaclitic patients who were also treated in psychoanalysis (Ibid., 1015).

Thus at least in some cases there is indication that psychoanalysis is more effective than other forms of psychotherapy. This is confirmed in one of the reports from the Stockholm Outcome of Psychotherapy and Psychoanalysis Project. In that report one studies the "capacity to prevent the return of symptoms after treatment" rather than "the sheer reduction of acute symptoms" (Blomberg, 1). The report documents that both "psychotherapy and psychoanalysis produce highly stable effects" (Ibid., summary), but "patients who--for whatever reason did not undergo the recommended psychoanalysis were significantly worse off than patients who did not undergo the recommended psychotherapy" (Ibid., 3). Stability means that the patient did not fail a Clinically Significant Outcome (CSO) once he had achieved the CSO in one of three measurements at 12 months interval (Ibid., 1). A clinically significant outcome was defined as scoring "better on the SCL-90, Social Adjustment Scale and the Sense of Coherence Scale, than the worst or lowest scoring 10% in a norm group consisting...of psychology students and a random community sample" (Ibid., 2). If psychoanalysis is in some cases the treatment of choice, then the therapeutic community can benefit from a dialogue with updated psychoanalytic theory.

Conclusion

In this paper I have reported some shortcomings of medication. I have argued in favor of a dualist approach in the treatment of mental illness in which psychoanalysis could be either the secondary or the primary approach. Finally, I have argued that there is scientific evidence, both in the form of statistics and in the form of arguments, that psychoanalysis or psychoanalytically inspired psychodynamic approaches are superior to other approaches.

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Column: Mind and Brain

A Theory of the Neural Basis for the Psychoanalytic Perspective on Schizophrenia

Brian Koehler, PhD

As a psychoanalyst who has worked with individuals with a diagnosis of schizophrenia or bipolar disorder for many years, I became quite impressed with the contributions of many in our field, colleagues of mine in ISPS, etc., but in particular the work of Gaetano Benedetti (1987) and his younger colleague, Maurizio Peciccia (Peciccia & Benedetti 1998). I feel myself fortunate to have the opportunity to dialogue with them about their clinical work and theories concerning schizophrenic psychoses. In particular, their view on impaired integration of separate and symbiotic selves in schizophrenia made a great deal of sense to me. In this model, aggression and hate arises from annihilation anxiety secondary to fusion or autistic isolation. As someone who continues to relate psychoanalytic/ psychotherapeutic observations with affective neuroscience (social cognitive neuroscience), I would like to ground Benedetti's and my own findings/ theories in current neuroscience research, in particular contrasting the closed-system model of the brain articulated by NYU neuroscientist, Rodolfo Llinás (2003), and what neuroscientists such as Gallese (2003a&b) and Rizzollatti have been discovering about mirror-neurons and their relationship to the neural basis of empathy and intersubjectivity. I believe the latter research holds great promise to those of us attempting to formulate a more effective and helpful psychotherapy and psychoanalysis for persons diagnosed with schizophrenia. I shall begin by summarizing the basic research of Llinás.

Rodolfo Llinás (2003), Professor of Neuroscience and Chair of the Department of Physiology and Neuroscience at the New York University School of Medicine, described the brain as a reality emulator that is basically a dreaming brain that constructs virtual models of the real world. He maintained that although the brain receives various sensory inputs, it is also a self-contained system. Llinás noted: "The closed-system hypothesis...argues for a primarily self-activating system, one whose organization is geared toward the generation of intrinsic images....It follows that such a self-activating system is capable of emulating reality (generating emulative representations or images) even in the absence of input from such reality [e.g., hallucinations and delusions?], as occurs in dream states or daydreaming....This intrinsic order of function represents the fundamental, core activity of the brain" (p. 57). This state seems to represent the autistic position of the psychotic patient who must 'down-regulate' stimuli, particularly interpersonal, from the world and replace it with solipsistic internal stimuli in the form of self-resonance, e.g., hallucinations, as a way of maintaining self-coherence and a sense of personal existence. However, Llinás creates a place for the salience of the environment in his concept of the 'mindness stat**e'** evolving to allow predictive interactions between mobile organisms and their environment.

