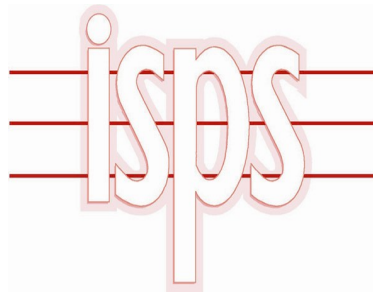


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THE INTERNATIONAL SOCIETY
FOR THE PSYCHOLOGICAL TREATMENTS
OF THE SCHIZOPHRENIAS AND OTHER PSYCHOSES

UNITED STATES CHAPTER

Abandoning Occam's Razor: The Art of Reconstructing the Self

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With some small changes in style in order to make speaking notes into essay-worthy sentences, what follows is my keynote address at the 2008 annual meeting of ISPS-US.

I am grateful for this opportunity to speak. I am honored to have this impressive array of individuals interested in what I have to say. And with this privilege, I am acutely aware of an immense responsibility to communicate and use what I have learned so that others may have a somewhat easier task navigating the difficult and diverse states we call madness.

I have devoted more than 40 years to the study of extreme mental states—my own and others'. I have witnessed the extraordinary ability of people to survive and thrive after living through horrendous experiences. Remarkable feats of resilience attest to our untapped potential.

I am drawn to the words of anthropologist Edward Hall. He said, "The failure to fulfill one's potential can be one of the most damaging things to occur to a person."

After 25 years of stops and starts in the ongoing struggle to effectively write about and articulate what I believed, in late June of last year I self-published what was in my heart and memory, my book, *A Fight to Be: A Psychologist's Experience From Both Sides of the Locked Door*.

I began writing to clarify my experience with madness and to learn how I developed into who I now am. The writing went through many revisions as my

experience with madness and change mixed with new experiences, churned in my psyche and demanded a more nuanced understanding. I had to let go of the anger and grieve for what I had lost. I fought to remember, bear witness and give testimony.



Ronald Bassman (left) delivering his keynote address at the 2008 ISPS-US annual meeting.

As part of my self-directed study to improve my writing, I began reading the works of the great writers. I avoided reading other people's accounts of their psychiatric

experiences. I was afraid their stories and mine would merge. I knew that I had to be very careful to hold onto what I could remember. Because of the memory losses I suffered from psychiatric treatments, I knew the danger of taking on an other's similar experience and confusing it with my own.

While reading Dostoevsky's "Brothers Karamazov," I came across a statement that resonated at a deep level: "The most difficult thing to do in life is to live without lying and not believing one's own lies." That quote, that theme, would guide my writing and become an integral part of my life's journey. I copied it, framed it and hung it in my office. It is still there.

I weathered the high hopes and disappointments of several book publishers' interest—and then the rejections when I refused to write my story in the way they thought would generate sales. I endured the frustration while supported by my wife Lindsey's belief in me and my

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President's Column

Brian Koehler
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I am gradually feeling my way into the position of President of ISPS-US. It is an honor to be the current chair of our organization. Ann-Louise Silver, our founding President, and Karen Stern, our Executive Director, have been of significant help to me as I navigate my way into this position. I am hoping to work effectively with our Executive Board (Ann-Louise Silver, Karen Stern, Marty Cosgro, Lori Kalman-McCartney, Kay Ellen Lowenthal, Daniel Mackler, Jessica Arenella, Ron Abramson, Marilyn Charles, Warren Schwartz, Ayme Turnbull Lilly, Courtenay Harding, Yulia Landa, etc.—a list of the board members can be found on our website) to sustain our accomplishments and increase our development in key areas, e.g., outreach to students, clinicians, researchers, patients and family members, etc. I hope to help the recently convened research committee, co-chaired by Courtenay Harding, Yulia Landa and myself, to connect with the national and international community of like-minded researchers and to engage in relevant research which will demonstrate to the wider mental health community the value of various psychosocial approaches in severe mental disorders. In addition, the formation of new local branches is key to our capacity to reach out to patients, clinicians, students, etc. We encourage members and clinicians to form local branches so as to provide a community of persons engaging in supportive and educational opportuni-

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"Innate among man's most powerful strivings toward his fellow men... is an essentially therapeutic striving."

Harold F. Searles (1979)

Mental Health Parity: Is Mental Illness Like Any Other Illness?

Grace E. Jackson

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Mental Health Parity refers to the policy or legislative changes which place psychiatric disorders on equal footing with medical conditions. As a consequence, mental illnesses become eligible for compensation by governmental and/or third-party insurers.

The debate about mental health parity generally assumes one of two forms: 1) utilitarian (can taxpayers, small businesses, and/or governmental entities afford it?) or 2) ontological (what does it mean when a society or culture equates mental illness with physical disease?). The focus of this article will be the latter.

The ontological status of mental health parity demands the consideration of the following question: in what way is *mental* illness an illness like any other? Common to medical and mental conditions are the following variables: an authorized professional, who is empowered to make diagnostic pronouncements, a nosology (classification of disease) according to which the professional renders his or her assessments, an identified patient with impairing or disabling symptoms, and beneficial treatment. Based upon a superficial review of these variables, parity between medical and mental illness would appear to be self-evident. However, a closer inspection suggests otherwise.

First, in the case of medical illness, *only certain kinds of professionals* (allopathic medical doctors or MDs, osteopathic physicians or DOs, nurse practitioners, and physician assistants) are authorized to deliver diagnostic pronouncements. This is different from the mental health field, wherein medical and non-medical personnel (such as school counselors, pastors, social workers, psychologists, philosophers) can and do render diagnoses.

Second, in the case of medical illness, *the nosology* (method of classifying disease) *depends primarily on scientific facts* reflected in textbooks of pathology and pathophysiology, rather than numerical listings in manuals created for insurance purposes (e.g., the International Classification of Diseases, or ICD; the Current Procedural Terminology, or CPT). This is different from the *Diagnostic and Statistical Manual of Mental Disorders (DSM)*, whose various iterations have demonstrated the socioculturally and historically contingent nature of what qualifies as psychiatric disease.

Here, it is important to appreciate the

fact that the definition of medical illness is, at times, no less controversial and contingent than the definition of mental disorder. For example, critical observers have questioned the legitimacy of medicalizing a number of biological phenomena associated with normal aging, such as erectile dysfunction, prostatic enlargement, hot flashes, osteoporosis, and changes in sleep and metabolism. Others have questioned the legitimacy of medicalizing risk factors, such as high blood pressure, high cholesterol, or obesity. Nevertheless, there exists an essential difference between the quality of judgment which occurs in diagnosing a medical infirmity (since this involves the value-neutral assessment of the body as object), and the quality of judgment which is made in diagnosing mental infirmity (since the latter involves a value-laden assessment of the person as subject).

Third, in the case of medical illness, patients generally seek help voluntarily for symptoms which they, themselves, construe to be indicative of abnormal functioning or limitations. The ethical precepts of physician non-maleficence, benevolence, and patient autonomy are upheld. In the case of mental illness, however, patients are frequently forced to receive treatment for symptoms which are construed by *others* (e.g., parents, school teachers, employers, courts) to be indicative of wrong thought or action, and in this process, physician opprobrium and patient autonomy are ignored or overruled.

Fourth, treatments for medical illness

are generally limited to somatic therapies (e.g., medication, surgery). By contrast, some of the most effective treatments of mental illnesses are only *indirectly* somatic (e.g., psychotherapy, meditation).

Advocates of mental health parity might challenge the aforementioned claims, suggesting that it nevertheless remains possible for a mental illness to satisfy each of the criteria which I have established for a medical condition. One would only require the involvement of: 1) a medical practitioner, 2) a scientific nosology, and 3) a voluntary patient who presents with symptoms that have been identified as much by the patient as by anyone else. The problem here is the absence of an impartial psychiatric nosology. There exists at this time no pathologically or pathophysiologically proven *cause* of any mental disorder other than those which would be attributed to a *general medical condition*. In other words, the *DSM* makes a clear distinction between *somatic* disease (in which case the clinician is instructed to attribute symptoms to the body) and *non-somatic* disease (in which case symptoms are acknowledged, but there is no way to distinguish between the locus of cause and effect).

