International Society for the Psychological Treatments of the Schizophrenias and Other Psychoses
UNITED STATES CHAPTER

ISPS-US Newsletter

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

Volume #6 Issue #1, Summer 2005

From the President

Ann-Louise S. Silver, MD

As we recall our stunningly successful meeting in Chicago, crafted by David Garfield and his committee, we now are well into plans for our next meeting. "The Validity of Experience" will be held in Boston at the Brookline Holiday Inn, November 11-13, with Ron Abramson, MD as chair. George Atwood will be our keynoter. Already, we have received some exciting paper and panel proposals. We hope to see you there!

Now in our seventh year, we have formed friendships and teamed up on projects that have brought us closer together, and have given us a sense of real progress and success. Our group is a professional organization for many who would feel quite isolated without us. As we all tell others about ISPS and its initiative of keeping psychological treatments of psychosis a valid pillar of treatment, we no longer feel like lone souls out of step with the professional culture around us. The validation we provide for each other is fundamentally sustaining, especially as we buck the strong tide of advertising which claims that schizophrenia is a brain disease best treated chemically and supportively. We are trying to keep professionals mindful of the thought processes of those who need us to be attentive and hopeful listeners.

We must support the ISPS meeting in Madrid in June of 2006. Please answer the call for papers! Manuel Gonzalez de Chavez is doing a splendid job of organizing the event, "Global Views and Integrated Therapies." Visit the impressive website, **www.ispsmadrid2006.com**. Save the dates, June 13-16, 2006. The triennial ISPS meetings give us a grand opportunity to learn from clinicians in other parts of the world who are not beset by the problems in the U.S. These include the contributors from Scandinavia, who are setting the world standard for humane, active, well-researched and individualized treatment for people struggling with psychosis.

Regarding the day-to-day workings of our group, I want to express my gratitude to Karen Stern for the class-act job she does, keeping our house in order and moving us forward. She has produced a very helpful directory, is working through the application process to allow us to send mailings at the much lower rates afforded to non-profit organizations, and is helping David Garfield in his new post as head of Membership Recruitment. He is developing plans for fellowship awards to students in our field, and Karen will be assisting him with the task of contacting potential Fellows.

I want to welcome our new webpage designer, Lorraine Ellis. Everyone should check out our transformed webpage, **www.isps-us.org**. It resonates well with that of ISPS, **www.isps.org**, and is crisply organized. Marty Cosgro is our website editor. He needs all the web-links you can suggest, since our big problem still is that search engines are not finding us (or ISPS) when one searches "schizophrenia." He needs articles you have written, the texts of lectures you have given, anything that will be helpful to those treating people who have psychotic disorders, or providing information to these sufferers and their families. If you have your own webpage, be sure to include this with the materials you send him. Presenters at past ISPS-US meetings should consider posting the texts of their presentations at our website. *[Editor's note: E-mail contributions for the website to MCosgro@charter.net.]*

We are exploring the possibility of applying for a grant from George Soros's foundation, The Open Society. This would support an educational venture, in the psychotherapy of psychosis. We would study the effects of such a training program on the morale of both patients and staff at the institutions in which we introduce such instruction, comparing these with the morale at control institutions. Patricia Gibbs is exploring teamwork with Wayne State University. David Garfield is developing a publication proposal for a book, *Medications are Not Enough: Working with Severely Disturbed Patients*, with chapters written by ISPS-US members. This book would be the backbone of our seminars. We are happy to contribute to the ISPS publication series edited by Brian Martindale, M.D., at Brunner/Routledge, and hope that they will welcome our book proposal.

Meanwhile, Bill Gottdiener has prepared a practice survey for our membership and for others who might respond to a posting at a survey website. This survey will form the base for clinical studies. We aim to collect the various reports of treatments which when presented individually are discounted as anecdotal, but when grouped, make a statement that such treatment is well worth the effort.

Continued on Page 2

Table of Contents

Regular Features

From the President 1
From the Editor 2
From the Treasurer 5
From the Executive Director 5
ISPS-US Web Site 5
Column: Mind and Brain 11
News from Local Branches 16

Special Features

Dangers of the Overuse of Medication for Treatment of Psychosis in the U.S. 7
In Search of Better Homes and Gardens 10
Catherine Penney Poems 14
In Memory of Loren Mosher, M.D. 16

From the President, Continued

Thus, as our organization grows, we are setting our sights further into the future, taking on more long-range and ambitious projects, while continuing to support our members through our listserve, meetings, newsletters and website.

Ann-Louise S. Silver, M.D.
4966 Reedy Brook Lane
Columbia, MD 21044-1514
410-997-1751
fax 410-730-0507
asilver@psychoanalysis.net
www.CAPsy.ws

ISPS-US Members:
Recruit new members and receive a discount on your ISPS-US 7th Annual Meeting registration fees!
For details, see "From the Treasurer" or contact Karen Stern:
contact@isps-us.org
610-308-4744

From the Editor: Understanding Schizophrenic Delusions: Comprehending the Incomprehensible

Brian Koehler, PhD

One branch of the science of psychopathology tries to understand the human experience of madness–the meanings and structural/functional requirements for psychosis. As is well known, Karl Jaspers, the German psychiatrist-philosopher, in his 1913 text *General Psychopathology*, formulated a descriptive psychopathology that has strongly influenced generations of psychiatrists. He believed that primary delusions were in the realm of the incomprehensible. Jaspers emphasized understanding through empathy. Schizophrenia was excluded from empathic understanding and was exported, along with the patient, to a realm which is today typified by an approach which emphasizes understanding along the lines of DSM and psychopharmacological interventions. This view of schizophrenic delusion as un-understandable minimized the crucial importance of understanding from within schizophrenic experience. Schizophrenia is treated as epiphenomenon of disclosed and yet-to-be-disclosed neurogenetic and neurobiological dysfunction. My view is that the neurobiology and neurogenetics of the schizophrenias is largely the neurobiology of the person's encounter with a kind of lacerating nothingness, with annihilation and disintegration of the self and the lived world of the individual, i.e., the neuroscience of the schizophrenias is largely the neuroscience of severe and chronic stress/fear/anxiety/ as well as trauma and neglect. I believe the psychopathology of schizophrenia to be intimately involved with the coming-into-being of the autonomous-relational subject. What Jaspers did not consider was the possibility that incomprehensibility could be a function of one's own resistance to engage in empathic understanding of this horrific situation. Gaetano Benedetti once speculated that much of the social antipathy towards persons with schizophrenia may very well be this resistance to identifying with the catastrophes of their lived experiences. It seems to me that there exists in our encounter with madness a depersonalized method of understanding. I am impressed by the degree of reductionism endemic to our field, e.g., neurotransmitter levels are viewed as the 'cause' of complex emotional and behavioral states, i.e., viewing the brain as a kind of endocrine gland, albeit a complex one and that complex behavioral states, e.g., depression and anxiety, are reduced to molecular interactions.

Giovanni Stranghellini (2004), a phenomenologically-oriented psychiatrist, noted:

> Psychopathological phenomena's rate of comprehensibility increases dramatically in function to the psychiatrist's own personal engagement in understanding and to her knowledge of her patients' socio-relational style and social contexts (p. 34).

Stranghellini lamented:

> Psychopathology seems to have lost sight of its own centaurical nature–a discipline aimed at both understanding and care–and so it has forsaken its own mandate: elaborating conceptual tools which would allow a rigorous comprehension of the pathological phenomena of subjectivity. Instead it has been recycled as a discipline that merely selects those symptoms which are supposed to be useful to the diagnostic procedures, and to define these symptoms operationally (pp. 40-41).

Stranghellini issues a call to return to a phenomenological grounding of psychopathology as opposed to hyper-technical algorithms. To grasp the experience of the other one must engage in empathy (as I have noted in previous writings, we are helped along in this by our God-given mirror neurons-we empathize with the other through our bodies–we replicate within our own brain what we experience and observe in the other). Empathy attempts to understand a person's communications and actions from the standpoint of the person's subjective frame of reference. Stranghellini notes:

> Empathy is not only a cognitive performance, since it bridges the gap between two individuals' experiences by establishing not only a cognitive understanding, but is based on the intuitive recognition of others' intentions and mental states through the identification with the other's body. This is what the philosopher Merleau-Ponty called intercorporeality (p. 42).

Phenomenology is a kind of active gathering of letting the other speak for herself. In order to obtain a coherent viewpoint, we need to see from above, without superimposing general theories or hypothetical presuppositions. Meaningfulness is a product of this way of approaching phenomena. As

Wittgenstein suggested, we should not strive merely for exactness, but rather, for a view of the whole. I would add that it is through the patient and therapist engaging in this process, that coherence and meaning are created.

Stranghellini stated:

> Phenomena can only be gathered by interactive (emotional) involvement, not by dispassionate observation; concepts should not be used as labels of experience, but as expressions which function in an interpersonal, indexical context; the goal of inquiry should preferably be understanding, not hypothesis testing; meaningfulness, and not simply agreement with observation, should validate psychological expression; and, finally, understanding should require a holistic approach which expands rather than constricts the realm of relevant phenomena (p. 44).

For Stranghellini and many others, what counts in delusion is not the delusion itself. Schizophrenic delusion is probably rooted in an alteration of sense of self, of self-consciousness, downstream to the condition of perplexity and foreboding that might immediately precede the delusion itself. The individual's self-experience is constituted and colonized by the other. The other permeates through and dislocates the experience of autonomy-in-relatedness. The psychotic person suffers an initial 'laceration' of self in an overwhelming experience of an encounter with one's own helplessness and with nothingness, i.e., the perception of non-being.

Barbro Sandin (1993), Swedish psychoanalyst of persons diagnosed with schizophrenia, had this to say about the contradiction at the heart of the schizophrenic dilemma:

> How can we understand the schizophrenic view of the schizophrenic? To be no one. Every schizophrenic patient expresses it time again and time again, even if the personal non-being has many forms. Let us call this the schizophrenic's [I would prefer the term the individual with psychosis] paradox. He or she who is no one. Someone is and expresses his or her being in words of non-being (p. 23).

Stranghellini noted that at the origin of delusion may be an "ontological emptiness," the perception of not having a cohesive identity, the experience of non-being. For me, the unbearable contradiction in which the psychotic individual is trapped, may be what Louis Sass (1994a, 1994b) has referred to as 'self-as-all' and 'self-as-nothing,' that is, the patient feels both that the world is undifferentiated from and constituted by her or his own mind, and paradoxically, they are at the utter mercy of the other, the world by which they are constituted, colonized and controlled by, etc. Stranghellini suggested: "Delusion is triggered as a safety net, a life preserver, upon the experience of feeling ungrounded" (p. 189).