Neuroscientists Gallese (2003a&b) and Rizzolatti and colleagues at the University of Parma, Italy (see Chris Frith and Daniel Wolpert's edited 2003 volume *The Neuroscience of Social Interaction: Decoding, Imitating, and Influencing the Actions of Others* published by Oxford University Press) have opened up an important area of research in their discovery of 'mirror-neurons' in primates. These neurons, some of which are in the rostral sector of the ventral premotor cortex which have specific histochemical and cytoarchtectonic characteristics and which have been termed area F5, respond when primates see an other performing a specific action as well as when they do the particular action themselves. They are thought to be the neural basis of imitation. Studies in humans have demonstrated that observing an other's action facilitates the neural pathways the observer would use to perform the same action (applied to affects, this may be a neural basis for the mutual identificatory processes so necessary to achieve in psychotherapy). Arnold Modell (2003) pointed out that Vittorio Gallese and Giacomo Rizzolatti, co-discoverers of mirror neurons, recently demonstrated that the experience of witnessing pinpricks that an experimenter applied to his own finger stimulates the very same neurons as when an observer receives a pinprick. Modell noted: "The implication is that our brains resonate to the other's feelings in manner similar to how we resonate with the other's intentional actions...This research suggests that we use our bodies as a template that enables us to feel our way into the other's experience. This supports the contention that the roots of empathy are in the body, and as with projective identification, this process occurs unconsciously" (p. 187). This mirroring system could underlie the development of empathic attunement (e.g., Benedetti's theory of the therapist's identification with the catastrophes occurring within the patient) and intersubjectivity. The research of Meltzoff (Frith & Wolpert 2003) has demonstrated perception and action (e.g., identification and countertransference?) are not independent and that the very early capacity of infants to imitate their caregivers may have as a neural base this innate mirroring system. Along with this immersion in the experience of the other is the capacity to distinguish the self from other which neuroimaging studies have suggested is mediated by the right inferior parietal lobe. The integration of representing others as both like me and different from me is fundamental for the establishment of intersubjectivity. This neural viewpoint is similar to Benedetti's emphasis on the de-integration of separate and symbiotic selves at the core of the psychotic structure. Gallese (2003a) examined three fundamental aspects of interpersonal relationships: imitation, empathy and mentalization (intuiting feelings and intentionality in the minds of others and in one's own mind) and has suggested that they all share a common basic operative defining a shared interpersonal space: embodied simulation which is pre-reflective, automatic and unconscious (Searles and Benedetti's point on unconscious symbiosis with others). Gallese hypothesizes that this basic level of embodied simulation processes enables the construction of a shared

meaningful interpersonal space. Gallese noted: "The shared intersubjective space in which we live from birth continues to constitute a substantial part of our semantic space. When we observe other acting individuals, and face their full range of expressive power (the way they act, the emotions and feelings they display), a meaningful embodied interpersonal link is automatically established by means of simulation" (p. 177).

Gallese (2003b) has applied his shared manifold hypothesis and the neural base of intersubjectivity to the phenomena of schizophrenia. He noted: "In schizophrenia, self and other are not anymore mutually interrelated, but they tend more and more to diverge and crystalize into segregated, incomprehensible and impenetrable realms. In spite of this lack of interpersonal relatedness, the self can experience dramatic loss of its boundaries...as epitomized by Schneiderian positive symptoms such as thought insertion, auditory hallucinations, and delusion of action control" (pp. 177-178).

Minkowski (1927), like Eugen Bleuler (1911), was impressed by the nature of schizophrenic autism, the patient's impaired vital contact with her or his world and incapacity to resonate, to establish meaningful emotional bonds with others. Gallese (2003b) commented on the patient's difficulties in establishing a precognitive, intuitive interpersonal bond with an other in schizophrenia.

Gallese views schizophrenia as a "lack of resonance," as an empathic disorder; the shared manifold of intersubjectivity is disrupted. This approach emphasizes the relational character of the psychopathology of schizophrenia and therefore "has the merit to disclose the possibility to establish a more insightful therapeutic bond with psychotic patients" (p. 178).