Thus, the legitimacy of mental health parity hinges upon an interpretation of what, precisely, the *DSM* itself intends to convey whenever a person manifests symptoms for which there is no discernible, biological cause. In the absence of

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definitive neuropathology (whether that be anatomic or physiological), critics of mental health parity argue that it is disingenuous to reduce undesirable perceptions, thoughts, or behaviors to *imagined* brain disease. The crux of this dispute can be illustrated by a non-medical analogy.

Imagine that a motorist arrives at an auto garage, demanding parity (insurance coverage) for damage to his car. In keeping with the criteria of the aforementioned medical model, the motorist seeks repairs voluntarily and accepts assistance from a certified mechanic (authorized professional) who renders a professional opinion (diagnosis) and repairs (treatment). According to the motorist, the problem (illness) involves the car which will not roll backwards. The mechanic examines the vehicle carefully, but finds no evidence of structural abnormalities or malfunction. He confers again with the driver and asks for more details about the context in which the mobility problem has occurred. Finally, upon examining the driver in action, the mechanic discovers that the motorist has not properly disengaged the emergency parking brake. He concludes that no repair is required, since the problem exists with the driver, and not the car.

Despite the admittedly absurd nature of this vignette, the implications are hopefully clear. A mechanic would make a grave error if he or she inferred the existence of defects in the car when the problem originated in the performance of the motorist. To the extent that mental illnesses reflect disruptions in the operations of the individual, the search for a broken brain will be forever misguided and futile. It is in this sense that mental health parity is philosophically untenable, for it mistakenly identifies the consequences of *misdirected Agency* (wrong driving) as proof of a *diseased Agent* (broken car).

At the core of the debate about mental health parity must be the negotiation of what constitutes the person as Agent (what philosopher Gilbert Ryle referred to as "the Ghost in the Machine") and whether or not the phenomenon of misdirected Agency is sufficient to satisfy the requirements of biomedical disease.

It is at this juncture that one might reasonably inquire about the nature of cognitive-behavioral neurology. That medical sub-discipline deals with the brain diseases responsible for disruptions in thoughts and actions. In contrast, psychiatry is properly viewed as a metaphysical enterprise which focuses upon the operations of subjects in their attempts to tran-

scend life stressors. For example, one would justifiably identify vascular dementia as a neurological condition, based upon the existence of abnormal structures in the brain which *cause* disturbances in memory and executive functions. However, one would question a similar classification of the pseudo-dementia of depression based upon its origin in the reactions of a neurologically healthy, autonomous subject.

Mental health parity advocates might argue that this distinction is moot. Contending that the human Agent is nothing more than a *spontaneous*, genetically determined epiphenomenon which emerges from the brain and/or nothing more than a set of *conditioned* reflexes which drift in and out of harmonious functioning, they would conclude that the Agent (driver) himself is inseparable from the object (vehicle) upon which mental illness depends. To the extent that this is true, it makes sense that parity supporters would place all manner of human experience within the province of medicine.

But what about the possibility that the human Agent lies both *within and beyond* the brain? What if one could delineate the networks which constitute the fundamental building blocks of human Agency from those which represent the targets of intentionality (i.e., the ends to which Agency is applied)? Put more succinctly: What if it were possible to discern the difference between a problem which originates in the object (automobile) but not the subject (driver) – or vice versa?

Neuroscientists and philosophers often refer to "top down" processes when speaking about the capacity of humans to modulate mood, attention, appetite, impulsivity, and other processes within and beyond the brain. The reality of this capacity has been demonstrated by neurology patients, who have learned to control somatic disturbances like epilepsy and hemianopsia, and by psychiatric clients, who have learned to self-regulate learning difficulties, psychosis, and anxiety.

Let me take a moment to explain the concept of "top down" control. I can think of three ways in which writers and thinkers have considered this phenomenon. First, "top down" is sometimes used to refer to *levels of complexity*. For example, a completed poem would rank above the status of each line, and each line would rank above the status of a single word:

top down = higher levels of complexity control what lies below

A second meaning of "top down" refers to the spatial arrangement of brain

tissue. Paul MacLean's triune model of the human brain suggests that the anatomical regions which permit the most complex kinds of behavior are precisely those regions which appear last in each individual (ontogeny), and last within the history of evolution (phylogeny): top down = higher regions control the lower regions of the brain (see Fig. 1 below).

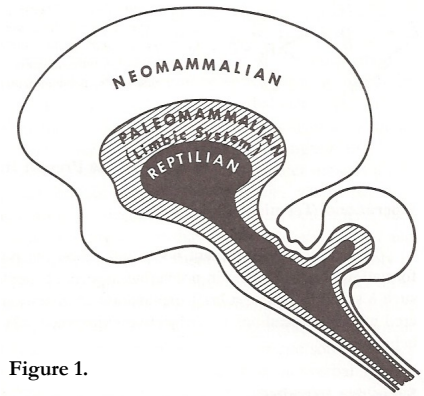
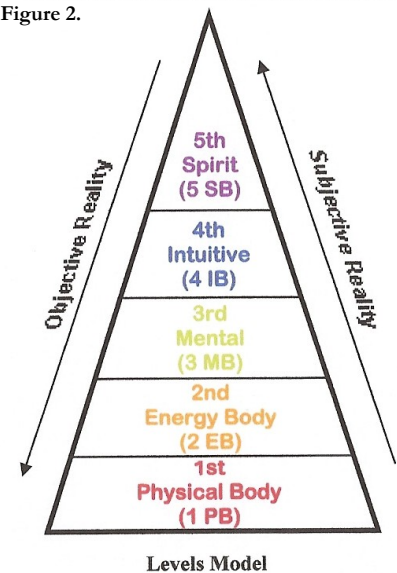


Figure 1.

A third meaning of "top down" refers to the metaphysical ideas of Dr. Dietrich Klinghardt, a German physician who defines healing according to multiple levels (bodies) of the Self (see Figure 2 below):

Figure 2.



level 5 = symptoms/interventions involve the spiritual body (personal connection to the Divine)

level 4 = symptoms/interventions involve the intuitive body (non-local mind, Collective Unconscious)

level 3 = symptoms/interventions involve the mental body (conscious mind)

level 2 = symptoms/interventions involve the electromagnetic body (bioenergetics)

level 1 = symptoms/interventions

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George Mason University's School of Art Presents Marilyn Charles' "Fragments"

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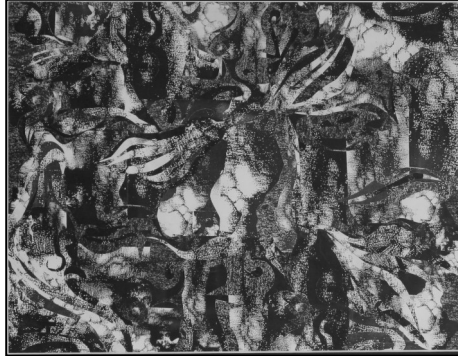
George Mason University's School of Art presented Marilyn Charles' collage exhibition, titled "Fragments," on display in the Mason Hall Alumni Atrium Gallery on Mason's Fairfax Campus from July 13-31, 2009.

"I have studied the nonverbal communicative aspects of pattern," said Charles. "For example, I've traced how prosodies of feeling become translated into line and color. Much of my previous work was in pen and ink, but in this most recent series, I turn to collage as a way of exploring possibilities of patterning from one primal and primary image."