This is similar to Edward Hundert's (1992) viewpoint that delusions may be an evolutionary development of the struggle for survival. Again, Stranghellini suggested:

> Defense from this encounter with nothingness can be nothing other than perceiving or intuiting threats, destruction, annihilation of one's mental or corporeal self, together with feeling in all this, something indecipherable, mysterious, uncontrollable, unshareable. [The schizophrenic delusional person] enriches his own existence in order to fill in an ontological emptiness; he is no longer a man who shares and lives in a structured world, but, rather, in an emptiness that he needs to fill up either with silence or with mortifying and negative conceptions of his own existence [e.g., persecutory hallucinations and delusions], together with contrasting and paradoxical rationalizations, with a phantomatic contrivance that expresses his 'being different' and his 'being against,' a being that is prey to hostile, external forces (p.189).

Stranghellini makes clear that he is referring to a sensorial experience of nothingness, not just some cognitive experience. As I suggested in my writing on auditory hallucinations, in which I bolstered my argument with current fMRI neuroimaging research (Hubl & Dierks 2004) as well as extensive clinical experience, the psychotic patient unconsciously enlists intact neural regions, including the primary auditory cortex (PAC), which is activated when a person is listening to external speech, in a mode that gives the hallucination the stamp of concrete lived experience. The hyperactivation of the limbic system (e.g., amygdala, hippocampus, etc) and the inhibition of prefrontal areas, lend support to the experience of nothingness/ annihilation, hallucinations, delusions, etc., as having a sense of concrete reality. In addition, hyperactivation of right parietal regions support the confusion between internal and external realities (Frith 2004). Stranghellini cogently points out that we are not dealing with a metaphoric expression of the sense of nothingness. Schizophrenic delusions are understood as a very deep transformation of the self-world relationship that reflects a solipsistic position prefigured in the prodromal stages of the illness. Stranghellini proposed:

> Within the schizophrenic condition, this experience of nothingness revolves around a fragile structure of the self, around profound anomalies in sensory self-consciousness and of its correlates: intersubjectivity and the significant perception of the world. The schizophrenic [again, there is no such reality as a "schizophrenic" or "schizophrenic brain," there are persons caught in an internal and social tragedy and predicament which results in their having certain psychobiological symptoms within a particular social context] one is an empty presence,' in the most concrete and literal sense of the term. The core of the schizophrenic condition is disembodiment...[a] lack of a sensory self-consciousness...which gives rise to a perception of the self as a soulless body, or as a disembodied soul (p.191).

Winnicott spoke of the difficulties some persons have in their psyche indwelling in their soma. Benedetti (1987) also understood the importance of the indwelling of the psyche with soma. Benedetti, based on his lifelong experience in the psychoanalysis of psychotic individuals, pointed out that the human psyche cannot observe itself without the mediation of the body and world of others. In the schizophrenic individual, the disorg-

Continued on Page 4

From the Editor, Continued

anization of the ego immediately appears as a transformation of the patient's body and world which are the self-mirror of the psyche. In psychosis there is a confusion of the body with others (transitivism and appersonation) and the disintegrated ego can have impressive bodily aspects, e.g., one patient had to continuously look in the mirror to make sure she still existed, another to make sure there were no missing pieces in her face. In this model, the therapist or psychoanalyst would serve as a bridge between the psychotic individual's psyche and soma–to help the patient safely inhabit her or his own body.

Stranghellini speaks of the separation of things, images and symbols, organized by consciousness. Many of our psychotic patients have difficulties distinguishing between them. He notes:

> In other words, the criterion that makes a given phenomenon a thought (and not an action or the perception of an external object) is our feeling ourselves as the thinker of this phenomenon. The attestation that makes a given action or perception a real action or perception (and not a mere thought, a figment of imagination) is one's feeling oneself as the agent, or the perceiver, of that phenomenon. Not being able to distinguish between 'thought, imagination and factual reality' is, in sum, the consequence of the crisis of sensory self-consciousness (p.196).

Stranghellini summarizes his view of the different forms of schizophrenic delusions:

> The root of schizophrenic delusion is not some semantic swooning, the temporary loss of the book of shared meanings. The epicenter, which is much deeper, has its roots in a metamorphosis of the consciousness, coinciding with the crisis of sensory self-consciousness, which nullifies the confines between bodies, images and symbols. For a deanimated body, or for a disembodied spirit, the bodies of the objects out there themselves turn into images that have been [solipsistically] created by consciousness (epistemological delusion); things lose their concreteness 'ready-to-hand' turning into divinatory symbols (alethic delusions); symbols, the metaphors that enable us to represent the stranger aspects of our experiences, cannot be distinguished from concrete objects and from mechanisms that explain the experience (catachrestic delusions); images, which are inside a consciousness and need to be spatialized to represent themselves, turn into things or bodies (hallucinatory delusion) (pp.202-203).

The self is born out of intersubjectivity. I believe that the insight of Harold Searles (1979) that the patient's symptoms must become transitional phenomenon for both members of the therapeutic dyad, as part of the therapeutic symbiosis, is crucial for the patient's establishment or recovery of being an embodied spirit or animated body.

References

Benedetti, G. (1987). *Psychotherapy of Schizophrenia*. New York: New York University Press.

Benedetti, G. & Furlan, P.M. (Eds.). (1993). *The Psychotherapy of Schizophrenia*. Seattle: Hogrefe & Huber.

Frith, C. (2004). Schizophrenia is a disorder of consciousness. In C. McDonald et al. (Eds.) *Schizophrenia: Challenging the Orthodox*, pp. 145-152. London: Taylor & Francis.

Hubl, D. & Dierks, T. (2004). Visualizing the cerebral alterations that underlie auditory hallucinations in schizophrenia. In C. McDonald et al (Eds.) *Schizophrenia: Challenging the Orthodox*, pp. 7-15. London: Taylor & Francis.

Sandin, B. (1993). When being is not to be. In G. Benedetti & P. M. Furlan (Eds.) *The Psychotherapy of Schizophrenia: Effective Clinical Approaches-Controversies, Critiques and Recommendations*, pp. 23-27. Hogrefe & Huber Publishers.

Sass, L. (1994). *Madness and Modernism: Insanity in the Light of Modern Art, Literature, and Thought*. Cambridge, MA: Harvard University Press.

Sass, L. (!994). *The Paradoxes of Delusion: Wittgenstein, Schreber, and the Schizophrenic Mind*. Ithaca, NY: Cornell University Press.

Searles, H.F. (1979). *Countertransference and Related Subjects: Selected Papers*. New York: International Universities Press.

Hundert, E. M. (1992). The brain's capacity to form delusions as an evolutionary strategy for survival. In M. Schwartz, et al. (Eds.) *Phenomenology, Language & Schizophrenia*, pp. 346-354. Springer.

Stranghellini, G. (2004). *Disembodied Spirits and Deanimated Bodies: The Psychopathology of Common Sense*. Oxford University Press.

CHICAGO PSYCHOLOGICAL ASSOCIATION
is proud to grant our

LIFETIME CAREER ACHIEVEMENT AWARD
to our distinguished colleague

DR. GARRY PROUTY
For your original breakthrough contribution to the field of Psychotherapy

PRE-THERAPY
Which teaches how to reach the unreachable.

Oct 23, 2004

From the Treasurer

Julie Wolter, PsyD (jwolterpsyd@aol.com)

Mark your calendars for the annual symposium in Boston, November 11-13, 2005 – and save money by signing up new members now! ISPS-US has begun a new policy to boost membership recruitment. For each new member that a current member sponsors, the current member will receive a $20 discount on the registration fee for our Boston meeting. If you sponsor enough new members, you could attend the symposium for free. The current member simply writes his/her name in the space marked "Member who encouraged you to join" on the ISPS-US trifolds and distributes them to potential members. Leave a stack of trifolds with your name in them at the information table at a meeting you are attending, a conference at which you are presenting, or your university's break room. Of course, we always welcome new members that you have recruited individually–just remember to put your name on the trifold's registration panel. The trifold can be downloaded from our website, **www.isps-us.org**.

I am happy to report membership renewals are coming in at a faster rate than last year. If you have not yet sent in your membership renewal, please do so promptly to keep our cash flow in line with our ongoing expenses. Thank you to all who have donated to ISPS-US. We have received 28 donations totaling $1802.50. Remember ISPS-US is a 501(c)(3) non-profit organization, so donations are tax deductible.

The 2004 symposium in Chicago was not only successful educationally and inspirationally, it also continued to be a significant source of ISPS-US revenue. This was the first year we have held the symposium at a hotel. The higher expenses were offset by solid attendance and an increase in the symposium fee. Thank you to all involved in making the symposium a memorable experience.

As many of you know, the executive committee agreed to increase membership dues to help meet the monthly administrative and website costs. Dues for licensed professionals are now $60 annually and all others are $30 annually. We have not had an increase since our organization started, and the dues are still low compared to other professional organizations.

May you all have an enjoyable summer!

From the Executive Director

Karen Stern, MAT (contact@isps-us.org)

It's hard to believe that I've only been working for ISPS-US "full time" for just over a year. 2004 was a busy year with a lot of accomplishments. David Garfield, Julie Wolter, Ann Silver, Jessica Wall and the rest of the conference crew organized quite a memorable annual meeting in Chicago in September. We also have experienced healthy growth in our membership, with over 250 members. And we launched a new website, to which we have made great improvements recently, thanks to our new Web Editor Marty Cosgro and Webmaster Lorraine Ellis.

We have also grown on the IRL (in real life) front: our local branches have been very active with regular meetings and events, and we've launched a New England branch, whose members have taken on the task of organizing our 7th Annual Meeting in November in Boston, "The Validity of Experience," which promises to be just as stimulating as Chicago was (see ad in this issue). Ron Abramson, MD is chairing this venture, and he welcomes volunteers (RonA976@aol.com).

We are running quite smoothly as an organization, thanks to monthly conference calls, and a dedicated executive committee and other volunteers who keep in touch through our several email lists. Not quite as exciting, but something that will make a big difference to us financially, is the fact that now that we have our 501(c)(3) status, we have secured a nonprofit bulk mailing permit, which will save us a significant amount in postage. In addition, folks can now join or renew their memberships on the web, through PayPal, which makes us much more accessible to the Internet enabled. Remember that I am here to provide administrative support for whatever projects the board and members initiate. So, if you are a member, I encourage you to become actively involved in a committee or project and recruit a couple of colleagues to join ISPS-US, and if you are not a member, join! You'll get a lot of bang for your buck.