I believe that the psychoanalytic approach of Gaetano Benedetti (1987) affords us a relational "way-of-being" with a person with schizophrenia which holds promise in terms of establishing the emergence of self from the dual terrors of the disintegrated self-states constituted at the poles of autistic loneliness and pathological symbiosis/fusion. Benedetti and Peciccia (Koehler 2003; Peciccia & Benedetti 1998), in a series of papers, have been articulating forms of psychotherapy based on their view of the psychotic structure in which the integration of separateness (autonomy, agency) and symbiosis (relatedness in which the patient discovers her or his own boundaries in the relationship and their therapeutic partner outside of the psychotic transference -- which is so palpable in working with these individuals, e.g., recently one of my patients, who has a history of paranoid unprovoked violent attacks on others, was convinced I was out to kill him, etc.) has an opportunity to cohere.

I believe I can now state my thesis: we have within our grasp a potentially fruitful neural basis for the psychotic structure, and its amelioration within psychotherapy and other forms of psychosocial interventions, e.g., involvement in a therapeutic community, identified by Gaetano Benedetti as well as many other psychotherapists working in depth with persons diagnosed with schizophrenia (it is possible to study this utilizing fMRI for both partners of an interaction involving theory of mind, empathy, intersubjectivity, to see the degree of plasticity involved in these neural regions mediating empathy and intersubjectivity). I believe that we have a coherent theory of the psychobiological basis of psychosis if we combine the basic neuroscience research on the brain as primarily a self-activating system, one whose organization is geared toward the generation of intrinsic images (e.g., in dreams), articulated by Rodolfo Llinás (2003), which articulates the pole of autistic protection and withdrawal from invasive control and colonization by an other, with the research on "mirror-neurons" by such neuroscientists as Gallese (2003a&b) and colleagues, depicting the pole of symbiosis and intersubjectivity. Both are essential for interpersonal relatedness; however, the more disintegrated they are (psychically and in terms of co-opting and "hijacking" neural systems), the more difficult it is for the patient to establish continuous and cohesive embodied subjectivity within the realm of interpersonal relations. Our "job" as psychotherapists with psychotic patients is to struggle to achieve this within ourselves as we struggle to achieve this with our therapeutic partners in the countless interactions and enactments taking place within the transitional therapeutic space.

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Firewalking

Grace Jackson, MD

straining --
something inside me
screams out against
the weight of systems gone insane

each one,
demanding conformity with
profitable mechanical assaults
upon objects who have no names and no stories --
there can be no subjects, after all

suffering like Sisyphus --
the rock of a soul-less psychiatry
rolls down again
and I feel weary, alone, and misused

sinking
into the depths
of the Pharmacaust,
I lie daily in the embers
seething and suppressed

waiting
for the fuel that rekindles me
through communion
with listeners who know
the gift of hearing,
Humans... Being... who wait
long enough to feel and to receive
the agony of our mutual condition

needing
fellow Fire Walkers
to bear witness to my pain,
breathing their spirit
into the ashes of a shared captivity
so that each flame not yet extinguished
can rise up once again

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Book Review:

After Lacan: Clinical Practice and the Subject of the Unconscious

By Willy Apollon, Danielle Bergeron and Lucie Cantin. New York: State University of New York Press, 2002, 192 pages, $19.95.

Charles Turk, MD

Cultivating Lacan's Garden in Quebec

In Quebec City, adjacent to the rolling Champ de Bataille high above the Saint Laurence river, lies a large formal garden. From the statue of Jeanne d'Arc implanted in its center, summer breezes course across lush lawns, setting the vibrant heads of massed flowers to nodding in defiance of the winter-winds that in a few months will still them. Willy Apollon, Danielle Bergeron and Lucie Cantin reside and work in this most European of North American cities. The fruits of their long collaboration have been collected in a slim volume, entitled *After Lacan* -- a work that occupies a unique place among the profusion of books about Lacan. The authors come "after Lacan," first in the sense of following in his footsteps, next by creatively reworking Lacan's concepts.