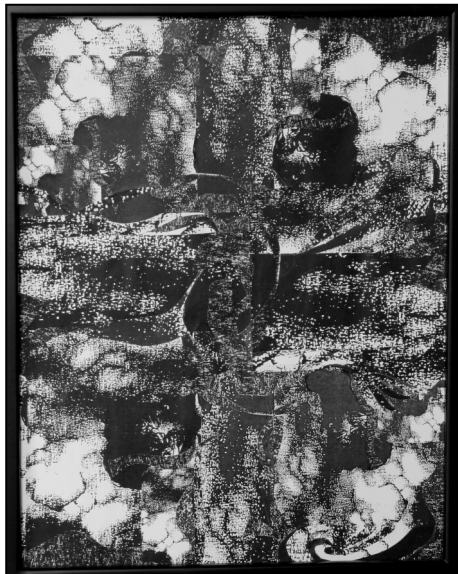
In "Fragments," Charles used one basic image and photocopied it repeatedly, enlarging and reducing it so that the image itself became obscured. "What emerges is the patterned form, a gray scale language of similar quality to what had been created previously by my hand when I worked in pen and ink," she said. "Much as my hand had learned to adjust to the tone desired, my eye began to learn the possibilities inherent in this new universe."

Charles experimented with the image by cutting it into fragments and piecing them together, finally creating four composite images that became the palette from which she worked. She wanted to form an alphabet through which to compose a visual language that evolved directly from the original. "In this way, there is a tension in my work between the original image, frozen in memory, and the capacity to create works that move forward while retaining their roots in the past," Charles said. "My hope was that the forms thus created would not necessarily be reducible to the original image, but would evoke in the viewer feelings resonant to the feelings that had evoked the work itself."

Charles is a psychologist and a psychoanalyst who has taught and published extensively, including three books and numerous journal articles, and has presented her work both nationally and internationally. As an artist, Charles has studied various media at the Cleveland Institute of Art, Cooper School of Art, Case Western Reserve University and Michigan State University.



"Minotaur," by Marilyn Charles.



"Crucifixion," by Marilyn Charles.

If you know an artist whose work reflects aspects of extreme psychological experience, please encourage him or her to submit artwork for upcoming issues of the ISPS-US Newsletter to:

wrrnschwrt@aol.com

Teaching in Russia: A Brief Comment

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After giving a lecture about treating Schizophrenia at a famous psychiatric research hospital in St. Petersburg, Russia and giving another one at the psychoanalytic institute in that city in 1991, I was asked to return and teach at the institute. Since that time I have visited, on average, twice each year. At the institute director's request, my wife and I moved to St. Petersburg in 1997 to live there for one year. My job was to train faculty, teach classes and do supervision and therapy with students and private patients. After returning to the States, I continued to visit St. Petersburg two or three times each year.

At the present time, my students in Russia are predominantly psychiatrists with a small percentage of non-medically trained psychotherapists. A few of these therapists have small private practices, while most of them work in government psychiatric mental health clinics where the patients, most of whom are psychotic, are treated both individually and in groups. For the roughly seven days I am in the city during my visits, I conduct group therapy with three groups of therapists and lead two supervision groups. In addition, I teach classes on the theory and practice of working with patients with schizophrenia and many other difficult disorders. The classes are popular and often have 60 to 100 people attending. They find my conducting supervision in front of the classes to be an important learning experience. I also see people individually for private supervision.

The Russian therapists I work with are hungry to learn methods of treatment that are not dependent upon drugs, and their use of pharmaceutical agents is reduced and sometimes eliminated. This is consistent with the observations that in countries where drugs are expensive and often not covered by medical plans, cures without drugs are more evident.

Relating to these intelligent, dedicated people is very rewarding for me. Over the years, I have seen distinct growth in their therapeutic skills and understanding. Because people come from all over Russia, I find that I am fairly well-known throughout Russia. The positive response to my teaching has motivated me to keep returning to a place where I am well respected and appreciated.

Nightmare in Albany: New York State's Reinterpretation of Social Work Licensing Laws and Its Impact on the Underserved

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In 2002, advocates of the social work profession celebrated the enactment of legislation that, for the first time, licensed New York State social workers. Proponents of licensure believed that licensing the profession would ensure the continuation of high professional standards, as well as elevate the social worker's position among the other service professionals. Advocates could not anticipate the enormous challenges the social work profession would face while integrating the new standards associated with the licensing laws. Among the many concerning consequences are recent interpretations of the New York State licensing laws that limit the individual's ability to obtain the highest level of social work licensure available. Limiting the ability of some agencies to offer mental health services could also result. The scenario in place has created a perfect storm.

On September 1st, 2004, the Social Work licensure bill S7711-A/A11761-A (which had been enacted into law as Chapter 420 of the Laws of 2002) went into effect. The new laws set forth licensing provisions for social workers and included four fundamental changes (paraphrased below), originally published in 2002 on the Frequently Asked Questions Page of the New York State Office of the Professions (NYSOP) website:

- Replacing the title "Certified Social Worker (CSW)" with a new title, "Licensed Master Social Worker (LMSW)," retaining the same requirements
- Adding a new license, "Licensed Clinical Social Worker (LCSW)," mirroring the former "P" psychotherapy privilege requiring three years of supervised experience
- Adding a specific educational requirement for the license, namely, "a core curriculum which includes clinical content" to be defined in regulation, and an exam requirement, the ASWB Clinical exam
- Defining and restricting the practices of "Licensed Master Social Work" and "Licensed Clinical Social Work" to social work licensees

The new laws retained the "R" psychotherapy privilege, which requires six years of supervised experience (three additional years following the LCSW).

Prior to the enactment of the 2004 Social Work licensure bill, a CSW could hire a supervisor to meet the supervision requirement for the "P" psychotherapy privilege. The 2004 law allowed for a limited window of opportunity for existing CSWs to obtain the new LCSW license, but that window is now closed; hundreds of eligible social workers were unable to update their licenses during the period defined in the grand-parenting clause of the law, for reasons that were systemic and beyond their personal control.

According to the new scope of practice defined by the State Education Department, only LCSWs can provide the clinical services that CSWs previously provided (i.e., diagnostic assessment, treatment-plan development, psychotherapy) and bill Medicaid and Medicare for services. LMSWs are considerably more restricted and can only provide clinical services under supervision of an LCSW, psychiatrist or licensed psychologist. Medicare does not reimburse services provided by LMSWs, even under supervision. Furthermore, in 2010, social workers without the LCSW designation will be prohibited from billing Medicaid, too, the fiscal backbone of the community behavioral health sector. This will have a serious impact on the revenue generation of community-based treatment providers. Some have urged the State Office of Mental Health to advocate that the "grand-parenting" application process be re-opened to help address workforce shortages in this field and the other potential consequences of the law for voluntary service providers.

Since the 2004 licensing statute was enacted, an LMSW is unable to hire a supervisor to meet the supervision requirements for the LCSW. The LMSW must be an employee in a legally authorized setting in order to gain psychotherapy experience. If an individual LCSW in private practice wishes to employ and supervise an LMSW, the LCSW must hire the LMSW to see the LCSW's patients and provide supervision. Billing must be done by the LCSW.

NYSOP is now interpreting the new

licensing laws as prohibiting an LMSW from practicing psychotherapy unless he or she is a full time employee (an LMSW providing psychotherapy may no longer be employed as an independent contractor including providing fee-for-service work being paid as a 1099 employee) or a part-time employee paid via W2 and supervised in such a way that the supervisor would have "dominion and control" over the LMSW (i.e., an LMSW may not hire a supervisor). In addition, NYSOP began investigating whether the entities in which the LMSW gained his or her experience operated in accordance with corporate practice laws. This increased scrutiny of settings resulted in NYSOP's determination that any clinical psychotherapy experience obtained in an entity that violated corporate practice laws, whether or not the LMSW had the ability to determine such violation, would not count towards the LCSW.