ISPS-US Website

WWW.ISPS-US.ORG

Marty Cosgro, Ph.D. (MCosgro@charter.net)

Our newly renovated website is now up and running and has drawn visitors from around the globe. Over the past 30 days (April 8th - May 8th) we have had visitors from 5 countries outside the U.S. : Greece (13), Netherlands (2), Portugal (2), and Ireland and Nigeria each with 1 visitor. It's exciting to know our message is reaching such diverse locations. By the way, if you haven't yet looked at the new website, we have a global map showing where ISPS chapters have formed around the world ... this is truly an eye opener! Other data from the past 30 days includes average daily visits from 20 first-timers; 20% of our visitors spend up to 5 minutes at the site; and the most frequently visited pages within the site are articles and members.

The web site has taken shape with the expertise of Lorraine Ellis who can be found at Webwomandesign.com (I highly recommend her!). She has taken our vision, prior web site design and lots of input from myself as well as Ann-Louise Silver and Karen Stern and put us in the public eye with a polished look!

As we look to the future, there will continue to be much growth and development with the web site. To keep up with this task, I'd like to have a few people join me on a web site committee that will continue to keep us on the cutting edge of our presence on the internet. No experience is necessary, just an interest in helping ISPS-US

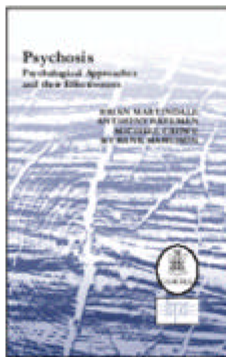
Continued on Page 6

ISPS-US Website, Continued

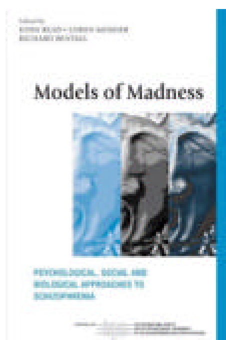
continue to forge ahead with our message to the world as well as our support of each other within the organization. With the new web site now in place, we can develop the site at a more relaxed pace, so the work can be more fun and creative rather than a constant burden. I hope to hear from a few of you so we can put more energy into an already successful web site. My contact information is located on the web site!

Finally, we now have a connection with Amazon.com, so if you go through the ISPS-US web site to get to Amazon and make a purchase we'll get a small cut as a referral fee. Our recommended reading page will take you there. We continue to look for good web sites to link with, or that would be useful to our members. As always, if anyone has suggestions, questions or comments regarding the web site, please contact me.

ISPS Book Series
Available at www.isps-us.org



Psychosis: Psychological Approaches and their Effectiveness



Models of Madness

ISPS continues to develop a series of books that illuminate the relevance and importance of psychological approaches in the treatment of schizophrenia and other psychoses.

Written by ISPS members from around the globe, these volumes reflect the compassionate and enlightened treatment that patients worldwide are receiving.

ISPS-US Executive Committee

ISPS-US Board of Directors

Founder: David B. Feinsilver, MD
President: Ann-Louise S. Silver, MD
Secretary: Julie Kipp, LCSW
Treasurer: Julie Wolter, PsyD
Newsletter Editor: Brian Koehler, PhD
Research Chair: William Gottdiener, PhD
Listserv Moderator: Joel Kanter, LCSW-C
Website Editor: Martin Cosgro, PhD
Membership: David Garfield, MD
U.S. Member, ISPS Executive Committee
Ann-Louise S. Silver, MD
U.S. Members, ISPS PORT Revision Task Force
William Gottdiener, PhD
Colin Ross, MD

Heads of Local Branches

Baltimore-Washington:
Ann-Louise Silver, MD
asilver@psychoanalysis.net
410-997-1751
Chicago: Garry Prouty, DSc
jproutyb@aol.com
Michigan: Patricia Gibbs, PhD
patricialgibbs@aol.com 313-274-5490
New England: Ronald Abramson, MD
Rona976@aol.com
New York City: Brian Koehler, PhD
brian_koehler@psychoanalysis.net
212-533-5687
Northern California Matthew Morrissey, MA
matthew@gsphc.net 415-986-5231
Philadelphia: Harold Stern, PhD
hstern1@verizon.net 610-949-9339
Southern California: Martin Cosgro, PhD
mcosgro@charter.net 805-547-0419

Honorary Board Members

Gaetano Benedetti, MD
Anni Bergman, PhD
Maurice Green, MD
Joanne Greenberg, DHL
Leston Havens, MD
Bertram P. Karon, PhD
Harold F. Searles, MD
John Strauss, MD

For more information about ISPS-US

Please contact Karen Stern, Executive Director
www.isps-us.org
contact@isps-us.org
610-308-4744
P.O. Box 491
Narberth, PA 19072

ISPS-US is a 501(c)(3) nonprofit organization.

Dangers of the Overuse of Medication for Treatment of Psychosis in the U.S.

Nels Kurt Langsten, MD

Author's Note: This paper was presented at the International Society for the Psychological Treatments of the Schizophrenias and Other Psychoses (ISPS) Symposium in Melbourne, Australia, in September, 2003. I have decided to publish it without any major editing or updating, though over a year has passed since the initial presentation. A number of papers and at least one book have been published since the Melbourne Symposium which address many of the issues discussed in the paper. New data on the connection between early trauma/abuse and psychosis was, in fact, presented in several papers given at the conference (by John Read, Richard Bentall, Paul Mullen,and others). Also, Models of Madness*, edited by Read, Bentall and Loren Mosher, had not yet been published. This book contains excellent and comprehensive critiques of reductionist biological psychiatry. I recommend it to anyone concerned about the problems discussed in this paper. Loren Mosher created an excellent website, The Biopsychiatric Model of "Mental Illness": A Critical Biography, which is still accessible [www.moshersoteria.com/litrev.htm]. Both he and Bert Karon were in the audience when I presented the paper and I felt honored by their presence.**

There has been a steady increase in the reliance on medication as the primary treatment of psychosis since Chlorpromazine (CPZ) was first used fifty years ago. During that time there has been a corresponding decline in the use of psychotherapy as a primary treatment for psychotic patients. The ISPS was started almost fifty years ago by two European psychiatrists, Gaetano Benedetti and Christian Muller, who believed in the effectiveness of psychotherapy for treating psychosis without medication. Even in the United States, where medication has been most heavily used, Bertram Karon[1] and Loren Mosher[2] (both members of the ISPS),* and others, were able to publish studies done in the 1970's and 1980's which showed psychosocial intervention with minimal or no medication was more effective than medication oriented treatment. When I started practicing psychiatry thirty years ago psychotherapy was considered a viable treatment for psychotic disorders by some psychoanalytically oriented therapists and family therapists, and a few others, who were treating psychotic patients without medications, often with good results.

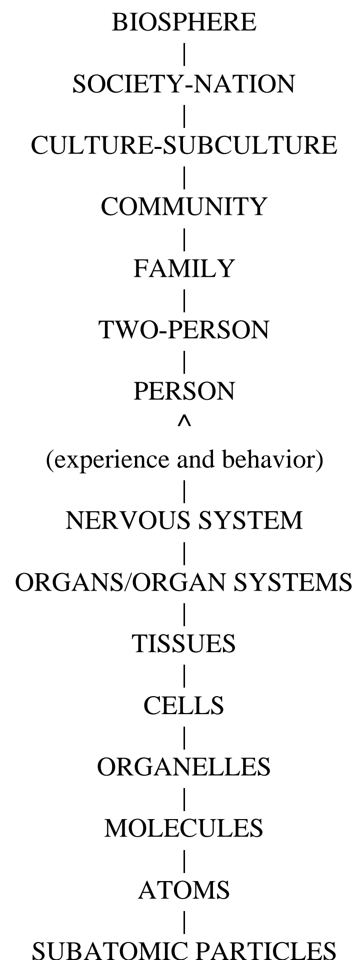
Today, it is virtually impossible to treat psychotic persons who are not on medication. The purpose of this paper is to focus attention on the overuse of medication in the treatment of psychosis, and to try to understand why medication treatment has become so dominant.

When George Engel wrote his 1980 paper, "Clinical Applications of the Biopsychosocial Model",[3] he proposed replacing what he called the biomedical model, which had been dominant for over a century, with a biopsychosocial approach. Engel gave good reasons for wanting to abandon the biomedical model in favor of a less reductionistic biopsychosocial model. He believed the biomedical approach was an inadequate scientific model for medical research and medical practice because it does not take account of the patient as a person and does not provide for psychological and social data. The biomedical approach is predicated on mind-body dualism which reduces human problems to physical-chemical processes. Engel believed it was necessary to change the theoretical model because he thought the manner in which physicians treat patients is much influenced by the conceptual model they use, whether they are aware of it or not.

The biopsychosocial model Engel proposed was based on systems theory. **Figure 1** shows how complex and comprehensive the model is. He believed the model is helpful in understanding the complex organization of biological systems. In his paper he presented briefly the case of a man suffering a second heart attack, in order to illustrate the usefulness of the theory in a clinical setting. Engel was trying to enlarge the scope of medicine, including psychiatry. He was a medically oriented psychiatrist who thought that all physicians, not just psychiatrists, were failing to take account of the patient as a person and were not paying sufficient attention to psychological and social data.

Engel believed the biomedical approach was limited because it can only extend knowledge on one level of organiza-

SYSTEMS HIERARCHY (LEVELS OF ORGANIZATION)



Am. J. Psychiatry 137:5, May 1980

Figure 1: Hierarchy of Natural Systems

Continued on Page 8

Dangers of the Overuse of Medication, Continued

tion by using increasingly diverse and refined techniques, but is unable to integrate this knowledge with lower or higher levels of organization. He thought the search for physical-chemical abnormalities as the causes of medical and psychiatric disorders is doomed to failure because it ignores, or fails to take adequate account of, the experiencing person, and of social and cultural factors.