The authors support a logical unfolding of various Lacanian concepts: signifier, the Other, jouissance, "letters of the body," absence and desire with clinical vignettes which bring them to life. The chapters of After Lacan are interwoven through a discursive style where one senses that the authors speak to each other--a notion corroborated at times by their explicitly referring the reader to each other's chapters. Thus the book itself is as a fabric of concepts laid out in three tiers: the authors speaking among themselves, the authors drawing upon Lacan, and Lacan returning to Freud.

In the first chapter, “The Trauma of Language,” Lucie Cantin lays out the foundation of Lacanian theory: that our humanity rests upon the phylogenetic rise of a creature who speaks. Once this being speaks, he is irrevocably detached from the rest of the animal kingdom, destined to live as a human in a manner totally different from any other creature. Willy Apollon pursues this theme in the next chapter by tracing out how language structures us as subjects. He describes how the most obvious property of language--that speech is addressed to someone--produces the concept of the Other. As language separates us from animals, it also severs us from the instinctual satisfactions we assume animals enjoy. This split-off inaccessible remainder, Lacan termed jouissance. While it is often mis-translated as "pleasure," jouissance in fact is beyond pleasure; thus it is not by accident that Freud was interested in what lay "beyond the pleasure principle" nor that Lacan linked jouissance to Freud's death drive. Apollon explicates the attribution of jouissance to the Other and its relation to narcissism, to sexual difference and to the drives-and how, if unchecked, it can course destructively through us.

Next, as if in response to Lacan's oft-quoted phrase, "The unconscious is structured like a language," Danielle Bergeron deftly illustrates the "stuff of language"--the signifier--by inviting the reader to accompany her on an excursion, first behind the stage at the Paris Opera, and then into the bowels of the City of Lights on a tour of its sewers. Through this metaphoric journey "behind the scene," and "into the depths," she demonstrates how Lacan transformed Freud's unconscious "memory traces" (*wahrnehmenzeichen*) into "psychoanalytic signifiers" (as distinct from the purely linguistic signifier).

Lacan taught that the subject is determined by and positioned with respect to three fields of experience: the Real, the Imaginary and the Symbolic. The authors emphasize the particular relevance of the latter field, the symbolic order, to analytic work. In practice this means that the analyst has only speech to rely upon, a fact that Willy Apollon develops in a sequence of three chapters. He traces out a trajectory, starting from the unrepresentable, to its partial inscription in "letters of the body," to its partial capture in the symptom, and finally to the symptom's dissolution into fantasy.

This tracing of the path of "the cure" brings home the disquieting proposition that much of the difficulty encountered in the course of analytic work is often aided and abetted by the analyst himself. Furthermore, the implications for practice as the full meaning of "absence" dawns upon the reader, will lead him to question whether he can ever be "an object" for the analysand, as an "object relations" perspective might imply. We note that "object relations" are representations and thus lie within Lacan's Imaginary field. As the analyst properly works within the Symbolic field, it would appear that our ears would be the only satisfactory "object" we could offer. To offer ourselves as an "object"--as in the contemporary preoccupation with the "here and now"--is to risk impasse by frustrating the subject's drives and obscuring the fact that his unconscious is ready and waiting to speak.

After Lacan helps the reader negotiate Lacan's dense thickets. In a chapter entitled “Perverse Features and the Future of the Drive in Obsessional Neurosis,” Danielle Bergeron provides access to Lacan's difficult text, "The subversion of the subject and the dialectic of desire." By using some of Lacan's "graphs of desire," she delineates how Freud's system of ideals (superego, ego ideal and ideal ego) are framed within a linguistic context and how this system functions with respect to the drives. By way of contrast with the neurotic structure, Lucie Cantin illustrates the perverse structure in a pair of chapters: “Perversion and Hysteria” and “The Fate of Jouissance in the Pervert-Hysteric Couple.” Cantin draws a useful distinction between the “scenario” that the pervert orchestrates with his partner, and the “perverse features” of the neurotic that Bergeron describes above. By revisiting such terms as: signifier, desire, Other, organism and "letters of the body," Cantin evolves a coherent linguistic framework for understanding perversion, connecting what is demonstrated in the pervert’s scenario to the structure that determines it.