Although presently LMSWs may have private practices, they can only provide those services delineated in their scope of practice, including engaging "in the administration of tests and measures of psychosocial functioning, social work advocacy, case management, counseling, consultation, research, administration and management, and teaching" (Part 7701 of Article 154 Social Work Education Law). Under the current interpretations of the regulations, an LMSW may not provide Clinical Social Work services (including diagnosis and assessment, treatment planning, and psychotherapy) independently (such as in a private practice setting), nor can an LMSW legally use the title "psychotherapist."

As social workers have no way of officially verifying, prior to beginning employment, that NYSOP will consider a setting or supervisor acceptable and creditable toward obtaining the LCSW license, most have accepted verbal confirmation from NYSOP via phone and relied on the prior experience of other employees at the setting who were able to obtain their LCSW via the same position/supervisor. LMSWs are encountering additional obstacles to licensure if they hired supervision outside of an agency without an express written agreement with the agency and supervisor,

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Nightmare in Albany: Social Work Licensing Laws, continued

(Continued from page 5)

if the supervisor (even in authorized settings) is or was initially licensed in another State, or if the criteria under which the supervisor was grandfathered in to the LCSW is now being called into question by NYSOP.

Left unchallenged, the application of recent interpretations of the licensure statute will deny numerous LMSWs the opportunity to obtain the LCSW license and will not only significantly narrow opportunities for future generations but also will jeopardize the services provided by organizations unable to absorb the increased expenditures required to comply with NYSOP's reading of current laws and governing regulations.

NYSOP is rejecting applications for LCSW licensure that document experience obtained in numerous facilities that were previously considered LCSW qualifying. These rejections are not limited to LMSWs who gained clinical social work experience within a supervised private practice but extend to applicants paid as independent contractors obtaining clinical experience in an otherwise approved setting. In addition, NYSOP advised LCSWs, psychologists and psychiatrists supervising LMSWs paid as independent contractors or working in a clinical private practice that they, along with the LMSW supervisees, are practicing illegally.

Community-based organizations providing mental health services have inadequate funding to incur the additional costs (of unemployment and health insurance and social security, among others) associated with converting LMSWs from 1099 contract employment to W2 employees. If required to do so, organizations will reduce the number of service providers, thereby reducing access to needed services and further limiting the LMSWs' employment opportunities. There will be increased competition for the few available LCSW qualifying jobs, resulting in decreased wages for an already underpaid work force.

Community-based agencies throughout the State of New York provide greatly needed mental health services to persons who otherwise would not have access to such treatment. Employment in programs such as case management, residential treatment, and crisis intervention no longer qualify as clinical positions meeting the licensure requirements toward the LCSW. Thus, LMSWs may be less motivated to

work and train in such programs. There has not been enough research done to evaluate the impact of the social work license law with regard to the ability to recruit and retain clinical social workers in high-need areas. Geriatric programs that bill Medicare are especially impacted by the changes in the social worker licensing, as only LCSWs can bill Medicare.

“There has not been enough research done to evaluate the impact of the social work license law with regard to the ability to recruit and retain clinical social workers in high-need areas.”

Few psychotherapy training institutes that provide advanced training to LMSWs can continue to do so as a result of the stringent limits placed on social work practice, depriving LMSWs the best possible training to practice psychotherapy. In addition, as candidates in training, LMSWs often provide low-fee psychotherapy, enabling individuals who would otherwise be unable to afford intensive treatment to benefit from long-term psychotherapy. LMSW services are not Medicaid reimbursable since only services provided by licensees with the highest license within a profession qualify for reimbursement. This is particularly detrimental since many otherwise LCSW-experience-qualifying settings rely on Medicaid reimbursements to fund operations and will be forced to limit the number of LMSWs employed.

Additionally, a scarcity of social workers who are properly experienced to work with certain high-needs populations (such as the geriatric population), for whom the qualifying pathways are even narrower and less accessible because Medicare does not reimburse LMSW services, is a likely consequence if this legislation remains in place. Lastly, sharp drops in enrollment in social work schools due to uncertain and severely limited career paths, especially those with adequate income potential, could change the face of social work in New York at a time when it is needed the most.

The New York State Coalition of LMSWs (NYSC of LMSWs) was formed in June, 2008, to respond to the NYSOP policy changes in relation to private practice settings. Soon after its inception, the

Coalition documented the myriad ways these “clarifications” negatively impacted social workers, extending well beyond those in private practice to those in facility settings, LMSWs who sought supervision outside of an agency, those working fee for service (paid via 1099), those wishing to pursue postgraduate training and many more.

The NYSC of LMSWs hired a legal representative with extensive lobbying and government affairs experience in an effort to resolve the matter through a combination of negotiation and legislative amendment.

On January 30th, 2009, after nine months of intense negotiations, the NYS Coalition of LMSWs made significant headway in regard to the issue of LMSWs functioning as private practitioners. The Coalition worked closely with the New York State Education Department/Office of the Professions to understand the unintended consequences and possible solutions to the current licensing crisis. As a direct result of the Coalition's efforts, NYSOP released a statement available on the NYSED/OP website: <http://www.op.nysed.gov/swprivatepractice.htm>.

Now, LMSWs who have been in a private practice and/or who hired their own supervisor (in a private practice or agency setting) are to be legally protected and permitted to continue doing so until February, 2015. Despite this recent victory, other hurdles remain. The implementation of social work licensing laws in New York State creates enormous challenges, not only to the present practice of social work, but also to the viability of the social work profession in its entirety. The application of NYSOP's interpretations of the New York State licensing statutes not only impedes practitioners' freedom to meet the high standards of our profession through diverse practices but also restricts clients' access to quality services.

Obituary of Pre-Therapy Pioneer Dr. Garry Prouty

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Dear members of ISPS, members of the World Association for Person-Centered and Experiential Psychotherapy and Counseling, members of the Pre-Therapy International Network, colleagues and friends, I wish we had better news to tell you. I'm sad to inform you that on May 17th, 2009, Dr. Garry Prouty passed away.

As coordinator of the Pre-Therapy International Network, I express my personal and our utmost professional respect for the friend, mentor and colleague Garry was and thank him and Jill, his wife, for endless inspiration and the work they have done. I am convinced that his work in numerous countries with numerous people, in writing and through his presence and presentations, helped and is still helping every day to bring better care to the people he cared for so much. The creation of the Pre-Therapy International Network by Jill, his wife, in Amsterdam in 1995 and the annual gatherings held in Gent, Belgium for more than 10 years now, with professionals coming from all over Europe—all deeply influenced by Garry and his work—testify to this.

Inspired by one of Garry's great examples, Dr. Martin Luther King, the last question of an interview we once did was, 'Garry, do you have a dream?'. Since Garry's response was so congruent and came from so deep, I vividly remember that this was an emotional moment for Garry as well for the people listening. Garry told us that he would like to see society take up the care for the people who suffer from mental illness. He wanted society to provide the care people need since much of the suffering, as he said, is avoidable and unnecessary, tragic. This comment showed Garry's dedication of his life and soul to his work. I have always remembered what he said; I, and many people with me, am still impressed by the way he lived his dream.

Dr. Prouty developed the work of Dr. Carl Rogers and Dr. Eugene Gendlin—his

mentor and friend—into "Pre-Therapy," applying it to people suffering from contact impairment. He was Professor of Psychology and Mental Health (Ret.) and Director of the Pre-Therapy International Network and was a Scientific Associate of the American Academy of Psychoanalysis and Dynamic Psychiatry. He was a Fellow of the Chicago Counseling, Psychotherapy and Research Center and a member of the Chicago Psychological



Dr. Garry Prouty (l.) and his wife, Jill Prouty (r.)