I agree with Engel that the conceptual model used by physicians and therapists strongly influences how they treat their patients, and I believe a truly scientifically based biopsychosocial theory is needed if the reductionistic biomedical approach is to be seriously challenged. Clearly, the general acceptance of a biopsychosocial approach has not occurred. I think at least part of the reason for this lack of acceptance is that we still lack an adequate integrated biopsychosocial theory. Many theories have been developed in an effort to understand abnormal mental functioning but none has achieved general acceptance and there is still much theoretical disagreement, even among advocates of the biopsychosocial approach. A theory is needed which can accommodate all of the existing theoretical orientations, including the more narrow biomedical views. Though this is a critical issue which needs to be resolved, a detailed discussion of theory is beyond the scope of this brief presentation. I plan to address the problem of theory in a future paper.

The persistence of the reductionist biomedical view is due not only to inadequate theory, but also to the powerful feelings aroused in other people by severely disturbed persons. These feelings include anxiety and fear in reaction to their unpredictability, strangeness and intense ways of communicating; anger and frustration in reaction to the difficulty in making contact with them when they cannot, or will not, respond to our efforts to connect with them; and our feelings of helplessness and pain in the face of overwhelming emotional distress.

The key to helping others is empathy. It is extremely difficult, sometimes impossible, to empathize with people who are in extreme pain, who may even, at times, seem to have lost some essential human qualities. Therapists who work with torture victims have been reported to sometimes experience failure of empathy with their patients, at times to the point of identifying with the torturer.[4] At the deepest levels of our beings we may be so threatened by the patient's pain that we have a need to see the deeply suffering person's condition as something that could never happen to us, as something intrinsic to their nature and alien to our own. The intense feelings aroused in us by psychotic patients can cause defensive distancing of ourselves from them emotionally, and a need to believe in physical-chemical substances that will control or cure their symptoms.

Though the narrow biomedical view of psychosis as a brain disease, reinforced by the powerful feelings aroused by psychotic persons, makes psychiatrists and other clinicians more receptive to drug company marketing, the role of the pharmaceutical industry and its allies, in the psycho-pharmaceutical-industrial complex cannot, and should not, be minimized. The profit motive is the engine that runs the complex, and money is the fuel that powers the engine.

The story of drug company promotion of neuroleptics, starting with the introduction of CPZ to the US market by Smith, Kline and French, in 1953, is documented in detail by Robert Whitaker in his book, *Mad in America: Bad Science. Bad Medicine and the Enduring Mistreatment of the Mentally Ill*, published in 2002.[5] His account of the transformation of the image of CPZ from an agent that causes lobotomy-like effects to the image of a safe, anti-schizophrenic medicine is painful to read. Other authors have documented the power and influence wielded by drug companies, and their unscrupulous tactics, (Peter Breggin, M.D., in *Toxic Psychiatry: Why Therapy, Empathy, and Love must Replace the Drugs, Electroshock, and Biochemical Theories of the "New Psychiatry"*, 1991,[6] and several later books; Joseph Glenmullin, M.D., in *Prozac Backlash: Overcoming the Dangers of Prozac, Zoloft, Paxil, and Other Antidepressants with Safe, Effective Alternatives*, 2000,[7] and others). Even the relatively conservative *New England Journal of Medicine*, in its May, 2000, issue published an editorial by Marcia Angell, M.D., titled "Is Academic Medicine for Sale?".[8] The same issue contained an article by Thomas Bodenheimer, M.D., titled "Uneasy Alliance: Clinical Investigators and the Pharmaceutical Industry".[9] Both authors criticize the illicit alliance between the pharmaceutical industry and organized medicine, medical research and medical education. These writings should be required reading for all trainees in the medical and mental health fields.

The marketing campaign by Smith, Kline and French was highly successful. Within a decade after CPZ came on the market an estimated fifty million patients were treated with the drug.[10] By 1970, two hundred fifty million patients had been prescribed neuroleptics.[11]

It hardly seems necessary to discuss the dangers of the neuroleptics, which have been extensively documented in the psychiatric literature. The story of tardive dyskinesia is a psychiatric scandal and a tragedy. Psychiatrists were slow to recognize and acknowledge the seriousness of the problem. Psychiatrist George Crane was writing articles in the early 1970's documenting the high incidence of tardive dyskinesia, but the American Psychiatric Association did not officially acknowledge the seriousness of this problem until the late 1980's.[12] Even when the severity of the problem was acknowledged, neuroleptic use was not curtailed until the new, profitable, "atypicals" came on the market. Many psychiatrists still seem not to comprehend the magnitude of the damage that has been done to patients, possibly because not much can be done to help those suffering from tardive dyskinesia. The only "treatment" available at present for severe cases are the very drugs which cause the disorder. Literally millions of patients have been affected by this iatrogenic, incurable condition. Though exact numbers are not available, an estimated 100,000 patients died of neuroleptic malignant syndrome between 1960 and 1980.[13] Countless others have suffered lethal cardiovascular effects and were put at risk of developing cancer and other life threatening diseases. Other permanent movement disorders like tardive akasthisia and tardive dystonia are not uncommon.

Some critics, for example, Breggin[14] and Mosher[15], cite evidence that tardive movement disorders are only the most obvious manifestations of the brain damage caused by neuro-leptics. There is substantial evidence in the neuropsychiatric

literature that neuroleptics cause severe permanent cognitive impairment (tardive dementia).[16] Cognitive dysfunction is much harder to detect than movement disorders. It is quite possible that thousands, possibly millions, of patients are suffering from, or will develop, serious cognitive impairment from taking neuroleptics. Instead of acknowledging this very real possibility, many psychiatric researchers are interpreting cognitive dysfunction in patients on neuroleptics as part of the patient's psychiatric disorder, one of the "negative symptoms". Many cognitive abnormalities found in neurological and neurocognitive assessments of patients on medication are attributed to their psychiatric disease, but these are more likely to have been caused by the medication.

Many psychiatrists believe the availability of the "atypicals" will solve the problems caused by the neuroleptics. This is far from the truth. Many of the claims made by drug companies and drug company sponsored researchers about both safety and efficacy of the "atypicals" clearly are not true. Breggin,[17] Whitaker,[18] and others, detail the major health problems caused by these drugs which have already become apparent. For example, the risk of adverse neurological effects from risperidal (Risperdal), which was initially marketed (and still is) with claims of low potential for neurotoxicity, has been found to be as neurotoxic as haloperidal (Haldol).[19] I have a patient, a woman in her 50's, who developed severe akasthisia after six months of treatment with risperidal at doses ranging from 1mg. to 7 mg. The akasthisia is so severe that she cannot sit still and cannot read or watch television. This condition has continued for over two years after she was tapered off the medication. I have seen serious adverse effects from all of the "atypicals" that have been marketed, including ziprasidone (Geodon) and aripiprazole (Abilify). There is clear evidence that a significant number of patients taking clozapine (Clozaril), olanzapine (Zyprexa) and quetapine (Seroquel) have developed elevated levels of cholesterol and triglycerides, which put them at increased risk of cardiac disease, and a significant number of patients on these three medications have developed diabetes mellitus.

The drug companies are marketing the "atypicals" more intensely than the neuroleptics were marketed, and are trying to minimize the frequency and severity of these adverse effects. There is a real danger that the tragic mistakes made with neuroleptics are being repeated with the "atypicals".

Many patients who go through acute emotional crises, including psychotic episodes, are reacting to current and/or past experiences of emotional trauma. They may need to cope initially with their emotional distress by dissociation or denial, or other extreme defenses, but they need to share their painful experiences with someone in order to integrate their traumatic experiences, and the feelings aroused by these experiences. The emotion blocking effects of medication work against the potentially healing process of therapy.

A large number of studies have been published documenting the high incidence of sexual, physical and emotional abuse, and neglect, in patients diagnosed with severe psychiatric disorders, including psychoses.[20] Most of these psychotic patients (and many non-psychotic patients) are treated with high doses of medication and are not given an opportunity to talk about their experiences of abuse and neglect. I see many patients in my practice who carry diagnoses of schizophrenia, schizoaffective disorder, bipolar disorder or major depressive disorder with psychotic features (often more than one of these diagnoses at various times) who have been treated for years with high doses of neuroleptics and other medications, and "supportive" therapy, but have never before told anyone about their experiences of abuse, neglect or other traumatic experiences.

The *DSMIV*[21] reinforces avoidance of discussion of traumatic experiences by its emphasis on description, symptoms and co-morbidity. Post-traumatic Stress Disorder (PTSD) is one of only a few etiology based diagnoses in the *DSMIV*, other than obviously physically-chemically based diagnoses like dementia and substance related disorders. Though the *DSMIV* lists hallucinations, and other severe disturbances of perception, cognition, affect and behavior as possible symptoms of PTSD, this diagnosis is narrowly defined and most patients with psychotic symptoms are excluded from a PTSD diagnosis. The growing literature about the possible causative role of trauma and abuse in the development of psychotic symptoms should help raise consciousness of the importance of looking more carefully for a history of trauma in our patient's lives.[22]

We need to inform our fellow clinicians, patients and the public about the evidence already existing of the potentially devastating effects of the medications used for treating psychotic symptoms, including the "atypicals". We should initiate careful long-term studies of the adverse effects of "atypicals", and curtail their use until they have been proven safe. Where it is still possible, we should do placebo-controlled, evidence based studies comparing the efficacy of drug free treatments and drug treatments of psychosis. While such research is being done, we need to find the means to prevent the spread of biased research reports and misinformation to our fellow clinicians, students and the public. We must find a way to stop drug company money from controlling research and medical education. We need to put aside theoretical, interdisciplinary and other partisan disagreements, and join together in an effort to develop a viable, integrated biopsychosocial frame of reference which will establish a less reductionistic, more humane, treatment approach for all patients.

I would also like to see more attention given both in research and in treatment to the stress/trauma part of the stress/trauma/vulnerability approach. We should make people more aware of the high incidence of traumatic experiences, including abuse, in the lives of psychotic patients, as well as in other patients. I hope psychiatrists and other clinicians will stop telling patients, and their families, that there is something wrong with the brains of severely disturbed persons that requires medication to correct.

It is difficult to imagine these things actually happening, but my pessimism is tempered by the realization that I am talking at a gathering of people who share my concerns about the dangers of medication treatment and my belief that treatment without medication, psychotherapy, can be effective for our most disturbed patients. Since learning of the existence of this organization, I have felt more comfortable sharing with my colleagues

Continued on Page 10

Dangers of the Overuse of Medication, Continued

and my patients my view that we need to change our approach to treatment of psychotic persons. Thank you.

*Loren Mosher died on July 10, 2004.