Continued on Page 18

After Lacan, continued

Lacan considered the Lack that language introduces into the human being to be symbolized by the phallus, imaginatively assumed to be missing part of a woman's body. Where better to distinguish between organism (women lack nothing biologically) and body (universally fantasized to be actually or potentially missing a part). Thus women's bodies come to be "lettered" as "lacking a phallus." The pervert denies castration by orchestrating a scenario that demonstrates that "nothing is missing." Such demonstrations serve to erase the (linguistically derived) drive and reduce the "drive-lettered" body to an organism pervaded by jouissance. The pervert promises access to Jouissance. But as Jouissance is impossible for the human, the pervert never succeeds, and so is compelled to repeat his scenario. At stake in the treatment of the pervert is to get him "off stage," to give up his demonstration and to speak of it.

Lacan formulated psychosis to be a structure determined by the "foreclosure of the Name-of-the-Father." This means that the psychotic lacks the symbolic father, as a position, upheld within the family structure, necessary for the reliable transmission of cultural values. *After Lacan* draws to a close in a style reminiscent of Freud's Schreber case, which relied solely on the memoirs of that unfortunate man. Danielle Bergeron explores the works of a psychotic writer, Yukio Mishima, to draw out his struggle to compensate for the absence of the "Name of the father." He attempted to use his extraordinary talent to capture unfathomable jouissance within a network of words. But, unable to stem with his pen the workings of jouissance that coursed violently within him, he took up a sword and ended his life in ritual suicide.

In a panoramic introduction, Robert Hughes and Kareen Ror Malone, the editors of *After Lacan*, locate this work within the breadth of the Lacanian field. They go on to describe how over thirty-five years ago Willy Apollon, Danielle Bergeron and Lucie Cantin founded an organization known as GIFRIC (Groupe interdisciplinaire Freudienne de recherches et d'interventions cliniques et culturelles) that developed both a school, EQF (Ecole Freudienne du Quebec) and a treatment program for psychotic young adults, known as "388" (its street address). The painstaking work the authors have done on the problem of psychosis excerpted in *After Lacan* provided the foundation for "388" -a wedding of theory and practice that seems to fulfill Freud's prophecy that one day a method of treating psychosis would be found. To achieve this they focus upon the interplay of jouissance, delusion and dreams in the treatment of psychosis.

While delusion and dream bear a superficial resemblance, they have totally different relationships with jouissance. When the psychotic breaks down he constructs a delusion that first attempts to explain what happened as he witnessed the destruction of the world, and next activates a restitutional effort. The hallmark of delusion is absolute certainty. Delusional work requires that the psychotic must right some wrong or repair some great damage--generally viewed as a defect in the universe. In contradistinction, the dream employs language in a functional way to interpret what arises from the unconscious. This provides the psychotic with an alternative to the delusion that traps him. The true dream offers access to the past, including the events that traumatized him.

The distinction between delusion and dream is exploited to clinical advantage by regarding the psychotic as a speaking subject and offering him a place where he can speak his mind. But he is also required to produce and report dreams. By listening the analyst demonstrates that he "does not know," tacitly acknowledging that it is only the psychotic "who knows." In this way the psychotic's delusional certainty remains unchallenged, and this ensures that persecutory and erotomanic transferences will not be generated. The awaited dream will emerge like tendrils that grow and break into the frozen delusion. There develops a new transference that the psychotic makes use of to experiment with the reliability of the spoken word, whose source in the dream opens him to the truth of his history.

Over the past twenty years, the young psychotics treated at "388" have all engaged in analysis. They were not "previously high functioning" individuals, who constituted those "rare" cases of psychotics who are amenable to psychoanalytic treatment. Quite to the contrary, they were a group of repeatedly hospitalized schizophrenic young people, already embarked on a chronic downward course unaltered by the administration of high doses of medication that had served only to perpetuate their frozen delusional world.