Association. He served as an editorial consultant to the journal "Psychotherapy, Theory, Research and Practice" as well as to the "International Journal of Mental Imagery." He was a consultant to American, English, Austrian and Italian client-centered journals and served on the editorial board of the "World Journal of Person-Centered & Experiential Psychotherapies." He was a member and elected president of the Chicago chapter of the International Society for the Psychological Treatments of the Schizophrenias and Other Psychoses, an organization he also felt well respected in.

Dr. Prouty lectured in European clinics, hospitals and training organizations over the past twenty years. He published numerous articles in several languages and wrote "Theoretical Evolutions in Person-Centered / Experiential Therapy: Applications to Schizophrenic and Retarded Psychoses," published in 1994 and

translated into Japanese and Portuguese. He recently edited "Emerging Developments in Pre-Therapy: a Pre-Therapy Reader," published in 2008, and wrote, together with two close colleagues, "Pre-Therapy: Reaching Contact-Impaired Clients," published in 2002, originally written in German and translated into Dutch and Czech. An updated list of references on Pre-Therapy is available at http://docs.google.com/Doc?id=dck3gzxk_5cwq8j6.

Dr. Prouty delivered the Frieda Fromm-Reichman Memorial Lecture at the Washington School of Psychiatry in 2002. In 2004 he was awarded a "Lifetime Achievement Award for Pre-Therapy" by the Chicago Psychological Association.

Reprinted from http://www.psychological-wellbeing.co.uk/?Garry_Prouty_Obituary

NOTE: A second tribute to Garry Prouty, written by Gertrude Pollit, will be published in the next issue of the Newsletter.

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A View from the Inside: One Medical Student's Experience

Alex Kipp

(ajk34@georgetown.edu)

Editors' note: Alex Kipp recently shared, on the ISPS-US listserv, his experience of his psychiatry rotation at a psychiatric hospital. In his post, he criticizes traditional psychiatric approaches to severely disturbed patients, but at the same time, asserts that individuals engaging in these practices do so out of care. Alex takes into account the fact that psychiatrists and residents are embedded in a system that promotes these values and practices. He thus advocates for changes in training at the systems level and asks us not to vilify individual practitioners who are doing the best they can within their culture.

As some of you know, I am a 3rd year medical student at Georgetown. I recently finished my psychiatry rotation at Washington Hospital Center in DC, and I wanted to share some of my thoughts about my experience with mainstream psychiatrists and the way they approached their patient's psychiatric conditions. This is no way is meant to be an endorsement of how these physicians acted or their approach, but I wanted to discuss some of the experiences I had with them.

First of all, it was very clear to me that both the residents and attendings cared pretty deeply for their patients. While I personally disagreed with their treatment modalities, I rarely felt that they were not acting in what they thought was the patient's best interest.

Certainly, most of what they did, especially on an inpatient level, was medical management. Within their modality, medications WERE the best way to care for an acutely psychotic patient. There is much anti-medication sentiment on this listserv, for good reasons, but I think it's unfair to rest the blame solely on residents and physicians who have been trained to think that anti-psychotics are much like steroids. Both have a wide list of harmful side effects, but, according to them and their training, the harms of not being on the medication outweighs the harmful side effects. The physicians I interacted with knew of the harmful side effects, but they felt that being on an anti-psychotic was better than being psychotic and possibly harming oneself or others.

Secondly, I was surprised to see so many defense mechanisms used by the residents, attendings, and other medical students. Humor was used widely in an attempt to dispel the harsh reality of the situation. Similarly, the other clinicians

distanced themselves emotionally from the patients, pathologizing their manners of speech and hand movements. It seemed so harsh, to distance oneself emotionally from the people most in need of compassion and emotional comfort, but I can understand why that defense is in place. I, on the other hand, probably connected too emotionally to my patients, and felt burdened with the sadness of their lives even after leaving the hospital. While the patients seemed to be relieved to have an empathic clinician by their side at times, it came at a heavier cost to me, and not something that I could foresee doing for more than a month. I didn't feel comfortable expressing my thoughts of how these were people trying to cope with the trauma they had experienced and that their responses seemed in many ways natural to me. It seemed more dangerous for us to accept that "we" could become "them" with enough trauma in our lives. By establishing this us/them dichotomy, residents and attendings did not have to fear such a future for themselves, even if they were exposed to traumatic events. Of course, this seems counter-productive in the long run, but there seemed to be little insight into this response.

Lastly, I found it difficult to structure the diagnoses in the DSM manner. After leaving a patient's room, I found myself wanting to discuss her trauma and why she responded to that trauma in a particular way more than deciding whether she met the criteria for a depressive episode or if she was hypomanic at any time in the past. The criteria for the DSM disorders seemed so fake and contrived, for example, that anxiety and depression were com-

pletely different entities. The assumption that patients needed to be placed in neat little boxes and only then treated seemed too simplistic for me. For example, Julie Kipp once compared the differentiation of the different types of schizophrenia with the ancient description of medical diseases in terms of the four humors. These are such artificial distinctions that are made because so little is known about the disease process right now, and most likely end up getting in the way of our understanding of the disease instead of helping us along.

In the end, I feel like I understand the other side of psychiatry a little bit better, and I'm much less likely to demonize them, or place the blame on individual physicians, but instead focus on the system as a whole, and the training process. While I certainly think drug companies are, on the whole, unethical entities willing to make money at the expense of patients' health, I think psychiatrists view their medicine much like a rheumatologist or transplant surgeon views their drugs: as very dangerous, but life-saving treatments. I think one of the most laudable goals of this organization is to show other psychiatrists that there are non-medical options for patients with psychosis and other psychiatric conditions that do not carry such harmful side effects, and indeed, gets more to the etiology of these conditions in the first place.

I welcome any thoughts that anyone may have, but I would greatly appreciate it if the conversation could remain civil, even around such controversial subjects as medication. I would love to hear others' thoughts on any or all of these matters.

Michigan Branch Report

Patricia L. Gibbs

(E-MAIL)

ISPS-US Michigan members meet while serving obligations to psychology, social work, or psychoanalytic professions. As ISPS-US members, we connect through these professional organizations, and then also present papers, check the ISPS-US listserv, attend ISPS-US Conferences, and write for ISPS-US. Bertram Karon, Ph.D. (together with Ann-Louise Silver) wrote the forward to the ISPS-US Book: Beyond Medication: Therapeutic

Engagement and the Recovery from Psychosis. Patricia L. Gibbs, Ph.D. contributed a chapter to the ISPS-US Book entitled: "Technical Challenges in the Psychoanalytic Treatment of Psychotic Depression."

New England Branch Report

Ronald Abramson
(RonA976@aol.com)

Our New England Branch, currently consisting of a working group of 7 to 10 people (All ISPS members are invited.), is continuing to meet monthly at the home of Max Day in Newton, MA. We presented a workshop on psychosis at the Copenhagen meeting and are currently developing research investigating the therapeutic action of psychotherapy in treating psychoses. The type of research will be the development of data through Participant Action Research. Courtenay Harding has joined our meetings and is guiding us. In this project we hope to collaborate with other ISPS people including the group in Switzerland who have communicated interest.

In addition to these issues, we continue to discuss clinical matters as they come up. Also, we recently discussed a reply to a recent article in "Psychiatric Times" whose authors claimed a reductionistic pharmacological position in the development of DSM-V. Our strong reply is that a psychodynamic point of view is needed for proper understanding.

We announce our meetings on the list serve and through mail and all ISPS members are invited. These meetings continue to be very interesting and a nice way to spend part of a Saturday afternoon.

New York City Branch Report

Brian Koehler
(brian_koehler@psychoanalysis.net)

The New York City Branch continues meeting monthly at NYU on Saturday afternoons from 3 to 5 p.m. Each meeting consists of an invited speaker and an active discussion of her or his paper. We also view documentary films (e.g., Daniel Mackler's "Take These Broken Wings") or taped lectures. The subjects are relevant to the practicing clinician and are free. The general public is also welcome to attend. Should you wish further information, please contact Brian Koehler at brian_koehler@psychoanalysis.net or 212.533.5687.