References

1. Karon, B. P., & VanderBos, G. R. (1981). *Psychotherapy of Schizophrenia: The Treatment of Choice*. New York: Jason Aronson.

2. Mosher, L. R., (1978). "Community residential treatment for schizophrenia: two year follow-up." *Hospital and Community Psychiatry* 29:715-23.

3. Engel, G. L., (1980). "Clinical Applications of the Biopsychosocial Model", *The American Journal of Psychiatry*, 137: 5, 124-28.

4. Elsass, P., (1997). *Treating Victims of Torture and Violence: Theoretical, Cross Cultural and Clinical Implications*. New York: New York University Press.

5. Whitaker, R., (2002). *Mad in America: Bad Science, Bad Medicine and the Enduring Mistreatment of the Mentally Ill*. New York: Perseus Publishing.

6. Breggin, P. R. (1991). *Toxic Psychiatry: Why Therapy, Empathy, and Love Must Replace Drugs, Electroshock, and Biochemical Theories of the "New Psychiatry"*, New York: St. Martin's Press. See also, Breggin, P. and Cohen, D., (1999). *Your Drug May Be Your Problem: How and Why to Stop Taking Psychiatric Medications*. New York: Perseus Publishing.

7. Glenmullen, J. (2000). *Prozac Backlash*. New York: Simon and Schuster.

8. Angell, M. (2000). "Is Academic Medicine for Sale?", *The New England Journal of Medicine*, 342:20, 1516-18.

9. Bodenheimer, T. (2000). "Uneasy Alliance: Clinical Investigators and the Pharmaceutical Industry", *The New England Journal of Medicine*, 342: 20, 1539-44.

10. Breggin, P., (1991). *Toxic Psychiatry*. (see above).

11. Whitaker, R., (2002) *Mad in America*. (see above).

12. Crane, G. (1973). "Clinical Psychopharmacology in its 20th Year". *Science*. Vol. 181: 124-28.

13. Whitaker, R. (2002). *Mad in America*. (see above)

14. Breggin, P. (1991). *Toxic Psychiatry* (see above).

15. www.moshersoteria.com/litrev.htm.

16. McShane, R., et. al. (1997). "Do neuroleptic drugs hasten cognitive decline in dementia? Prospective study with necropsy follow-up". *British Medical Journal*, 314:266-70. Myslobodsky, M. S. (1986). "Anosognosia in Tardive Dyskinesia: Tardive Dysmentia or Tardive Dementia?". *Schizophrenia Bulletin*. 12: 1-6.

17. Breggin, P. and Cohen, D. (1999). *Your Drug May Be Your Problem*. (See above).

18. Whitaker, R. (2002). *Mad in America*. (see above).

19. Trosch, R. (2002). "Neurologic Complications of Psychiatric Medications". Paper presented at the Spring Scientific Meeting of the Minnesota Psychiatric Society (May 10, 2002).

20. See for example: Bryer, J. B., et. al. (1987). "Childhood Sexual and Physical Abuse as Factors in Adult Psychiatric Illness". *American Journal of Psychiatry*. 144:1426-1430; Muenzenmaier, K., et. al., (1993). "Childhood Abuse and Neglect Among Women Outpatients With Chronic Mental Illness", *Hospital and Community Psychiatry*. 44: 7, 666-70. Carmen, E. H., et. al.,(1984). "Victims of Violence and Psychiatric Illness". *American Journal of Psychiatry*. 141: 378-83. See also Read, J, Mosher, L. R., and Bentall, R. P. (Eds.), *Models of Madness*, for an extensive bibliography on this subject (pages 244-252).

21. *Diagnostic and Statistical Manual IV* (1988).

22. Read, J., et. al., (Eds.), (2004). *Models of Madness* (Chapter 16) "Childhood trauma, loss and stress", pages 223-252, (which includes an extensive bibliography on this subject).

In Search of Better Homes and Gardens

Jessica Arenella PhD

The house is dilapidated and at the edge of town. It was a small, shoddy place decades ago and the voracity of the termites was truly eviscerating. Some say it had been a bed and breakfast, maybe even a brothel. It became Arlene's home under unfortunate circumstances: she was born there. Arlene desperately reminds me that she never asked to be born. She wants to know why she never received an "instruction manual for this stupid life." Arlene's father never signed her birth certificate. He was drunk but not foolish enough to marry Arlene's mother, an outcast who was mentally and physically unwell. He bought them the house instead.

Growing up was hell for Arlene. She ran away from her erratic mother but when she was picked up and sent to residential treatment facilities she ran back home again. When Arlene was 21, her mother died and she moved back into the house alone. The house, like the family, had fallen even further into a state of disintegration. Arlene's father gutted the house so that it could be renovated. But his alcoholism, gambling and physical deterioration prevented the completion of repairs.

Arlene lives in this fragmented home, torn down but never rebuilt. The bathtub is the only source of running water and the oven doesn't work. The freezer is completely frosted over and dust and mold proliferate. It is too much trouble to cook. Besides, she complains, "the produce is lame, the meat is rotten and the grocery stores are too expensive." There is old dirty furniture and artifacts from her dead mother and childhood shoved into old closets whose ceilings threaten to cave. Passersby often mistake the home for an abandoned building.

Arlene visits me weekly without fail, walking in rain and snow to deliver her despair and deadlock. After a few moments of silence she blandly states, "Well, I'm here," as if this is all either of us can expect from her. I must remain open to the impact of this communication in order to be present. I must remain alive while feeling the gravity of her deprivation, threatening to crush me as it flattens her into what she calls "total boredom." I watch myself watching the minutes of the session tick away.

I start to slip and reach for omnipotent fantasies to sustain the hour. I wish I were Oprah Winfrey; she is always "making over" people's lives, buying them cars or sending them to college. There's a friend of the family who buys and renovates houses, maybe he'd do me a favor. Remember Miracle on 34th Street when it turns out that Santa Claus is real and the cynical little girl gets her dream house!

Arlene wants an education, a job, a boyfriend, decent food and clothes. But does she? Can her fragile, envious, enraged and terrified self withstand contact with this unpredictable and unfair world? All of these things are now beyond the "fortress of her solitude." I try to scale the walls, feeling for footholds, for a crumbling cinderblock that I might gently loosen. But she tolerates so very little. She yells at me if I suggest going to the public library or to the park to break the monotony of staring out the window all day. The park is too dangerous. She can't think about taking free classes at the library because she has to "deal with the house" and there are "too many things to do." She remains ensconced in her dangerously decaying home, unable to fathom a way out. In fact she may be unable to think at all, stuck in a sort of mindless state without the capacity for objectivity or reflection.

Arlene's path is a rigid and reactive one. The telephone stopped working, but she can only handle one call to the phone company to get it repaired. Anyway, the weather is too crummy for her to stand at a pay phone today. And yesterday the weather was too nice for her to waste her time with this problem. I offer to let her use my telephone, but the suggestion is lost in her indignation. Arlene slips into her own malevolent fantasy world. She loosely weaves a conspiracy theory about the telephone company and the government. "Uncle Sham" is screwing her just like her mother and her father have. Maybe someone is trying to scare her out of the house. Maybe Islamist terrorists or drug addicts are trying to invade the building.

Connections, both to others and to her own desires, have never been securely developed. She cannot take me in as a loving object but she doesn't abandon me altogether. Instead, she keeps me in a "peculiar half alive state" (Bell, 2005), needing my presence so that she can replay the incompetent and ill-conceived parenting that she received. I am limited in what I can say in the sessions. When I comment on her sadness, fear, and loneliness, she returns to the concrete problems of the house. She cannot bear the experience of depression. When I address practical issues, I am lambasted for my failure to appreciate the paranoid anxiety that paralyzes her. When I focus on the dilemma at hand, she says she doesn't know what to do except wait for a solution to come to her. We are at an impasse. Steiner (1987) refers to this insidious development as a "pathological organization" that emerges when neither the depressive nor the paranoid-schizoid positions can be tolerated.

Rosenfeld (1987/2002) writes that a severely disturbed patient often expects the therapist to share the terrifying experiences she or he has endured and that the force of this expectation becomes a demanding, "painful and difficult situation" for the therapist. Yet, he warns that it is better for the clinician to "err on the side of providing a corrective experience" lest an "anti-therapeutic" response should recur. Some days I feel like a fool doing this ramshackle therapy, speaking gingerly when the whole damn structure is fractured beyond repair. Her house is collapsing and my words will never be enough to keep Arlene safe. She is scared and stubborn and won't move. I try to imagine myself as a compassionate and cosmopolitan Sherpa helping Arlene navigate her way toward relatedness. But how can I expect her to trust an emotional guide who can't even provide her a shelter? Well, "I'm here," in my office, the place that houses our relationship.

References

Bell, D. (2005). Quotation from an unpublished paper presented at the New Directions in Psychoanalytic Thinking Conference at the Washington Psychoanalytic Society, April 29, 2005.

Lethem, J. (2003). *The Fortress of Solitude*. New York: Vintage Press.

Rosenfeld, H. (1987/2002). *Impasse and Interpretation*. New York and London: Brunner/Routledge.

Steiner, J. (1987). The interplay between pathological organizations and the paranoid-schizoid and depressive positions. *The International Journal of Psychoanalysis*, 68, (69-80).

Column: Mind and Brain

Genetics and Genomics in Contemporary Psychiatry

Brian Koehler, PhD

The following is an attempt to elucidate current neurogenetic paradigms in order to have a deeper understanding of the complexities involved in the pathways from susceptibility genes to the complicated phenotypes of psychiatric disorders. In addition, it is my hope that the scientific weaknesses of neurogenetic reductionism will be more readily apparent. Bolton and Hill (1996) noted that intentionality (beliefs, goal-directed plans, fears, etc.) pervades biological systems to the molecular level (see their *Mind, Meaning, and Mental Disorder: The Nature of Causal Explanation in Psychology and Psychiatry*. NY: Oxford University Press). This is borne out in neuroscience research in which psychogenic stress was genotoxic in various body cells. Fishman and colleagues (1996) reporting in the *International Journal of Neuroscience* noted that in rats behavioral/psychogenic stress can result in DNA damage and chromosome aberrations. They noted: "behavioral stress can induce genotoxic damage on at least two levels, chromosomal and molecular, and in at least two cell types, bone marrow and leukocytes" (p. 224).