If *After Lacan* had simply explicated Lacanian difficult concepts and animated them with clinical vignettes, it would have accomplished a great deal. But clearly this volume is more than that. It reshapes the psychoanalytic landscape by recasting a theory of psychosis and basing successful treatment upon it. At the same stroke it provides an answer to neurobiological concepts and treatments, by demonstrating how the psychotic can take leave of his illness by having his speech well received.

Noteworthy ISPS Books

Davoine, F. & Gaudilliere, J-M. (2004). *History Beyond Trauma: Whereof one cannot speak, thereof one cannot stay silent*. NY: Other Press.

Dorman, D. (2004). *Dante's Cure: A Journey Out of Madness*. NY: Other Press.

Honig, A. M. (2001) *Hard Boiled Eggs and Other Psychiatric Tales: The Rebirth of Psychotherapy of Severe Mental Illness*. To order: www.dramhonig.net

News from Local Branches of ISPS-US

Baltimore-Washington, D.C.

Ann-Louise Silver, MD

The Washington Chapter has not held meetings this past year, but we did gather for the Washington School of Psychiatry's Frieda Fromm-Reichmann Lecture on March 19, 2004. ISPS Board Member, John Read, PhD of Auckland, New Zealand spoke on "'Schizophrenics' have Childhoods Too: Resurrecting Buried Knowledge." I'm taking this opportunity to urge everyone to read the book he has co-edited with Loren Mosher and Richard Bentall, *Models of Madness: Psychological, Social and Biological Approaches to Schizophrenia*, published for ISPS by Brunner-Routledge. ($80 hardback; $28.95 paperback) e-mail orders at book.orders@tandf.co.uk.

We are very proud of Joel Kanter's major accomplishment this year, publication of his excellent book *Face to Face with Children: The Life and Work of Clare Winnicott*. You can order this book ($35) through usa@karnacbooks.com or call 866-312-2894.

Next year, the Columbia (Maryland) Academy of Psychodynamics (www.CAPsy.ws) will focus on severe mental illness and the most difficult symptoms. Our monthly meetings are co-sponsored by Sheppard Pratt Health System, which allows us to provide continuing education credits to all mental health professionals. We meet on the second Wednesday of each academic month from 8:00 to 9:30 at Humanim, a mental health system in Howard County. We will also co-sponsor with the ISPS-US-Baltimore and Washington Branch, and hold an ISPS-US-DC & Baltimore Branch dinner meeting preceding some of the regular meetings. Wilfried Ver Eecke and Richard Chefetz will be among our speakers. The schedule should be posted by early August.

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Boston

Editor's note: The Boston branch is being organized. For more information, please contact:

Ronald Abramson, MD
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Chicago

Editor's note: The Chicago branch is busily organizing the ISPS-US Annual Meeting (Sept. 18-19), and it promises to be a fascinating conference. For more information, please contact:

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Detroit

Patricia L. Gibbs, PhD

The ISPS-US Detroit Chapter now has nine members. Though the Chapter has never met as a group (and may not ever meet!) the members are active in the community and within various organizations as they engage in professional activities supportive of the mission of ISPS-US to promote humane, psychological treatment of schizophrenic and psychotic patients. The Chapter's Head, Patricia L. Gibbs, Ph.D., is currently teaching classes on psychosis to Candidates and Psychotherapy students at the Michigan Psychoanalytic Institute. The classes assume recovery from schizophrenia and psychosis is possible, and emphasize a psychoanalytic approach. Her paper, "The Struggle to Know What Is Real," will be published later this year in *The Psychoanalytic Review*. Patrick B. Kavanaugh, Ph.D., presented two papers in the past year. The first, "The Dead Poets Society Ventures into a Radioactive Space," was presented at the Academy for the Study of the Psychoanalytic Arts. The Academy is an ISPS-US Institutional member. Dr. Kavanaugh's second paper was presented though the Michigan Society for Psychoanalytic Psychology (MSPP), and was entitled "Frankenstein's Genie-ology: The Magical Visionary Experience and the Associative Method." Bertram Karon, Ph.D., continues to be active in MSPP, and had his paper, "The Tragedy of Schizophrenia without Psychotherapy," published in *The Journal of the American Academy of Psychoanalysis and Dynamic Psychiatry*, Spring 2003. Ms. Mary Karon is active in the Michigan Psychoanalytic Council. Ms. Susan Knapp, M.A. is a member in the Rochester Hills area. Teresa Bernardez, MD, a training and supervising analyst at the Michigan Psychoanalytic Council, has published a recent paper (Spring 2004) in the *Journal of the American Academy of Psychoanalysis and Dynamic Psychiatry* entitled "Studies in Countertransference and Gender: Male patient/Woman analyst in two cases of childhood trauma". Elizabeth Waiess, Psy.D., is in private practice in the East Lansing area. She is active in the Michigan Psychoanalytic Council and teaches psychology classes for Lansing Community College. Henry Krystal, M.D., teaches and supervises Candidates and Psychotherapy students at the Michigan Psychoanalytic Institute, and has written many books and papers on the areas of affect, trauma, and alexithymia. Margaret Walsh, Ph.D., is a