President's Column, continued

(Continued from page 1)

ties. My guiding vision is to help extend our reach to the many patients and family members who are being denied or do not have access to competent psychosocial therapies.

Our executive Board members convened in November 2008 at a comfortable midtown New York City apartment offered to us free of charge by ISPS-US member Ruth Rosenbaum. Members subsidized their own travel and accommodation expenses. This two day meeting was very helpful in fostering our connection to each other and our devotion to creating a strong and vibrant ISPS-US. We alternated direct work on various relevant projects (e.g., membership, fund raising, education, outreach, conference planning, etc.) with time to play and socialize. The latter was wonderfully facilitated by the guitar and voice of Daniel Mackler. We entered into a passionate sing-along of various old folk songs-it reminded me of my early student days in the late 1960s and onwards of the various peace and social justice meetings and concerts I attended.

This analogy might be quite relevant as we consider the ethical dimensions of what we do-persons with severe mental disorders should have rightful access to empirically demonstrated psychosocial therapies and to the crucially important, stabilizing, long-term psychotherapeutic

relationship.

The board continues to have monthly teleconferences on the first Sunday of the month from 10:30-11:30am. Our group welcomes new participants-please contact Karen Stern at contact@isps-us.org for details on these meetings.

Our ISPS-US group is growing in very dynamic and interesting ways. Our ISPS-US listserv, moderated by Daniel Mackler, is maintaining a very active dialogue on a range of clinically relevant subjects as well as being a source of recent research developments in the field of psychosis. Our ISPS-US Newsletter, edited by Warren Schwartz and Ayme Turnbull Lilly, continues to publish pieces on such clinically salient subjects as the role of the therapeutic relationship in psychosis psychotherapy; delusions and hallucinations; first-hand subjective accounts of psychosis; comments on contemporary mental health systems; the relationship between brain, mind and culture, etc. In addition, the Newsletter reports on relevant upcoming conferences, books, articles, etc. Our ISPS-US website (www.isps-us.org), managed by vice-president Marty Cosgro, is a treasure trove of information on our field. It lists our membership, conferences, articles, our newsletters and books, an extensive bibliography of relevant volumes, weblinks, etc. Daniel Mackler's moving

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President's Column, continued

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documentary film "Take These Broken Wings" can be ordered through our website, as well as books through Amazon (which helps to support ISPS-US). ISPS (www.isps.org) publishes the journal "Psychosis: Psychological, Social and Integrative Perspectives" which is being received by all members of ISPS-US and ISPS as part of the memberships fee. Please consider bringing our new journal published by Routledge to the attention of colleagues, institutions and university libraries so that they can subscribe (information on our new journal can be found at www.isps.org). If you are not a member of ISPS-US, please consider joining as membership will offer you many opportunities to dialogue and relate to others in the field who are devoted to the psychosocial treatment of persons with a psychotic disorder. In addition, one will

have access to our enriching and informative listserv, as well as other benefits and a free copy of Daniel Mackler's inspiring film "Take These Broken Wings" will be mailed to you.

Our upcoming ISPS-US Tenth Annual Meeting, chaired by Ann-Louise Silver and hosted by ISPS-US Baltimore/DC, "Interpersonal Approaches to Treating Psychosis: The Living Legacy of Chestnut Lodge," will be held October 2-4, 2009 in Rockville Maryland. John Kafka will be the Keynote Speaker and Daniel Mackler will be this year's honoree. Please make plans to participate in this ten year anniversary of our annual conferences. It is sure to be a very enriching and informative conference. Come to reconnect with old friends and colleagues and to make new ones. The 16th international conference of ISPS, chaired by Bent Rosenbaum, "Differentiation, Integration

and Development," will be held June 15-19, 2009 in Copenhagen, Denmark. My personal involvement with ISPS began at the international meeting held in 1994 in Washington

DC chaired by David Feinsilver. My wife, Julie Kipp, founding secretary and treasurer as well as founding co-editor of the ISPS-US Newsletter, and I were so impressed and moved by the people we met and the talks we attended that we became very active in the organization. It has been a truly enriching experience for both of us. Please consider attending both of the above ISPS conferences.

I am very interested in hearing from our membership, as well as potential ISPS-US members, as to your ideas on our projects, goals, services, etc. I can be reached either through brian_koehler@psychoanalysis.net or 212.533.5687.

Mental Health Parity, continued

(Continued from page 3)

involve the physical body (chemistry/structure).

According to this model, a patient's symptoms would be conceptualized according to their source. Interventions would target the appropriate level. "Top down control" reflects the existence of a hierarchy, through which higher bodies influence those below.

What are the implications of "top down" phenomena for mental health parity? Advocates of mental health parity err when they confuse symptoms arising from

lower levels of the Self (or brain), with those which arise from the *intentional*, top down reactions of an autonomous Agent. (Recall that this would be tantamount to demanding insurance compensation for the motorist who failed to dislodge the parking brake). This is not to say that people with mental "illnesses" desire their symptoms. Rather, the use of the word *intentional* speaks to the goal-directed (teleological) nature of those processes by which a non-diseased Agent uses his or her mind in an effort to resolve intra- and interpersonal crises.

To the extent that anatomical pathology or pathophysiology can be shown to impair the apparatus of human Agency (the substrates of consciousness and intentionality), one would justifiably refer to the presence of medical illness. However, I believe it would be a dangerous tautology to infer disease whenever an *intact Agent* fails to maximize his or her ability to cope with life stressors. Similarly, it would be a mistake to *medically* indemnify the treatment of disturbances when they originate beyond the physical determinants of volition and will.

Join us for the ISPS-US Tenth Annual Meeting

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Abandoning Occam's Razor, continued

(Continued from page 1)

own unwillingness to give up the idea that I had meaningful things to say.

For a long time, I had resisted Lindsey's suggestion that we self-publish, and I was only convinced to do so when a psychologist friend reminded me that in many indigenous cultures one's story—when it has potential value to the village—is owned by the community rather than the individual. It was the additional piece that I needed to be able to let go of the ego and pride that kept me knocking on inaccessible doors.

During the time we were waiting for the book to be printed, Lindsey and I were constantly aware that her mother was very close to death. Due to extreme peripheral neuropathy, she had lost just about all motor ability and remained in bed most of the day. Up to recently, she had, with the aid of round-the-clock personal assistants and nurses, been able to continue living in her own non-institutional apartment. But now, home hospice care had begun. We were racing the clock, hoping to be able to get a copy of my book to her. That book—my life and work—was the subject of many discussions among us over the years.

When the first books arrived from the printer, we immediately drove the five hours to her home. I laid the first copy in her hands. She held it there and seemed to be mentally weighing the book. She looked down at it for a few seconds, looked up at me, looked back at the book and said, "It took you 25 years to write this little book." I burst out laughing and then sat down on the bed, held her hand and began reading my book to her.

The laughter we shared reminded me of an e-mail exchange I had with professor Bill Anthony, psychosocial rehabilitation's pioneering trainer and theorist. He told me, "It is difficult to be humble when you've written a book about yourself." I have learned the hard way that wanting to be special can easily get you in trouble. Extinguishing as much ego as one can is a task that I continue to work at achieving.

In 1966, I did not have the physical or mental agility to avoid capture in the large and powerful psychiatric net hurled over my being. More damaging and difficult to escape was the subsequent tattoo of my new label—paranoid schizophrenic. The

psychiatric artists were revered for and societally justified in the application of their craft by four damning words, *For Your Own Good*. Renowned author and fellow traveler Janet Frame wrote, "For your own good is a persuasive argument that will eventually make a man agree to his own destruction."

The diagnosis, paranoid schizophrenia, was etched into my consciousness with seizure-inducing currents of electricity and coma-inducing insulin treatments. And like other tattoos, it has been extremely difficult and painful to remove.