Simply phrased, there is no single genetic switch that when turned on causes a specific psychiatric disorder. It is accepted by many neurogenetic researchers that that there is not sufficient information in the entire human genome to explain the

Continued on Page 12

Genetics and Genomics, Continued

information content of neuronal connections in the adult human brain, and that psychiatric disorders are complex adaptive systems that are multidimensional and mutifactorial in their origins and non-linearly interactive in their development.

The source of the information in this review of genetics is primarily contained in Kenneth Kendler's (2005) "Psychiatric genetics: A methodological critique" which is to be found in Andreasen, N. C. (Ed.) (2005). *Research Advances in Genetics and Genomics: Implications for Psychiatry*. Washington, DC: American Psychiatric Publishing, Inc.

Four Genetic Paradigms

Paradigm I-Basic Genetic Epidemiology

The goal of basic genetic epidemiology is to quantify the degree which individual differences in risk ("liability") to illness result from familial effects or genetic factors (as determined by twin or adoption studies). In twin studies, the task of basic genetic epidemiology is to estimate the proportion of liability in a given population due to genetic differences between individuals. This proportion is called heritability.

Paradigm II-Advanced Genetic Epidemiology

Once there is an indication of significant heritability, the goal of advanced genetic epidemiology is to explore and understand the nature and mode of action of these genetic factors. In both basic and advanced genetic epidemiological research paradigms, genetic risk factors are inferred, through the use of statistical methods, from the patterns of resemblance among particular classes of relatives such as monozygotic versus dyzygotic twins, and not directly measured.

Paradigm III-Gene Finding

The goal of gene finding methods is to determine the locations on the genome ("loci") of genes variation, which influence liability to psychiatric disorders. Molecular methods are used for detecting the genetic variants ("markers"), but gene finding methods are statistical in nature. By observing the distribution of genetic markers within families or populations, these methods (linkage and/or association) infer the probability that a locus in the genomic region under investigation contributes to disease liability. Furthermore, the goal is to clarify the history of the pathogenetic variant or variants in the susceptibility gene by determining the background pieces of DNA ("haplotypes") on which these variants are found.

Paradigm IV-Molecular Genetics

The goal of the molecular genetic paradigm in psychiatric genetics is to trace the biological processes by which the DNA variant identified with gene finding methods contributes to the disorder itself. The primary and most critical goal is to identify the change in gene function and/or expression resulting from the identified DNA variant. The more complex goal involves the use of a wide range of methods (molecular, pharmacological, neuroimaging, neuropsychological) to trace, at a biological level, the etiological pathways from the DNA variant to the abnormal neural/psychic functioning that characterizes the disorder.

Basic genetic epidemiology has the following critical limitations:

- The goal of science is conceived to be the elucidation of causal processes. The basic genetic epidemiological paradigm is fundamentally descriptive in nature. The latter method quantifies the importance of genetic risk factors, it does not provide insight into causal or explanatory pathways.
- Heritability estimates apply to populations and not to individuals. The heritability of a disorder in an individual is undefined.
- In a defined population with a particular set of genes, the heritability of a disorder is not immutable and would be altered by the introduction of new sources of environmental risk. Therefore, the magnitude of heritability of a disorder is not solely a result of gene action, rather, it is a ratio of the variance in risk in a population due to genetic differences between individuals and the total variance of risk in that population. Heritability does not designate a characteristic of a disorder but only of a disorder in a given population at a specific time.
- The liability-threshold model that underlies most genetic epidemiological studies is biologically nonspecific and divorced from actual genetic processes.

The methodology of advanced genetic epidemiology offers only partial reductive explanations involving several adjacent levels of a complex causal chain. These causal explanations cannot reach the level of genetic/biological processes, e.g., DNA base-pair variation.

Although gene finding methods are based solidly on meiosis, e.g., gene recombination and segregation, and are more specific and informative than those of basic genetic epidemiology, they also have their limitations. As with heritability calculations, the statistical methods for gene localization do not directly reflect gene action, rather, they assess the ratio of genetic to total variance in liability. This means, for example, the evidence for linkage in a family would vary as a function of the strength and frequency of the environmental risk factors to which its members have been exposed. Susceptibility genes are difficult to localize, many tests have to be performed for detection to be realized. Positive results from gene finding methods are statistically less reliable than results from basic genetic epidemiological studies.

Molecular genetics raise the possibility of a reductive biological explanation that would describe the causal chain from molecular variation in DNA to the manifestations of psychiatric disorders. Molecular genetics, unlike the other genetic paradigms, are not fundamentally statistical in nature. However, there are significant practical problems which obstruct the elucidation of the very complex biological pathways from DNA variation to psychiatric disorders. Individual genetic variants which cause classic genetic diseases are usually easy to detect because they reflect alterations in coding for key amino acids or the destruction of well-defined regulatory sequences. The DNA variants which may predispose to complex psychiatric disorders may be very subtle in their effects and more difficult to detect. Molecular genetic studies of psychiatric illnesses need to be concerned about the details as to how disease risk emerges from interactions between genetically controlled biological processes and environmentally induced changes in brain function and structure, e.g., the neural effects of early abuse, neglect, isolation, etc.

Selective Review of Current Status of the Four Genetic Paradigms

Basic Genetic Epidemiology

Heritability estimates differ significantly between disorders, but a growing body of research implicates genetic factors as being important in all of the major psychiatric disorders. However, there is no way within this level of research to differentiate nongenomic from genomic pathways of heritability (e.g., epigenetics).

Advanced Genetic Epidemiology

A number of twin and adoption studies (e.g., Tienari et al in Finland) have provided evidence for the importance of gene-environment interactions (demonstrating genetic control of sensitivity to the environment or environmental control of gene expression). Genetic risk factors may moderate the pathogenic effects of environmental risk factors. Genetic risk factors probably do not map very well onto DSM or ICD categories of mental/psychiatric disorders. Environmental risk factors such as isolation and lack of social support, can be influenced by genetic factors. Genetic risk factors may influence susceptibility to psychiatric disorders in part by altering the probability of exposure to certain environmental stressors. Gender effects may also be important.

Gene Finding

Recent research reviews have documented what many suspected-a substantial proportion of positive results in gene association studies for complex psychiatric disorders, e.g., schizophrenia and bipolar disorder, do not survive the test of replication. Kendler (2005) notes what I think is a very important point: that whole genome linkage scans fail to corroborate the more robust findings of basic genetic epidemiological studies such as those comparing monozygotic and dyzogotic twin pairs. Rather than assume it is a problem of needing further refinement and technological development in the former (although it may very well be this is the key factor), I believe that there are sources of error variance and bias permeating the twin research which researchers have failed to address, e.g., the neuropathological effects of prenatal stress, the role of a common blood supply for a majority of MZ twins (chorionic factor), epigenetic factors, the actual psychosocial experience of being an identical twin, etc. Kendler noted:

> Whole genome scans have been reported for many psychiatric and substance use disorders, including schizophrenia, bipolar disorder, alcoholism, autism, attention deficit hyperactivity disorder, bulimia, panic disorder, nicotine dependence, and major depression. A sufficient number of linkage studies of schizophrenia and bipolar illness have been conducted to show the rate of replication of positive regions across studies has been low. This pattern contrasts strikingly with the high level of consistency seen in the results of basic genetic epidemiological studies–for example, the results of twin and family studies of schizophrenia (p.14).

Positional candidate gene strategies have recently appeared in which association methods are applied to genomic regions identified through linkage results. Variants in several genes, and their replication, have been observed to affect risk for schizophrenia using these methods.

Molecular Genetics

In the last year, we have seen the first viable effort to trace the biological pathways from potential susceptibility genes to psychiatric phenotypes. Mice were developed in which neuregulin 1, a recently identified potential susceptibility gene for schizophrenia, was rendered nonfunctional ("knocked out"). These mice demonstrated reduced expression of N-methyl-D-aspartic acid receptors and abnormalities in prepulse inhibition (PPI)–a neuropsychological feature found in persons with schizophrenia (as I pointed out in previous papers PPI is also associated with rats being raised in social isolation).

Interrelationships Between the Four Paradigms

The crux of the problem is the relationship between genetic risk factors as defined by genetic epidemiological studies and susceptibility genes as defined by gene identification methods. The crucial question is as follows: do genetic risk factors reduce to susceptibility genes? This question can be addressed on two different levels with divergent answers. On a theoretical level, the results of twin and adoption studies should reflect the distal effects of genetic variation coded in DNA. From this perspective, genetic risk factors are nothing more than signals of susceptibility genes. However, at the practical level, the answer to the question is ambiguous in two important ways. First, it is reasonable to assume whether it will ever be possible, regardless of technological advances, to trace a clear and unambiguous complete set of causal links from DNA base-pair variation to complex psychiatric disorders such as schizophrenia or bipolar disorder. Kendler (2005) cogently, and to his credit, noted:

> The problems of psychiatric illness, involving some of the most complex conceivable questions, including questions of consciousness, self-concept, and reality testing, may involve emergent properties that are not predictable from basic biological phenomena such as DNA variation (p. 16).

Competing Paradigms

The hope of many geneticists is that instead of having to infer genetic risk factors from patterns of resemblance across relatives, as is done in genetic epidemiological research, it may become possible to measure directly all relevant variants within susceptibility genes and to combine this information with relevant environmental exposures to determine individual liability. However, if ever achievable, this is a long way off and therefore, the field of psychiatric genetics needs to work towards an integration of findings from many domains of scientific inquiry, including developmental psychobiology and psychopathology, and from my perspective, the findings which emerge from the long-term immersion involved in the psychotherapeutic/psychoanalytic situation.

Psychiatric Genetics and Reductive Models for Psychopathology

Kendler (2005) highlighted the broader discussion about the relative value of 'hard' reductive models in psychiatry and what he termed "explanatory pluralism." He notes:

> With the remarkable advances in neuroscience and molecular biology, an increasingly common view within

Continued on Page 14

Genetics and Genomics, Continued

> psychiatry, and especially biological psychiatry, is that the only valid etiologic models for psychiatric disorders are in basic biological or molecular terms. By contrast, advocates of explanatory pluralism would argue that our ignorance about the underlying causes of psychiatric illness is so profound that we are not in a position to be so selective about the origins of our knowledge. We should not reject, they would argue, partial etiologic explanations, even when they are expressed in nonbiological terms [I would understand attachments and interpersonal relationships as part of human biology]. They would see this kind of patchy reduction to be a much more realistic goal than a complete top-to-bottom hard reductive model (pp. 19-20).