Continued on Page 20

News from Local Branches: Detroit, continued

Candidate at the Michigan Psychoanalytic Institute with previous experience at the Menninger Foundation which sparked her interest in psychoanalytic work with schizophrenic and psychotic patients.

We are a group that tries to remain free-thinking, and opposes restrictive and dogmatic interpretations of psychoanalysis and psychotherapy. Though we do not wish to meet in yet another organizational setting demanding of our time, most of us are active periodically on the ISPS-US Listserv. We welcome all interested in joining our loosely knit "freely associated" Chapter!

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New York

Brian Koehler, PhD

The New York Chapter of ISPS-US has been meeting monthly on a regular basis since October 1997. We are a group of about 30 active members from the various mental health disciplines. At our meetings, which take place once per month (except for August), we take turns presenting case material, articles and papers we have published and/or presented at conferences, etc. We also invite outside distinguished clinicians/authors/ researchers to meet us and present their work to us. Meetings are held on late Saturday afternoons (usually 4:00-6:30 p.m.) and they take place in Manhattan at the New York University Postdoctoral Program in Psychotherapy and Psychoanalysis, 1 Washington Place (corner of Broadway), conference room. We are co-sponsored by the Independent Track of the NYU Postdoctoral Program and ISPS-US. For information on how to participate, please contact:

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Philadelphia

Harold R. Stern, PhD

The past twelve months were very eventful for our Philadelphia group. The passing of Victoria Conn left us with not just sadness at losing a very precious member and leader, but also someone who was contributing in a very energetic way. Her loss was especially felt in the preparation and implementation of the ISPS-US annual meeting here in Philadelphia held at the Thomas Jefferson Medical University. Brenda Byrne and Harold Stern as co-coordinators of that meeting managed to create what appears to have been a very successful conference. We were greatly assisted by Karen Stern, now Executive Director of ISPS-US. Included in our monthly meeting presentations were Paul Fink, Leigh Whitaker, and David Wilson. Our only presentation this year was given by Brenda Byrne, who spoke on the "Assessment and Early Treatment of a Woman With A Dissociative Identity Disorder." The meeting was on Thursday, February 19th, at Harold Stern's home. In May, Harold Stern addressed the Montgomery County Pennsylvania Chapter Of NAMI and spoke about "Successfully Treating Schizophrenia." His talk was well received and he was requested to return again to speak.

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San Francisco

Editor's note: The San Francisco branch is being reorganized. For more information, please contact:

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Southern California

Marty Cosgro, PhD

Jack Rosberg and I have a list of 13 present, past or prospective members to use a starting point for a new branch on the west coast. With the training institutes in the LA area we expect to stimulate much more interest for our new local group. Our goal is to solidify an initial membership and have a local meeting by the end of the year. With any luck we'll be hosting a fall symposium before too long!! Anyone with names of prospective members in the southern California area are asked to E-mail them to:

Marty Cosgro, PhD
MCosgro@charter.net.