Give it a name, have something to call it, and the unfamiliar darkness takes on the illusion of light. It is still murky and unknown, but now you feel that it is understood and predictable. If you get others to accept the name, then they too respond accordingly. There is validation, but is this rational? Is this our reality?

In June, 1966, I earned my master's degree in clinical psychology from Temple University and, three months later, celebrated my 23rd birthday by being drugged, restrained and confined to the seclusion room of Fair Oaks Hospital. Not my idea of a birthday celebration, but a birth of sorts—a naming ceremony for my new identity—Paranoid Schizophrenic.

Fair Oaks, a private mental hospital in Summit NJ, held me for six months and at first "treated" me to massive doses of Thorazine and Stelazine while throwing in Artane to deal with the side effects. Those drugs failed to make me compliant; I refused to give up my psychotic thinking.

I demanded my rights. How naïve and foolish I was to demand autonomy, to be the one to decide what risks to pursue in my search to define me in my own way. I told them that I didn't need their protection. I would not worship safety at their altar. I was 23 years old, but I was still in the throes of teenage rebellion, trying to find out who I was.

They insisted that I give up my sense of self, my newly forming and still-fragile quest for meaning, my identity. My naïve innocence, my futile beseeching to be set free, my ever-repeating cries, my mantra, "THIS IS NOT FAIR," forced them to see no other option than to give me a series of 40 insulin comas combined with electroshock. Five days a week for eight weeks, I endured their assault until I was too weak to scream for my rights or to continue my plaintive cries that this was not fair. I was to learn what comedian George Carlin

says in one of the humorous riffs he uses to jolt us out of our belief that we have rights. No, he says, we don't have rights; we have privileges, and privileges can be taken away.

I left that hospital cured of my grandiose notions, no longer paranoid, no delusions, no hallucinations, huge gaps in my memory, slowed in thought and movement, and without even the energy to contemplate who I was, what I had become or what possibilities, if any, the future offered. I had no energy to be suspicious or hopeful, and I didn't care anyway. Yes, with their broad brush they had vanquished my symptoms, but what, if anything, of me was left?

For years, I looked at my breaking down and giving in to the psychiatric assault as proof of my weakness. In my heart, I knew that I would never again be the comic-book hero. My myth of invulnerability was punctured. I could be broken under torture. No more dreams of inviolable principles. I could be stripped of everything—identity, dreams, ideals, freedom to move or even to think. My dreams were bashed, and I only had nightmares to replace them. We all need dreams!

For the next three years, I worked to get my memory back, to find a job, a dream, something that would enable me to get a life. I made progress: That first year out, I stopped taking Thorazine and Stelazine, but I could not overcome my sadness, my lethargy, the absence of motivation.

After a few years, glimmers of hope emerged. My mental acuity began to come back. I saw vaguely lit, then increasingly brighter paths that I hoped might lead me to growing into the person I wanted to become. Now, looking back, I could say I had glimpsed a hazy image of a path to developing—the "becoming" that psychologist Gordon Allport thought was so important. But after three years of growth and development, I was again hospitalized.

I was devastated. Why did this happen again? Had I grown too quickly without grounding, without integrating my experiences—wanting too much—wanting to forge ahead too quickly? Another six months in the hospital, this time a public hospital. The food sucked and the coffee wasn't real coffee. This public hospital was not as nicely appointed, but I was glad for its one distinct benefit; they

(Continued on page 12)

Abandoning Occam's Razor, continued

(Continued from page 11)

did not do insulin or electroshock treatments. But, as before, I was subjected to heavy doses of drugs.

Again, I withdrew from the drugs after my release. And again it was more than a year before some of my energy, motivation and mental acuity returned. I was close to giving up. How would I ever be able to reject my label? Would I always have the specter of re-hospitalization hanging over my head, regardless of what I accomplished?

The above is the abstract of my psychiatric experience; the fully detailed version is in Part I of my book, *A Fight to Be*.

So, what have I learned that I can share with you? How can you benefit from my experiences as a mental patient struggling to overcome the “disease,” the label, the category, the identity—the confining box we call schizophrenia?

I have thought long and hard about my experiences as a patient and a seeker of meaning, as a therapist, a psychiatric survivor, a peer, an advocate, an activist, a change agent, a husband, and a father. Who am I? How did I transform myself into who I am now, someone who does not take psychiatric drugs, who is considered a well-grounded, reasonably contented, competent individual?

In my enthusiasm about the chance to speak here, I forwarded the conference program to several groups of my peers who are members of organizations I belong to and share values with. Their responses were interesting. What stood out was their feedback about the language in the titles of the workshops. Several people criticized the emphasis on fixing something that was wrong. They were sensitive to the implication that people were being regarded as objects to be fixed.

I thought about the feedback I was getting. Mixed with my admiration for the wonderful group of professional and lay seekers gathered here—many of whom are outsiders swimming against the current of their own professional discipline—I humbly say, without really knowing much about this distinguished group of presenters beyond the title of their workshops, that we must be a bit more humble, embrace the mystery, monitor our egos, and most importantly listen to the experientially based wisdom of those who have

swam and survived their immersion in the seas of madness. . . and those who have drowned and been re-born. We need to listen to, respect and thoughtfully consider their suggestions and criticism. If we are to assist those who are diving too deeply into the mysterious raging seas, we must not offer premature lifelines. A heavy emphasis on safety often exacts too steep a price.

Let me address the significance of Occam's Razor in relation to the principles and values I believe are important. The English philosopher William of Occam, who lived from 1300-1349, said, “*Entia non sunt multiplicanda praeter necessitatem*,” Latin for, “Entities should not be multiplied more than necessary.” His words may be read as, “The fewer assumptions an explanation of a phenomenon depends on, the better the explanatory principle is.” Or: “All other things being relatively equal, the simpler of two competing theories is to be preferred.” All of the above seem reasonable. So where is the problem?

I see the problem in the oversimplification. It is Occam's Razor becoming the law of parsimony. The excessive use of economy in making our decisions eliminates too much that may be valuable. Used judiciously, this razor of Occam can work well in simple situations. But that is the rub for us.

The simplest-appearing things are often very complex. And we who deal with the vast array of factors contributing to or inhibiting the development and expression of one's authentic self must be actively aware of the complexity and mystery of being an individual human and the instability of our current state of knowledge. When we put a person in a category, we save time but lose much useful information. We shape and twist too much material to make it fit.

Our operating knowledge is based on our education and our lived experience. What happens when education and experience do not fit together? How do we develop the belief systems we use? Are your beliefs and their underlying assumptions the same as those of the person sitting next to you? Doesn't our belief system shape how we take in information and guide how we treat people? What do we do with the person who does not match our expectations? Surely we need a wider array of supports and approaches for people. Even the original DSM—the one used

to diagnose me—had eight different kinds of schizophrenia listed.

I think we can guard against going off course by looking at how people live their stories. What do they do when the unfolding events do not match the script that they and their families planned and envisioned?

Let me move on to the second half of the title for my talk: Re-constructing the Self.

Too often, the mental health professions have constructed spurious answers to our most troublesome questions about madness. The answers are bound to speculative assumptions derived from ever-changing favored theories. When complex individuals who share similar elements of diverse experience are reduced to symptoms and pathological syndromes, their personal and special life stories are misunderstood. To enhance our understanding of the myriad altered states of human consciousness, we must not ignore the unique and precious stories of individuals. We should not cheat the narrators

“Too often, the mental health professions have constructed spurious answers to our most troublesome questions about madness. The answers are bound to speculative assumptions derived from ever-changing favored theories.”

from discovering and revising the stories for themselves.

Medical anthropologist and cancer survivor Arthur Frank writes about how life changes when one's being is disrupted by illness. Our capacity to reconstruct our interrupted stories offers transformative opportunities. And when those who survive and thrive bear witness, their testimony helps others move through the experience of an illness-interrupted life. Reconstructing the stories offers hope, possibility and choices that can give meaning to our experience and help us move forward rather than remain mired in our pain.