Whatever we discover about the role of genetics and epigenetics (in which the environment can play a significant role), there is robust research data demonstrating the role of the social environment, not only in the course and outcome of the schizophrenic disorders, but in their initiation as well (see Jane Boydell, Jim van Os and Robin Murray's "Is there a role for social factors in a comprehensive developmental model for schizophrenia?" in *Neurodevelopment and Schizophrenia* edited by Matcheri Keshavan, James Kennedy and Robin Murray in 2004 for Cambridge University Press).

Brian Koehler, PhD
New York University
80 East 11th Street #339
New York NY 10003
212.533.5687
brian_koehler@psychoanalysis.net

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

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

Deadline: November 30, 2005

Newsletter Editor: Brian Koehler, PhD
brian_koehler@psychoanalysis.net
212-533-5687

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

Transmigrations

Catherine Penney, RN

How lonely it is when the noises stop,
When the sword of silence cuts through the tumultuous frenzy
Of voices that once were.
Now, new voices must be permitted to live and thrive
Where once only cacophonous sounds ruled the mind's inner domain.
Though laid to rest and given proper burial,
There is no guarantee that an eternal sleep will quiet the ancient ones.

For the silence brings with it new fears and torments.
If I am not careful, I will lose the battle
And resurrect the demon mind which held me for so long in bondage.
Death, it seems, appears to be the only answer.
Although I have died many times before.
And with each corridor of the mind that gives up its ghost,
The body crumples and folds awaiting its final rest.

In the anguished waiting the soul is seized by a light,
Seen only by the inner eye.
The flame of hope that agitates
And fuels its ambivalent state of despair.
The old self dying
The new self fighting
To make its existence known.

Voices from a distant past tell me to have faith–
In the seed brought forth from this light,
Whose nature it is to grow and flourish
Birthed deep within the midnight soil
Baked and bathed by sunlight and rain
Nurtured by darkness and shadows
That once engulfed its interior terrain,
Now enhances the quickening.

And through labors toil
Is born a soul clothed in regal attire.
This, I know, is who we truly are.
Born not of sin but of majesty.
And this is where I begin again,
Having sloughed off many skins from many times past,
Eons ago.

I somehow recall and remember it all
That here in the present–in the eternal now,
Is where resurrection of the self takes place.
Where the soul, weary and forlorn, can cry out for nourishment
Be heard and filled.

Where knowledge and wisdom gained from pain and terrors of past hells–
And short glimpses of heaven,

Are seen not as external manifestations, grandiose delusions of the seer,
But as mystical visions of one who has found the truth of paradise within.

For this, the legacy of madness which visited my youth has not been a shame,
The rape of innocence
The scourging of spirit
A dark night of the soul for which there seemed to be no beginning nor end,
Can be let go
Can be surrendered.

And as water was once changed into wine,
So the soul transformed emerges,
Out of the ashes of its former self.
Leaving behind a primitive world–
That once served it well,
But no longer has a reason for being.

Leaving the Monastery

Catherine Penney, RN

Leaving the monastery lane
out to the new road winding
among the fresh oblivious houses
in the former fields. Lawns and driveways scabbing over
the backhoe's wounds.

I had come out
to see what (if any) birds still lived in the fragments
of woods too marshy to be built on.

In cold bright sunlight
aware of the proud houses but not wanting
really to be among them
I let myself be drawn instead
to the unexpected barn
derelict but dignified, its silvered boards still straight and true
the way my frail old father stood
nearly to the end
knowing his mortality yet honoring his life and the world around him
by his dignified bearing.

Inside all was ruin, of course:
thick mud afoot, stalls collapsed
worn tools about.
Still, old presences seemed there—
the breathing warmth and heft of cows
chickens' nervous searching, heads cocked, bright eyes intent.
Perhaps even the farmer's ghost.

And coming out again in the bright light
I felt the sadness of good things lost
the quiet death unobserved, unmourned.
What was happening here?
This life and all it held and said
was gone now,
nearly replaced by the different life
of these eyeless houses
in rows behind the barn.

The Window

Catherine Penney, RN

There exists within the soul of man, within the torment of insanity, that tries the human mind and lays to waste his humanity - a window.
It is a window wherein the light can glow and illumine the darkened wasteland,
Thus making barren deserts green, fertilizing the entire self,
planting the seed of awareness wherein blossoms the flower of hope,
And grows the tree of understanding,
Thus paving the way for transcendence and enlightenment,
And grateful acceptance of the path that life's journey has chosen for the humble spirit, a once fearfully tormented soul.
No matter how lost, forsaken, physically or mentally incapacitated a person may appear, they have within them a window that is still intact.
It is to this window that I direct all my attention and love,
Allowing for a light more radiant than the world knows of to shine.

Morning Song

Catherine Penney, RN

I have ventured toward the light of a thousand dawns
And plunged the depths of night-time's eternal raging seas.
The hallowed shores of destiny's sweet embrace
Have thrown me into savage places
As well as have lifted me up into the most loftiest of heights,
Where heaven and hell intermingle
Dissolving into foggy mists.
And fierce fire-breathing dragons
Adorned with angels wings
Whisper songs of enchantment,
Enticing me into the lands that have no voice
So therefore cannot sing.

Today I saw a white breasted bird
Sail across the gray ocean sky.
And oh, thought I,
What sweet beautiful music there is–
In uninhibited flight.

In Memory of Loren Mosher, M.D.

Julie Kipp, LCSW Secretary, ISPS-US
julie_kipp@psychoanalysis.net

Loren Mosher, long time ISPS contributor and member of ISPS-US, died last summer of liver disease in Germany. He was 70 years of age.

Dr. Mosher served as the first chief of the Center for Studies of Schizophrenia at NIMH from 1968 to 1980. While there he founded and edited the prominent journal *Schizophrenia Bulletin*. However the heart and soul of his career was the innovative Soteria House, and the communities which grew out of Soteria in the United States and around the world.

After graduating with honors from Harvard Medical School, Dr. Mosher spent a year in Great Britain at the Maudsley and the Tavistock, and was a regular visitor to R. D. Laing's Kingsley Hall. He was fascinated by what he saw at Laing's experimental community of psychiatric patients and mental health professionals. However, he was critical of the rundown, dirty conditions and the lack of structure, even in basics like the provision of meals. He also saw that the voluntary nature of the professionals' participation resulted in less attention being given to less attractive patients.

When Dr. Mosher returned to the US he tried his ideas out, first on an inpatient ward in Connecticut. However, soon he returned to his native California, where he set up the first of the Soteria projects in San Jose. Soteria House was a small residential treatment program for first break young adults. No neuroleptic medications were used, unless patients were suicidal or homicidal, or did not show improvement by six weeks. Six "residents," as they were called, lived with six paraprofessional staff, two of whom were on duty at a time in 36 to 48 hour shifts. There were few rules: no street drugs, no violence. The job of the staff was to live with the residents, and do so in as normal a way as possible.

The results were impressive, and were first presented at the 1972 ISPS symposium in Turku, Finland. Dr. Mosher did careful research, including comparison to a hospitalized and medicated control group, and a two year follow-up study. Soteria residents did better at six weeks, and were more likely to be working and living independently two years later. And Soteria treatment was less expensive than hospitalization. Other sites, including Emanon in the Bay Area, Crossing Place and McAuliffe House in the Washington, D.C. area, and Soteria Berne in Switzerland resulted in continuing research.

Unfortunately, this promising psychosocial approach to treatment of first break schizophrenia has remained outside the mainstream of psychiatric practice. Dr. Mosher's findings called into question the necessity of neuroleptic medication for first break patients, and highlighted the benefits of using almost entirely paraprofessional staff to treat the patients. He was a "contrarian psychiatrist," as the *Washington Post* obituary called him, and not one to soft pedal the implications of his research. His 1998 resignation from the American Psychiatric Association in protest of that organization's "unholy alliance" with "Big Pharma," the pharmaceutical industry, was in no way subtle or conciliatory.

In fact Dr. Mosher could be downright feisty and irritable even with those of us who were on his side. Some of us witnessed - and regretted - his salty departure from our ISPS-US listserve about two years ago. He seemed to enjoy a good fight. While I am as fascinated by his work as he was by Laing's Kingsley Hall 35 years ago, I have to wonder whether he relished his outsider status, or rather had become embittered by the lack of institutional respect for his wonderful achievement. Would a more diplomatic innovator have garnered more support for Soteria, or are the combined forces of Big Pharma and the psychiatric establishment just too overpowering a Goliath to stand up against? Unfortunately, it's a relevant question for our organization, and for each of us in ISPS-US.

Online information on Loren Mosher:

www.moshersoteria.com - His website includes his bibliography, the whole text of many articles by and about Mosher and Soteria, a short movie about the original Soteria House, and his letter of resignation from APA.

Obituaries: (search for Loren Mosher)
The British Medical Journal bmj.bmjjournals.com;
The Guardian www.guardian.co.uk
The Washington Post www.washingtonpost.com
The New York Times www.nytimes.com

News from Local Branches of ISPS-US

California–Northern

Matthew Morrissey, MA
matthew@gsphc.net 415-986-5231

First Meeting: Open to the general public
WHEN: Thursday September 8, 6 PM to 8 PM
WHERE: Golden State Psychological Health Center
100 North Point St., San Francisco, CA 94117
Food and drink will be provided.
PRESENTER: Walter Stone, MD, clinical professor of psychiatry at UCSF and noted authority on psychodynamic group therapy. Dr. Stone's presentation is entitled: "Process In the Therapist Leaving a Long-Term Group of Patients Diagnosed With Schizophrenia."
IMPORTANT: If you will be attending, kindly RSVP (so we know how much food to get) to Matthew Morrissey at matthew@gsphc.net or 415.986-5231.
DIRECTIONS: 100 North Point is right near Pier 39 @ Fisherman's Wharf. We are between Grant & Stockton, right off the Embarcadero. From BART or Muni: get to Embarcadero station. Then head upstairs to the Ferry building and catch the F line towards Fisherman's Wharf. Get off at the Aquarium stop. Cross over Embarcadero and go down Grant St. Take a right on North Point.