Check out the ISPS Website: www.isps.org
And the *new* ISPS-US Website: www.isps-us.org
Send contributions and comments about the ISPS-US website to: Jack Rosberg, PhD, JARosberg@aol.com

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This year ISPS-US will be dedicating its annual symposium to exploring the various ways psychosis is understood by individuals from a variety of disciplines and theoretical lenses. While differences are apparent between these conceptual lenses, they overlap, often clarifying our picture rather than blurring it. Psychosis is an extreme experience as is its treatment. In our era, many have given up on bearing with the psychotic patient, opting instead to keep him or her at a safe distance. It is hoped that this symposium will provide us with some grounding in the severe and trying conditions of psychosis and help us to face the patient and the treatment. Presenters from a variety of disciplines are invited to explore different ways of understanding psychotic conditions and the challenging treatment of persons suffering with them.

We are honored to have renowned author and clinician Leston Havens, M.D. as our keynote speaker and recipient of our 2004 ISPS-US lifetime award. On each day, a detailed case report will be presented by a seasoned clinician with two discussants from different theoretical orientations. Well-known clinician/scholars from the object relations, self psychological, interpersonal/relational and classical/Lacanian schools will offer their insights and perspectives into these cases. In addition, there will be afternoon papers and workshops and finally, participants will be able to share their own thoughts in lunchtime and small group discussions. A dinner for all will be held on Saturday night. Details on CE credits pending: see www.isps-us.org.

Special needs: ISPS-US is committed to providing access and support to persons with special needs who wish to participate in the programs we sponsor. For more information and accommodations, please e-mail Karen Stern at karen.s.stern@earthlink.net or call 610-308-4744.

ISPS-US is a 501(c)(3) non-profit organization. Your donations are welcome and are tax deductible. WWW.ISPS-US.ORG

Registration Form: Please make check payable to ISPS-US and mail with form to ISPS-US, P.O. Box 491, Narberth, PA 19072

NOTE: PREREGISTRATION IS REQUIRED! THERE WILL BE NO ON-SITE REGISTRATION.

Before August 24, 2004	After August 24, 2004
___Conference fee 2 days $150	___Conference fee 2 days $175
___Conference fee 1 day $100	___Conference fee 1 day $125
___**Non-members** *must* add $40 (for annual dues)	___**Non-members** *must* add $40 (for annual dues)
___Student fee $20	___Student fee $30
___Students may add $20 for annual dues	___Students may add $20 for annual dues

___I will be attending the small group lunch discussion. I have enclosed $10 to cover the cost of lunch.

Total amount enclosed: $_____ (Conference fees may be refunded, less a $15 administrative fee, prior to Sept. 12, 2004.)

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Models of Madness: Psychological, Social and Biological Approaches to Schizophrenia

Edited by John Read (Director, Clinical Psychology, Psychology Dept., The University of Auckland), Loren Mosher (Clinical Professor of Psychiatry, University of California at San Diego), Richard Bentall, (Professor of Experimental Psychology, Manchester University)

ISBN 1-58391-905-8 2004 400 pp. US$80.00 hbk • ISBN 1-58391-906-6 2004 400 pp. US$28.95 pbk
Published by Brunner-Routledge for ISPS, the International Society for the Psychological treatments of the Schizophrenias and other psychoses

Models of Madness shows that hallucinations and delusions are understandable reactions to life events and circumstances rather than symptoms of a supposed genetic predisposition or biological disturbance. International contributors:

- Critique the "medical model" of madness
- Examine the dominance of the "illness" approach to understanding madness from historical and economic perspectives
- Document the role of drug companies
- Outline the alternative to drug based solutions
- Identify the urgency and possibility of prevention of madness.

Models of Madness promotes a more humane and effective response to treating severely distressed people that will prove essential reading for psychiatrists and clinical psychologists and of great interest to all those who work in the mental health service.

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Articles, commentaries, vignettes, poems,
book reviews, movie reviews???

Contribute your piece to the next issue of the ISPS-US Newsletter

Deadline: August 31, 2004

Newsletter Editor - Brian Koehler

brian_koehler@psychoanalysis.net 212-533-5687

(All contributions should submitted by e-mail or on diskette.)

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Global Views and Integrated Therapies

June 13-16, 2006 • Madrid, Spain • Palacio de Congresos de Madrid

For more information, contact:
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