Will today's state-of-the-art treatment be regarded by future historians in similar

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ways to discarded treatments of the past—the dunking, leeching, organ and teeth removals, lobotomies, the insulin coma treatments, electroshock and the chemical straitjackets legislated as Kendra’s Law in the state of New York and euphemistically called AOT, Assisted Outpatient Treatment? Few feel like they are assisted when they are forced against their will to do something in their best interest. Those four words, “For your own good,” have become too accepted a tenet of public mental health systems.

As an alternative, I offer this empowering statement: “If you come to help me, you are wasting your time. But if you have come because your liberation is bound up with mine, then let us work together.” This insightful negation of altruistic fixing is attributed to Lila Watson, an Australian aboriginal activist.

Psychologist Frank Reissman, a strong advocate of self-help groups, investigated and participated in various configurations of peers helping peers with all sorts of health and mental health problems. He saw the benefits and named it the “helper therapy principle.” When you help someone else, you feel good and reap benefits for yourself. Aren’t most forms of treatment more useful when they are regarded as a collaboration where growth and development permeate the relationships?

Let us embrace the richness and diversity of human being. Most of us are aware of the beauty brought to us by those who are different, those who do not fit the normal mold, who have denied the pulls and pressures of the culture from which they have emerged to bring us art, literature, poetry, music, science and technology. One does not need to be crazy to be creative, but I do believe that when we do not leave enough room for freedom of self-expression, and when we are too fearful of the risks required for exploring new ways of being, we diminish our place in the universe.

I would be foolishly presumptuous to assert that everyone who steps through the doorway into the unknown has made an active, conscious decision to do so. But would I be more foolish than those who proclaim that passage into madness is preordained by one’s genetic makeup? No one is immune to the physical and emotional pain of living. Such is life, perhaps especially so in the times that we live in. Who would not want a quick fix, a pill, a strategy that works quickly with no ill effects, one that would not interrupt the pursuit of our potential or corrupt our

values?

Many who are here are therapists and/or persons who have been in therapy. As therapists, what are the many roles we play? Do we, as rented strangers, take the place of wise uncles, grandfathers, village shamans, country doctors—those figures in the past who took on respect by virtue of the lives they led? For those of us who can use and benefit from psychotherapy, this is what I would want my therapist to do and be.

From my book: “I would want my therapist to have a life-long hunger for understanding and an awareness of his own limitations. His courage and integrity would enable me to trust him. A genuine humility would be evident in his sensitivity to the delicate process of exploring the psyche. My therapist would be my guide, not my leader.

She would be there to support, nurture and expand my choices, not her own. She would be able to show me through her being-in-my-world that I am not isolated, alone and unworthy. My therapist would be able to convey her caring about me as an individual. I would know she cared because I could feel that she was attentively present in the very moment in which we are relating to each other.”

I am not suggesting that the therapist I just wished for needs to be the perfect manifestation of all those qualities I desire. And please do not assume that I am asking for my ideal therapist to be what everyone wants and needs. It’s what I would want—what would suit me!

Some points for therapists to consider:

1. Individuals are more than their diagnoses. Treat the person as a unique individual with strengths and weaknesses.
2. You and the person must work together to find out what works.
3. That person you are working with is the expert on his or her self.
4. Listen, listen, listen—with an open mind.
5. Learn, learn and learn from each person you see. Perhaps what is most important is what you learn about yourself when you try to understand that person you are working with.
6. Know that there is always hope, and communicate it. You cannot fake it; you must feel it.
7. Be the Boy or Girl Scout of counseling; be genuine, empathic and respectful.
8. Get comfortable with the expression of strong emotions. Anger can be beneficial; do not medicate away feelings or be too quick to get those feelings ex-

pressed and integrated. That powerful energy may need to be accessible.

Again from *A Fight to Be*, here are the factors that supported and propelled me forward on my journey: “Hope, safe niches, natural supports, reconciliation with family, the absence of irreversible damage from treatment, self-discipline (development of will), belief in myself, successful experiences, meaningful work, psychotherapy, intimate relationships and the passage of time were all significant in my movement out of the mental illness role into becoming a valued member of society. The varied combinations and relative importance of each of the elements were unique to me, yet I believe that the above identified concepts are common to others’ transformations. But each of us defies set formulas. For all of us, the timing and options are different. Underlying all of the above is the question of whether a person has the freedom to choose.”

Of great importance to my growth was the development of the capacity to be part of a full, loving, intimate relationship. To be able to trust enough to let down my guard and defenses, to be able to be open to another person and allow myself to give up some of my hard-won independence was an imposing hurdle. Developing the trust, the love and full sharing with my future wife was an essential step in separating myself from the specter of another potential collapse into the not-person world of the mental patient.

The passage of time holds critical importance. Staying out of the hospital is essential to the development of self-confidence. It is almost impossible not to measure your success by the increased time you are able to take care of yourself and live in the community.

Progressive thinkers in the recovery movement point to the non-linear nature of the recovery process, and although I agree with the non-linear premise, each setback, even if short and less intense, becomes another blow to one’s fragilely developing sense of self-efficacy and self-esteem. Hospitalization is not a good option and should be avoided. Increasingly greater periods of time when you are free are the ultimate proof of growth and change. Assuming that we and the communities we live in are committed to diversity and believe that each person should be afforded the opportunity to seek out their potential and pursue the development and expression of their authentic self, we must develop more options than biological treatments and psy-

(Continued on page 14)

Abandoning Occam's Razor, continued

(Continued from page 13)
chotherapy.

Psychotherapy and medicine may have their uses, but what about those for whom they are not the optimal choices? Many who are struggling to find their way—consumers, psychiatric survivors, those with cognitive, sensory, or other physical disabilities—regardless of the label—need more creative and substantial assistance than psychotherapy and pills.

We ask for safe, affordable places to live (not segregated), educational opportunities, friends, intimate relationships, to have our own families, raise our children, get jobs that give us the chance to advance and be able to see the future with hope and optimism. We cannot continue to rely solely on therapists to FIX people. We need communities that can appreciate and benefit from difference so that those who look act or perceive differently can still find a community or social network of their choice where they can be fully integrated and valued.

Changes need to be made in our thinking about mental illness and our mental

health policy. We must have more than a smattering of under-the-radar alternatives to the medical model. People need and desire research to be less dominated by measurable numbers. Randomized controlled trials should not be held up as our gold standard while qualitative research is relegated to that of an under-funded fringe pursuit. People need to have informed options in which the strategies and goals—whether relief of symptoms or personal transformation and development—are chosen by the individual.

My story, along with those of fellow travelers, tells us that it is possible to support and elevate people rather than restrict them to a life of maintenance and stabilization. My journey through recovery/transformation is not presented as a model path, but rather as an example of possibility. The opportunity to discover what you can do and be needs to be much more available.

Peculiar to humans is the ability to imagine future possibilities and consciously design a course of action. We are capable of contemplating the prospect of

life outside the present moment. Having the uniquely human capability of governing our instincts enables us to live in precarious balance within worlds of our own constructions. Unfortunately, the struggle to find meaning has become more of a privilege than a birthright. The quest for identity, authenticity, and the struggle to realize and act upon one's potential should not be denied. Our human frailties and anxieties need not be at odds with the natural flow and dynamics of an ever-changing universe. It is time to relinquish our reverence of power and evaluate and modify our relentless quest to dominate nature. Perhaps then we will honor what sets the human species apart from other forms of life and relearn that we are all parts of a whole.

The last and maybe most important thing I have to offer comes from Bella Abzug, New York congresswoman, a lioness who fought for so many progressive causes. She said, "Never underestimate the importance of what we are doing. Never hesitate to tell the truth. And never, ever give in or give up."

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