California–Southern

Martin Cosgro, PhD
mcosgro@charter.net 805-547-0419

You are cordially invited to the first meeting of The Southern California Branch of ISPS-US.
WHEN: Sunday, September 18, 2005, 1:00- 3:30 p.m.
SPEAKERS: Daniel Dorman, MD and Catherine Penney, RN will be presenting *Dante's Cure: A Journey Out of Madness*.; 2003, Other Press, L.L.C.
LOCATION: Acapulco's Restaurant
385 N. La Cienega Blvd., West Hollywood
Los Angeles, CA 90048
(310) 659-6831

DIRECTIONS :
Driving from Downtown L.A. on the 10 Freeway:
Take the I-10 toward SANTA MONICA - go 5.8 mi.
Take exit #7A/VENICE BLVD onto CADILLAC AVE toward LA CIENEGA BLVD - go 0.6 mi
Turn on LA CIENEGA BLVD - go 2.7 mi to 385 N LA CIENEGA BLVD, WEST HOLLYWOOD

We will be in a private banquet room in the restaurant, ask for Mary or Marty. ***Lunch is dutch treat.
Contact Mary for any questions at 714-504-8840.

Chicago

Garry Prouty, DSc
JProutyB@aol.com

David Garfield, after several terms has stepped down as president of Chicago Branch of ISPS-US.

Garry Prouty, D.Sc. was elected president for a year long term. Programming for our members has been scheduled for approximately every six weeks. Programs have been scheduled about mirror neurons, the psychoanalytic thought of Melanie Klein and the theory and practice of Lacan. In September, Dr. Judith Trytten will present her dissertation on cognitive research with schizophrenics. An effort is made to keep programming eclectic.

Dr. Prouty has made a recruitment speech for graduate students at Reed Mental Health Center in Chicago. Dr. Shiela Curren made CEU arrangements for psychologists, counselors and social workers. Dr. Charles Turk has coordinated our group with the Chicago Lacan study group. Dr. Prouty is suggesting a possible joint meeting with the Michigan ISPS-US branch. Dr. Curren will become president at the end of 2005. Our current focus is on recruitment and a more active membership.

Michigan

Patricia L. Gibbs, PhD
patricialgibbs@aol.com

The ISPS-US Michigan Branch now has nine individual members, and one organizational member. The Branch does not hold meetings or charge Branch dues, but acts as a coordinating and referral network for ISPS-US members, and other Michigan professionals. The ISPS-US members are active in their local communities, the ISPS-US e-mail list, and the ISPS-US Annual Conference, supporting the mission to promote humane, psychological treatments of schizophrenic and psychotic individuals.

The organizational member, The Academy for the Study of the Psychoanalytic Arts, is located in Ann Arbor, and hosts professional presentations related to ISPS-US's mission. Patricia L Gibbs, Ph.D., in Dearborn, teaches candidates and psychotherapy students at the Michigan Psychoanalytic Institute, and spoke on the life and work of Sylvia Plath at MPI's study of the film *Sylvia* in March 2005. Patrick Kavanaugh, Ph.D., in Farmington Hills, has presented papers on ethics, theory and practice, and psychoanalytic education at the International Federation of Psychoanalytic Education, Roehampton University in London, Division 39 Spring Meetings, and the Northwest Center for Psychoanalysis in Seattle. His paper on ethics will be published in the August 2005 issue of *The Psychoanalytic Review.* Carol S. Jones, Ed.D., Effie Kokkinos, Ph.D., and Thomas W. Ross, Ed.D., ABPP, FAP, all practice in Kalamazoo. Bertram P. Karon, Ph.D., is a psychoanalyst in East Lansing, and teaches at Michigan State University. Elizabeth Waiess, Psy.D., is a psychologist and psychoanalyst in East Lansing. Mary Karon is an ISPS-US member in East Lansing. David Lundin is an ISPS-US member in Bloomfield Hills.

New England

Ron Abramson, MD
RonA976@aol.com

In its first year of existence, ISPS-US-New England has been evolving into a stable working group of about six committee members (many more on the mailing list) who meet monthly at the home of Max Day, MD. The aim was to develop an ongoing study group in the psychotherapy of psychoses that would enhance knowledge for all members and attract interest from other clinicians in the New England region.

In its first year, however, this chapter has been the steering committee for the planned national meeting of ISPS-US in November 2005. Planning for this has consumed all the time of this chapter and has had the effect of promoting its evolution into a cohesive working group. This has been an exciting process, and hopefully will provide momentum to continued growth after the meeting takes place.

New York City

Brian Koehler, PhD
brian_koehler@psychoanalysis.net 212-533-568

The New York Branch of ISPS-US continues to meet on a monthly basis (except for August) and has been doing so since 1997. We are co-sponsored by the New York University Postdoctoral Program in Psychotherapy and Psychoanalysis and meet in their conference room at 1 Washington Place (at the corner of Broadway), New York City on Saturday afternoons from 4:30-6:30pm. The group consists of clinicians and students from all of the mental health disciplines: clinical social work, psychiatry, psychiatric nursing, psychology and psychoanalysis.

In the past academic year we have had the following presentations: Marvin Hurvich PhD on annihilation anxieties; Zvi Lothane MD on Sabina Spielrein; Michael Vannoy Adams PhD on Jung and psychosis; Yuko Katsuta MD on her psychoanalytic psychotherapy with a Japanese adolescent with prodromal psychotic symptoms; Jessica Arenella PhD and Brian Koehler, PhD on auditory hallucinations in a person in psychoanalytic psychotherapy; Maurice Green MD on the psychotherapeutic and psychosocial treatment of persons with schizophrenia; and Brian Koehler PhD on a neuropsychoanalytic model of the schizophrenias. We also viewed a videotape of Murray Bowen MD, psychoanalytically trained family psychotherapist/theorist, interviewing a family with a member hospitalized at a state psychiatric facility because of her psychosis and suicidality. We will be hearing a presentation by Tom Federn LCSW on Ludwig Binswanger MD, and Scott Von PhD on Lacanian psychoanalysis and psychosis.

International Society for the Psychological Treatments of the Schizophrenias and Other Psychoses:

UNITED STATES CHAPTER

Seventh Annual Meeting: THE VALIDITY OF EXPERIENCE

Boston, Massachusetts--November 11-13, 2005

Holiday Inn Brookline • 1200 Beacon Street • Brookline, MA 02446 • (617) 277-1200

Hosted by ISPS-US New England

Cosponsored by:
Boston Psychoanalytic Society and Institute
Massachusetts Mental Health Center
In Affiliation with:
Dept. of Psychiatry, MetroWest Hospital

Keynote Speaker: George Atwood, Ph.D.

"The Experience of Personal Annihilation"

This year the seventh annual meeting of ISPS-US will be dedicated to exploring various approaches to understanding how people with psychoses experience their subjective personal universes and how they experience their disorders as well as their treatments. The experience of every patient is valid according to its own terms, as is the experience of the therapist. This symposium is dedicated to understanding that validity, and through this understanding, assisting these sufferers to recover from their disorders and to achieve adaptive, self-fulfilling lives.

ISPS-US is honored to have as our keynote speaker renowned author, teacher and clinician, George Atwood, Ph.D., Professor of Psychology at Rutgers University, whose writings concern the Intersubjective viewpoint in psychoanalysis. The varied conference program will contain presentations ranging from psychoanalytic and historical, to patient experiences, legal issues, research, therapeutic strategies, and dissociative disorders, among others. This will reflect the "broad tent" of orientations and interests of those involved with ISPS-US.

This program will interest psychologists, psychiatrists, social workers, nurses and other mental health professionals as well as members of the lay public interested in the psychoses.

Registration: Register online at **www.isps-us.org**, or contact ISPS-US to receive a registration form in the mail. **Register by September 15 and save!** Pre-registration must be received by **October 21**. On-site registration only after October 21.

Continuing Education: Credits will be available for physicians, psychologists, nurses, counselors and social workers. See registration form for details.

Hotel reservations: Contact Holiday Inn Brookline (617) 277-1200. Ask for the ISPS-US rate ($129/night single or double). **You must make your reservation by October 12 to receive this special low rate!**

For more information, contact ISPS-US:
P.O. Box 491 • Narberth, PA 19072 • USA
www.isps-us.org • contact@isps-us.org • (610) 308-4744
ISPS-US is a 501(c)(3) nonprofit organization.

Combined ISPS and ISPS-US Membership Application

(Please note: Local branches may assess additional dues.)

Name____Degree(s)__________________________
Address____
City__________________State_____Zip___________Country if not U.S.__________________________
Phone(s) (indicate if work or home & preferred number)______________________________Fax_______________
E-mail address____________________________________Web address___________________________
Institutional affiliation(s)____
Professional interests____
Join listserve: Yes:____No: ____ List in directory: Yes:____No:____ List on website: Yes:____No:_____
ISPS-US member who encouraged you to join (optional)______________________________________

Annual Dues:
___Mental health professionals (licenses allowing private practice): $60
___Institutional (include contact information and 100-word description of organization): $100
___All others: $30
Additional **tax-deductible** contribution: $_______
Total amount enclosed: $_______

Please make check payable to ISPS-US.
Send to: ISPS-US
P.O. Box 491
Narberth, PA 19072

Or join on the Web: **www.isps-us.org**
E-mail: contact@isps-us.org
Voicemail: 610-308-4744

ISPS-US is a 501(c)(3) nonprofit organization.

15TH ISPS SYMPOSIUM:

Global Views and Integrated Therapies

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

For more information, contact:
Dr. Manuel González de Chávez Menéndez
Chairman of the Organizing Committee
Chief of Psychiatric Service
General University Hospital “Gregorio Marañón”
c/ Ibiza no. 43 - 28009 Madrid. Spain

Phone + 34 91 586 81 32
Fax + 34 91 426 51 10
E-mail: mchavez.hgugm@salud.madrid.org
Website: www.ISPSMadrid2006.com

ISPS-US is proud to offer you a copy of the current issue of

The Journal of the American Academy of Psychoanalysis and Dynamic Psychiatry
Volume 31, Number 1, Spring 2003

Guest-edited by ISPS-US president, Ann-Louise S. Silver, M.D.
and Tor K. Larsen, M.D. of Norway

Special Issue: "The Schizophrenic Person and the Benefits of the Psychotherapies -- Seeking a PORT in the Storm."

Issue price: $10

Contact:

Ann-Louise S. Silver, M.D.
4966 Reedy Brook Lane
Columbia, MD 21044-1514

Phone: (410) 997-1751
Fax: (410) 730-0507
www.CAPsy.ws
asilver@psychoanalysis.net

ISPS-US
P.O. Box 491
Narberth, PA 19072

NONPROFIT ORG
U.S. POSTAGE
PAID
NARBERTH, PA
PERMIT NO. 5